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# Effects of two group approaches on life satisfaction and mood of older females in nursing homes

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*Wayne State University*

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**EFFECTS OF TWO GROUP APPROACHES ON LIFE SATISFACTION  
AND MOOD OF OLDER FEMALES IN NURSING HOMES**

by

**BEDE REDPATH RYAN**

**DISSERTATION**

Submitted to the Graduate School

of Wayne State University

Detroit, Michigan

in partial fulfillment of requirements

for the degree of

**DOCTOR OF PHILOSOPHY**

2011

MAJOR: COUNSELING

Approved by:

\_\_\_\_\_  
Advisor

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Date

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## DEDICATION

*This is dedicated to the four men in my life:  
Jack, Will, Patrick, and Peter.*

*Without your patience, support, and encouragement,  
My dream would not have been realized.*

*Without your kindness, laughter, and love,  
~ and all things boy related ~  
My life would not have been as enriched.*

*You have blessed me beyond treasure.*

*Thank you.*

*xxoo*

*Mum*

*This is also dedicated to my three sisters and two brothers:  
Charlie, Sharyn, Dale, Diane, and Pete.*

*I cannot imagine a single day without each and every one of you.  
Thank you for always being there.*

*xxoo*

*Bede*

*In Loving Memory of my Mother and Father,  
Madeline Mary Fusco and William Russell Redpath*



*The quality of (love) is not strain'd,  
It droppeth as the gentle rain from heaven  
Upon the place beneath:  
It is twice blest;  
It blesseth him that gives and him that takes.*

*~Apologies to Wm. Shakespeare  
The Merchant of Venice*

I have, indeed, been twice blest.



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Last, but not least: *Said Mrs. Browning, the poet, to Charles Kingsley, the novelist, “What is the secret of your life? Tell me, that I may make mine beautiful also.” Thinking a moment, the beloved old author replied, “I had a friend.”*

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## CHAPTER I

### INTRODUCTION

One of the most distinctive demographic events and one of the largest challenges facing the United States today, is population aging (United Nations [UN], 2009; Bongaarts, 2006). According to the United States Department of Health and Human Services, Administration on Aging [AoA] (2009a), approximately 38 million people, or 12.6% of the U.S. population are now aged 65 years, or older. In twenty years however, the number of adults' aged 65+ is projected to almost double, to 71.5 million people, or 20% of the U.S. population (AoA, 2009a). The increasing age, as well as the increasing strength in numbers of our older population, will have a profound effect on our society; not only on the overall demographic landscape of the United States, but more specifically, on the health and well-being of our older population (National Institute on Aging, National Institutes of Health [NIA-NIH], 2007).

#### *U.S. Aging Population*

According to the United States Bureau of the Census (2011), the resident population of the United States is approximately 311 million. These numbers include an approximate 78 million baby boomers: those born between the years 1946 and 1964 (Frey, 2007). As of January 2011, the oldest members of the baby boom generation started celebrating their 65<sup>th</sup> birthday; in turn, subsequent members will continue to reach this milestone at the rate of 7,900 per day (United States Bureau of the Census, 2011). Although increasing longevity can be viewed as an accomplishment to our society, the dynamic shift in our demographic landscape presents many challenges, according to Bongaarts (2006). One of the major challenges facing our society today, not only as our population ages, but also more specifically as our older population steadily increases, is the overall health and well-being of our older population (Bush, 2009). In addition,

according to Bush (2009), a more critical issue surrounding the health and well-being of our older population is the “corresponding increase in the number of older adults being evaluated and treated by mental health professionals” (p. 5). According to He, Sengupta, Velkoff, and DeBarros (2005), present among the many psychosocial and physical changes commonly associated, and found, within our older population, is the significant and often under-recognized (thus, undertreated) mood disturbance disorder: depression. Depressive symptoms, and other mental health concerns, especially in older adults, are often associated with personal experiences of grief, loss, residential changes, and social isolation (Bonnie & Wallace, 2003); however, because many mental health symptoms, in older adults, often coexist with a variety of other medical issues and symptoms, they are often mistakenly viewed as part of the normal aging process: hence, unrecognized and/or overlooked (Bush, 2009).

According to the National Institute of Mental Health (2008), an estimated 20% of Americans, age 65+, have either experienced some type of mental-health illness, or have exhibited symptoms of depression. In addition, depressive symptoms among those living in nursing home facilities increase to an estimated 25% of Americans, age 65+ (National Mental Health Association, 2003). As a result, focus, research, and data collected on the health and well-being of our older population, in general, should also include a focus and research on the mental health and well-being of our older population, as well.

### *Longevity and Gender-Specific Issues*

In addition to the general challenges associated with our ever-increasing aging population, gender-specific issues and challenges are also emerging; thus, highlighting the need for an increase in gender-specific research (National Research Council, 2001). For the past fifty-plus years, the combined strength and numbers of the baby boomer generation (both men and

women) has been the power and force behind numerous events and changes throughout the United States. However, as this generation continues to increase in age, as well as increase in numbers, critical gender-specific issues unfold. For example, as our older population increases in age, so does the mortality rate among one gender, the male population; thus creating a significant gender imbalance between the numbers of older females vs. males (Charnie, 2002). Correspondingly, as our population ages and eventually becomes predominantly more female, issues surrounding older women will also increase (Pirkl, 2009).

According to Shrestha (2006), a demographic specialist with the U.S. Domestic Social Policy Division, gender specific issues surrounding the sex structure of our population is a critical demographic consideration. For example, a study focusing on various behavioral issues of older adults (Centers for Disease Control and Prevention [CDC], 2008), revealed older women, age 65+, experienced (overall) more symptoms of mental health disorders than older men, age 65+; such as increased symptoms of mental distress (9.1% to 5.0%), increased lifetime depressive symptoms (19.1% to 11.7%), and increased symptoms of anxiety (16.1% compared to 9.2%). Consequently, a focus on female-specific issues will generate an increase in awareness, public health policy, and programs focusing on the health, mental health, and overall well-being of older women (CDC, 2008).

### *Living Environments*

Specialists in the field of environmental gerontology have long been aware of the impact and influence the built environment has on aging, health, life satisfaction, and overall quality of life (Wahl & Weisman, 2003; Gitlin, 2003; Krout & Wethington, 2003). The built environment “comprises urban design, land use, and the transportation system, and encompasses patterns of human activity within the physical environment” (Handy, Boarnet, Ewing, & Killingsworth,

2002, p. 65). According to Golant (2003), the issues between our aging population and our built environment are becoming some of the most examined and researched areas within the field of gerontology. Consequently, while Oswald and Wahl (2004) believe one's environment has the power to represent autonomy and identity, Rubinstein and de Medeiros (2005) see a correlation between home, identity, and well-being.

To many older adults, home is often the center of interaction and everyday living: it is the place where one grows, develops, and ages. According to Roush and Cox (2000), home is the place from where most people depart, and ultimately return, at the end of the day. As a result, home, or one's personal environment, has the ability to center one's life by allowing a person to feel rooted in a place, neighborhood, or community (Roush & Cox, 2000). Shenk, Kuwahara, and Zablotsky (2004) emphasize the concept of home and place through personal interactions and experiences shared and point out, what happens to most people throughout their lives most likely happens while living 'at home'. Consequently, as people age, their personal sense of belonging, connection, and purpose becomes increasingly associated with their living environment, home, or place (Shenk et al., 2004). However, although one's view, connection, or attachment of home or place varies, it is rarely one-dimensional (Rubinstein & de Medeiros, 2005).

As our population ages and decisions regarding personal living environments are faced, attachment and feelings toward one's home, environment, or place of living often increase. As a result, many older adults who are faced with the prospect of making household modifications or changes, or ultimately faced with making a permanent move (especially a move to a congregate facility), often experience a variety of feelings, emotions, and challenges. According to Lichtenberg, Kimbarow, Wall, Roth, and MacNeill (1998) and Oswald & Wahl (2004), although

there are many issues and variables associated with environmental change and relocation, the loss of connection, loss of independence, and the challenges of adjustment, are just three (of the many) factors which can adversely affect one's mood, well-being, and overall quality of life. From an environmental health perspective, Oswald and Wahl (2004) hypothesize a change in one's environment, such as relocation in later life, is often linked to adverse physical and mental health outcomes. Additional literature from environmental gerontologists supports the belief that negative outcomes, such as morbidity (illness) and mortality (death), increase as a result of residential relocation from conventional single-family homes to institutional environments (Golant, 2003; Parmelee, 1998). Consequently, interest and focus on the relationship between living environment and quality of life has been steadily increasing throughout areas of gerontology, environmental gerontology, and public health policy.

According to Wister (2005), the relationship between environment, health, and well-being is complex and multifaceted. For example, literature focusing on marginalized populations (such as older women) found a strong association between one's environment and morbidity/mortality rates. Consequently, the negative implications impacting our older population, in general, increase when combined with marginalized populations, such as older women.

If the increase in the number of older women continues to grow as projected, as well as the increase in the proportion of single women to married women, the natural consequences for the majority of older women will be the reality of living alone (Kaneda, 2006). Although today most older women (in the United States) prefer living independently, in their own home (or at least, in a familiar environment) for as long as possible (Pynoos, Caraviello, & Cicero, 2009), the reality remains: many single older women will potentially face decisions regarding home and

relocation; through reconsidering or reconfiguring their lifestyle, with an inclusion of outside help or with eventual relocation to a planned community, assisted-living facility, and/or a skilled nursing-home facility (Krout & Wethington, 2003; Wahl, 2003). As a result, female gender-specific research focusing on living environment should also include research on quality of life and mental health.

### *Life Satisfaction and Mood*

The variables of life satisfaction and mood are often studied in relation to older persons. According to Floyd, Haynes, and Doll (1992), satisfaction with one's life is often correlated to the condition of one's life. Consequently, life satisfaction becomes a critical variable to examine, especially as our society grows older and quality of life changes (Wynne & Groves, 1995).

*"Life satisfaction [emphasis added] refers to a cognitive, judgmental process"* (Diener, Emmons, Larsen, & Griffin, 1985, p. 71). Separate from material comfort however, the variable, life satisfaction, can be viewed as one's satisfaction or dissatisfaction with a cultural or intellectual condition (Buetell, 2006). Although, commonly used interchangeably with terms such as *quality of life* and/or *perceived quality of life*, life satisfaction can also be viewed as the level or degree to which a good life can be attained (Veenhoven, 1991; Veenhoven, 2000; Frisch, 2006). Over the past twenty years, various gerontologists have researched issues of life satisfaction, or quality of life, as it relates to one's environment, familiarity, happiness, autonomy, functional ability, and/or self-esteem (Kane, 2003; Frisch, 2006). Consequently, when older persons lose function, independence, or separated from their homes, familiar environment, and/or family and friends, personal life satisfaction can be negatively affected (Lichtenberg et al., 1998).

The term, mood, has been defined as a general attitude, prevailing emotion, and/or state or frame of mind (Mood, n.d.). According to Lichtenberg, et al., (1998), mood can be viewed in relation to one's positive and/or negative experiences in life. In a report focusing on the importance of mood studies, published by the National Research Council (2001), Kahneman, Diener, and Schwarz (1999) proposed the variable, mood, was significant enough to be listed under one of five conceptual levels, or measurements, for research on issues of life satisfaction and well-being. Additional research recommendations from the National Research Council (2001), include comparing the variables of life satisfaction and well-being with major life events; such as illness, retirement, and changes in lifestyle and activity. According to Wynne and Groves (1995), mood and life satisfaction are critical variables for older adults living in congregate facilities, for they are linked directly to one's quality of life (Shrestha, 2006; Wynne & Groves, 1995). Consequently, continued public policy and research in the field of gerontology should include a focus on the life satisfaction and mood of older adults.

### *Existential Approach to Counseling*

The existential approach to counseling is philosophical in nature, emphasizing a person's freedom to choose (Corey, 2005). It was born out of the beliefs of various existential philosophers such as Kierkegaard, Nietzsche, Heidegger, and Sartre (Yalom, 2005), who strived to define human existence, while at the same time, stressed individual responsibility. According to Corey, existential therapy can be seen as process of exploration while searching for value and meaning in life. Consequently, the existential approach to counseling offers participants and therapists alike, a collaborative, sensitive journey toward creating a life with meaning and purpose (Corey, 2005).

An existential approach implies faith, hope, or belief in the process, with *respect* central to the therapeutic relationship (Corey, 2005). Yalom (2005) regards existential therapy as a powerful approach when focusing on four ultimate concerns: death, freedom, existential isolation, and meaninglessness. In a 2003 qualitative analysis of the effects of a five-day intervention, Ventegodt et. al. (2004) identified the use of existential therapy as an efficient means of inducing a holistic state of healing and well-being. Consequently, although not effective in all situations, the existential approach to counseling, especially when utilized in a group, can offer those living in nursing home facilities the increased benefit of socialization along with the opportunity to explore self, meaning, and purpose (McDougall, 1995). According to Corey (2005), Dryden (2007), and van Deurzen (2002, 2007) existential therapy can enable group members to:

- Take stock of personal belief systems and values.
- Contemplate past, present, and future lives.
- Better understand or help make sense of conflicts and dilemmas.

The use of group therapy provides additional financial advantages, as well. With healthcare front and center in the news, issues of cost, effectiveness, and efficiency become highlighted. As a result of cutbacks and the high cost of insurance premiums, many areas of medicine and health care are critically impacted. Consequently, in the field of mental health, the group approach to therapy becomes a viable treatment of choice among many mental health practitioners (Gross, 2006).

The overall purpose of group counseling as opposed to individual counseling, according to Corey (2008), is to represent a “microcosm of the world in which participants live and function” (p. 218), while at the same time offer participants an opportunity to focus on four



(existential) human concerns: death, freedom, isolation, and meaninglessness (Yalom, 2005). Different from the purpose of group counseling, but equally important, is the therapeutic process, which is seen as a journey taken by participants, yet aided by the counseling therapist to help participants come to terms with their lives (Corey, 2005). Also, unlike one-on-one or individual counseling, group counseling offers participants a variety of unique opportunities and connections to facilitate acceptance, personal growth, and problem solving. According to Yalom (2005) these opportunities and connections occur through a variety of human experiences and while some are more complex than others, they are all interdependent (2005).

### *Group Art Therapy*

Art Therapy is the therapeutic use of making art (American Art Therapy Association [AATA], 2010). Although similar to other approaches grounded in both developmental and psychological theory, art therapy is unique in that it combines the resources of traditional psychotherapy with the creative process of art to help bring about hope, meaning, and change (AATA, 2010). Malchiodi (1999) maintains the practice of art therapy and the creative process has the ability to encourage personal growth, increase self-understanding, and assist in emotional renewal and atonement. Furthermore, unlike traditional mental health therapies, art therapy offers participants a unique, non-verbal, alternative means of communication and expression (AATA, 2010). Stephenson (2006), a registered art therapist in New York City, considers the use of art therapy, as well as the process of making art, to be a positive influence on the mental health, well-being, and self-esteem of older adults. During her professional experience, Stephenson witnessed the energy and exhilaration of art therapy, and its ability to empower older adults, by tapping into their strengths and interests. Furthermore, according to Rubin (1999), the use of art therapy in combination with a group approach, offers the additional benefits of

socialization, support, and connection; thus, an overall increase in mood, satisfaction, and quality of life.

In an experimental study of an art therapy treatment group and general activity of volunteer participants with dementia, Rusted, Sheppard, and Waller (2006) evaluated the effects of art therapy participation on changes in mood and cognition. The results showed significant positive changes for participants in the art therapy groups, on measures of mental acuity, physical involvement, calmness, and sociability. Although it was reported positive changes were also found in the activity groups, the improvements were limited. Consequently, according to Rusted et al., the art therapy treatment provided a more pronounced and durable positive effect over time (p. 519).

In the mid-20<sup>th</sup> century, Margaret Naumburg, Edith Kramer, Hanna Kwiatkowska, and Elinor Ulman used the term ‘art therapy’ to refer to their work (Malchiodi, 2003). Although all four women are considered pioneers in the field of art therapy, Naumburg, who looked at the art product and used it in free association, is considered the matriarch (Levick, 2001; Malchiodi, 2003); while fellow colleague and artist, Edith Kramer, focused on the process of art making (Waller & Dalley, 1992). However, regardless of the approach, both women utilized art and the creative process to facilitate and enhance emotional well-being.

Although art therapy has often been described as a *non-verbal* form of therapy, Moon (2003), a professional art therapist, describes it as a *meta-verbal* form of therapy: a therapy beyond words (p. 122). In a qualitative study involving the use of art therapy and art making, Collie, Bottorff, and Long (2006), found both the use of art therapy (with professional art therapist) and art making (working on art) to be effective vehicles for “using, releasing, and

showing emotions” (p. 769) and thus both art and art making are “distinguished from verbal expression as a unique avenue of psychosocial support” (p.769).

### *Group Life Stories Narrative Therapy*

Like Art Therapy, Life Stories Narrative Therapy also involves a process: the process of review, storytelling, and listening. Often utilized to facilitate Erikson’s eight stages of psychosocial development (Haight & Haight, 2007), the use of narrative therapy or storytelling, according to Kenyon (2003), often takes on a spiritual quality when participants explore existential issues such as purpose and meaning in life. Although there are conflicting results from research examining the therapeutic effects of life stories narrative therapy on life satisfaction, Haight (1992) and Cook (1998) believe narrative therapy is steadily becoming a viable therapeutic approach to mental health counseling (Amundson, 2001; Westerhof, Bohlmeijer & Valenkamp, 2004). An evaluation of an intervention program utilizing reminiscence and personal meaning, to reduce depression, found significant differences (i.e., less) negative feelings about self and social relationships (Westerhof et al., 2004) In addition, results from a study examining the effects of a narrative/life review approach with depressed older women, Mastel-Smith et al (2006) found a “positive effect toward decreasing and sustaining a reduction in depression scores” (p. 1046).

Although primarily thought of as a collaborative process, narrative therapy is based on the belief that while our identity is created in a social, cultural, and political context, it is also revealed through storytelling, review, or narratives (Gardner & Poole, 2009). In a study utilizing both art and writing, Keeling and Bermudez (2006) maintain the use of narrative therapy, life review, and/or storytelling offers participants a sense of empowerment; for the narrative activity,

according to Serrano, Latorre, Gatz, and Montanes (2004), involved the “emotional processing of events from one’s past” (p. 275).

Although the use of narrative therapy can be life affirming for many, it is especially powerful among older persons experiencing decreased mood levels and depression (Kropf & Tandy, 1998). According to Gardner and Poole (2009), narrative therapy involves uncovering people’s life stories, then retelling those stories in a more powerful and empowering way. Results from an experimental study assessing the effects of reminiscence and storytelling showed significant improvement in symptoms of depression in older adults (Watt & Cappeliez, 2000). Although empirical literature in this area is still limited, it is gaining a steady following within the field of gerontology.

#### *Statement of the Problem*

The purpose of this study was to examine the effects of two group therapy interventions, Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT), on the life satisfaction and mood of older women living in skilled nursing home facilities. Assisting older women coping with the many challenges of aging, such as increased physical limitations, isolation, and relocation (away from familiar environments and to assisted or skilled nursing home facilities) is critical (Rusted, Sheppard, & Waller, 2006). This is especially true considering the rapid increase in both need and utilization of these types of facilities, by today’s rapidly increasing aging population (UN, 2009). According to a 2004 national survey on nursing homes (Jones, Dwyer, Bercovitz, & Strahan, 2009), women (age 65+) account for almost 66 percent of the nursing home population, out of an estimated total of 1.5 million adults living in nursing home facilities throughout the United States. As a result, it has been hypothesized one of the ways to assist older females residing in skilled nursing home facilities, is to engage them in a

therapeutic group (Rusted et al, 2006). Although therapeutic groups can differ greatly, both in purpose and orientation, they all utilize the power of group counseling to affect change (Yalom, 2005).

### *Research Questions*

This study examined the differential effects of two group therapy interventions, Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT), on the life satisfaction (LS) and mood disturbance (MD) of older women living in skilled nursing home facilities. This study strived to answer the following two research questions:

1. Will Group Art Therapy (GAT) increase levels of life satisfaction in older women, age 65+, living in skilled nursing home facilities, more than Group Life Stories Narrative Therapy (GLSNT)?
2. Will Group Art Therapy (GAT) decrease levels of mood disturbance in older women, age 65+, living in skilled nursing home facilities, more than Group Life Stories Narrative Therapy (GLSNT)?

### *Definition of Terms*

The following definitions are relevant to this study:

#### *Population Aging*

Population ageing is a shift in the distribution of a country's population towards older ages. It occurs, according to the UN (2009), when increases in the proportion of older persons (>60 years) are accompanied by reductions in the proportion of children (<15 years of age).

#### *Sex Ratio*

Sex ratio is the number of males in a population per one hundred females (UN, 2009).

### *Older Adults*

For this study, the term older adults will refer to persons aged 65 years and older.

### *Older Women*

The population utilized in this study will be older women aged 65 years and older, living in two separate Metropolitan Detroit based skilled nursing home facilities. According to Houser, Grage, and Gibson (2006), an estimated 1.5 million people (over the age of 65) utilize some type of residential or skilled nursing care facility.

### *Life Expectancy*

Life expectancy, based on statistical probability, refers to the number of years one can expect to live. According to the UN (2009), life expectancy, at birth, is the average number of years a newborn would live if current age-specific mortality rates were to continue (pg. 7).

### *Aging-in-Place*

Aging-in-place is defined as living where one has lived for many years, or living in a non-health care environment. It supports the notion that older persons maintain a desirable lifestyle, or quality of life, by participating in their communities, remaining independent as their health allows, having access to educational, cultural, and recreational facilities, feeling safe, and living in an intergenerational environment (Neighborhood Reinvestment Corp dba NeighborWorks America, 2010).

### *Place Attachment*

Place attachment is a strong, emotional attachment or connection to home, place, and community (Ponzetti, 2003).

### *Skilled Nursing Home Facilities*

Skilled nursing home facilities are among the most widely recognized facilities for older persons. This type of residence offers skilled nursing care as well as a broad range of long-term care services, such as: supervision, nursing care, personal care, social services, and meals. Bedrooms and baths may or may not be private (Houser, 2007).

### *Existential Therapy*

Sharp and Bugental (2001) view the existential approach as a process; a way of searching for value and meaning in life. Yalom (2005) expands further on the definition by providing human concerns such as death, freedom existential isolation, and meaninglessness; while Prochaska and Norcross (2007) believe authenticity, or one's awareness, combined with purpose and meaning, define the hallmark of existential therapy.

### *Art Therapy*

According to Malchiodi, 2003, Art therapy is a hybrid discipline based on art and psychology. With numerous expressive materials, art therapy deemphasizes verbal directives while stressing the role of the client (as interpreter of artwork).

### *Life Stories Narrative Therapy*

According to Gardner and Poole (2009), life stories/narrative therapy is based on the belief that personal identity is created in social, cultural, and political contexts, and is revealed through storytelling or narratives. It involves unearthing stories, understanding them, and retelling them in an empowering way.

### *Life Satisfaction*

Life satisfaction, according to Sousa and Lyubomirsky (2001), is defined as the subjective assessment of quality of life and/or the contentment or acceptance of one's

circumstance. According to Rejeski and Mihalko (2001) the term life satisfaction can be used interchangeably with the term quality of life.

### *Mood*

Mood is defined a temporary state of mind, atmosphere or feeling: a prevailing psychological state (Collins English Dictionary, 2003).

### *Assumptions of the Study*

Assumptions to be considered in this research study include the following:

1. Older females living in skilled nursing home facilities experience decrease mood levels and life satisfaction.
2. Older females living in skilled nursing facilities will be cognitively and physically able to participate in Group Art Therapy (GAT) or Group Life Stories Narrative Therapy (GLSNT).
3. Confidentiality will help participants answer questions freely and honestly.

### *Limitations of the Study*

Limitations to be considered in this research study include:

1. This study was gender specific and limited to two Metropolitan Detroit based skilled nursing home facilities. Generalization to other populations must be made with caution.
2. This study relied on paper and pencil instruments and self-report which are subject to socially desirable responses.
3. Because of age and other physical limitations, some instruments were administered orally, if needed.



4. Additional unknown factors may have influenced levels of life satisfaction and mood and were not accounted for in this study.

### *Summary*

This study examined the differential effects of two group therapy interventions, Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT) on levels of life satisfaction and mood disturbance of older females residing in two, Metropolitan Detroit based skilled nursing home facilities. Chapter I introduced the problems to be addressed, the dependent variables, the population, and the modalities used.. Definitions, assumptions, and limitations relevant to the proposed research were also detailed. Chapter II presents a literature review relevant to the aging population of the United States, living environments, existential group therapy, the two dependent variables (life satisfaction and mood) and the two interventions, Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT).

## CHAPTER II

### REVIEW OF THE LITERATURE

Chapter II presents a review of literature, existing research, and data on the aging population of the United States, the demographics, health status, and living environments of our older population. A review of literature and existing research on existential group therapy and the use of Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT) on the life satisfaction and mood of older females residing in skilled nursing home facilities are also incorporated. Significant findings of life satisfaction and mood studies and their relevance to the study are also discussed.

#### *U.S. Aging Population*

Today's aging population is unprecedented and without parallel in history (UN, 2009). According to the UN report (2009), when there is an increase in the proportion of older persons along with a decrease in the proportion of younger persons, a population ages. Frey (2007) believes the United States will soon be facing an *age tsunami* (p. 2). As the composition of today's population shifts from young to old, with the combined populations of the World War II generation (born between the years 1936 and 1945) and today's baby boom generation (born between the years 1946 and 1964), the dynamics and concerns of our nation's political, economic, and social structures will explode; causing a domino effect throughout areas of healthcare, lifestyle, economics, and education, to name a few (Charnie, 2002). Consequently, as the shape of demographic landscape changes, thus exposing a more mature facade, the definition of what it means to be healthy, live, and grow older in the United States, changes along with it (United States Bureau of the Census, 2003).

Our aging population today is critical. It is broad in scope and affects everyone. The

steady increase of our older population not only impacts personal relationships within families, but also impacts equity across generations and lifestyles (Administration on Aging [AoA], 2009b). According to the AoA (2009a), the percentage of older Americans, age 65+, has tripled since the early 1900's, from 4.1% (3.1 million) of the U.S. population, to 12.6% (37.9 million) of the population. One of the fastest growing age groups (approximately 5.5 million) within the overall general population are older Americans who have reached the age of 85 years and are referred to as the *oldest-of-old* (NIA-NIH, 2007). Additionally, approximately .21% or 90,000 Americans, within the 5.5 million oldest-of-old, have reached the age of 100+ years (AoA, 2009a). Furthermore, along with the increasing numbers (of our aging population) is another variable to consider: the male-to-female ratio of our older population. According to Smith (2007), "women represent an increased proportion of the population, with each decade of age" (p. 277).

Although increased longevity is often viewed as a notable achievement in modern society (Bongaarts, 2006, p. 3), its impact is far more reaching and profound. According to the AoA (2009b), the rapid growth of our older population represents an extraordinary phenomenon to our emerging 21<sup>st</sup> century. As a result, with more and more Americans living longer than ever before, and with the octogenarian population expanding six times faster than the rest of the population, critical issues and challenges surrounding living environments, health care, life style, and quality of life, etc., become more urgent (Krout & Wethington, 2003, p. 3). As newly designated seniors continue to increase and thus, reshape our demographic landscape, the magnitude and characteristic of this new shape will also continue to increase (Frey, 2007).

Population aging is ongoing (UN, 2009). As our population continues to age, many questions and issues surrounding our aging population will continue to arise; such as

independence, quality of life, and well-being of our older population. Appropriately, one of the most basic, yet overriding issues affecting our nation, according to the AoA (2009b), is the health and welfare of our older population. In terms of healthcare and need, for example, Shrestha (2006) reports the numbers of our older population (reported to be in poor health) will increase. In addition to the numbers of older persons reported to be in poor health, will be the increasing proportion of our nation's older, disabled, population (AoA, 2009a).

In a study estimating the prevalence of long-term disabilities, Kunkel and Appelbaum (1992) predicted the levels of disability, as well as the numbers of older disabled persons to almost double by the year 2020, from the approximate 5.1 million in 1990, to approximately 10 million. Consequently, they challenged our nation to consider the impact this will have on society as a whole. Likewise, in an article of age-related changes in functional status, Manton, Stallard, and Liu (1993) projected the numbers of older persons with disabilities, or those limited in Activities of Daily Living (ADL) to reach approximately 14.4 million by the year 2040. More recently, however, Waidmann and Liu (2000) reported that although disability among our older population appears to be declining (as a result of a more educated population), the implications of our aging society will still be enormous.

As our older population increases in age, as well as increases in overall numbers, the occurrence and implications of various disabilities and/or chronic diseases will also increase (United States Department of Health and Human Services [HHS], Health Resources and Services Administration, Maternal and Child Health Bureau, 2009). Our increasing aging population not only includes those in categories mentioned above, but also includes the increasing number of older persons diagnosed with Alzheimer's disease. In a study estimating the future prevalence of Alzheimer's disease, in the United States, Brookmeyer, Gray, and Kawas (1998) projected over

the next fifty years, approximately 1 in 45 Americans will be afflicted with the disease; thus, quadrupling the occurrence from 2.32 million (in 1997) to over 10 million, by the year 2050. More startling, however, are the projections of Alzheimer's disease for those considered to be the oldest of old (85+ years), with 14.3 million cases projected by the year 2040 (Brookmeyer et al., 1998). Consequently, issues regarding our aging population, throughout areas of healthcare, housing, economics, etc., will continue to expand and intensify with increasing age and passage of time (National Institute on Aging Information Center [NIAIC], 2008).

As our older population increases exponentially, issues surrounding transportation, health, and well-being, among senior citizens, will “assume critical importance” (Evans, Kantrowitz & Eshelman, 2002, p. 381). The importance and severity of this issue is highlighted with the use of the phrase global nursing home (Eberstadt, 2002). Eberstadt, a demographer and global economist, coined this phrase while making reference to our aging population and the overall impact the increase has on their well-being, environment, healthcare, and housing. According to Lawler (2001), this impact highlights a unique reality for our older population, in that health, well-being, and housing are all interrelated. Today, a housing problem can create a health and/or well-being problem and a health problem can create a housing problem (Lawler, 2001). Consequently, with increasing age, decreasing mobility, serious health complications and/or disability impacting the lifestyle of more and more older Americans, the issue connecting health and housing becomes more of a reality; especially when independent living becomes more difficult, or worse, it becomes no longer a possibility. As a result, other types of living arrangements and housing considerations must be reviewed and/or considered. The likelihood of this outcome becomes even more prevalent when personal financial situations and family support are limited (AoA, 2009b; Golant, 2003). In addition, because an overwhelming majority of

homes and communities in the United States, today, are not currently designed for the needs of the our aging population, many older persons become both physically and socially isolated (when they are no longer capable of navigating personal surroundings and environment); thus, not only increasing the likelihood of moving to an alternative living facility, but also increasing the likelihood of depression and/or other psychological disorders (Scharlach, 2009).

As seen in the report compiled by the AoA (2009a), the next 30-40 years will bring not only dramatic increases in the number of older persons in general, but also dramatic increases in the numbers of those considered to be most vulnerable: older women. As a result, high concentrations of older women living in nursing homes and other alternative living environments are expected to continue; therefore, the demand for health care, special services, and support in this area will increase, as well (NIAIC, 2008).

### *Longevity and Gender-Specific Issues*

At a United Nations conference on aging, Starr (UN, Department of Public Information, 1999) coined the phrase *Longevity Revolution* and compared it to both the Renaissance Revolution and the Industrial Revolution, with its ability to transform life, as we know it. At the same conference, UN Secretary-General Kofi Annan (UN, 1999) highlighted the overall impact of our aging (global) society when he stated, “we are in the midst of a silent revolution, one that extends well beyond demographics: a revolution with major economic, social, cultural, psychological, spiritual, and environmental implications” (p. 1). In 2004, Matzo and Sherman (2004) recognized this longevity revolution was expanding further, with the growth of the-oldest-of-old: vulnerable adults (mostly women) who have reached 80+ years of age. As a result of this longevity revolution, where the average life expectancy continues to increase, particularly

the life expectancy of women, gender-specific issues surrounding healthcare, support, lifestyle, and living environments will intensify (CDC, 2009).

To provide context for gender-specific challenges and considerations facing our nation, it is helpful to briefly examine the demographic changes that have occurred, especially in ratio of men to women, as they age. One of the most dramatic factors related to our older population is the change in the ratio of men to women. Although, male births outnumber female births by approximately five percent, males continue to have a higher mortality rate. Thus, from approximately age 35+, women slowly start to outnumber men; however, these numbers become more pronounced with advancing age (United States Bureau of the Census, 2003). The average ratio of men to women, from age 55-64 is approximately 92%; age 65-75 approximately 83%; age 75-84 approximately 67%; and age 85+ approximately 46%.

Although many significant issues associated with our aging population require critical attention to both genders, the increasing ratio of older females-to-males requires a separate, yet careful, consideration (National Research Council, 2001; U.S. Bureau of the Census, 2011). According to Charnie (2002), as time continues and as the implications of our nation's gender imbalance becomes more urgent and significant, issues surrounding support, living environment, and quality of life will be amplified. For example, as our population ages and the ratio of older women outnumber men, women (more likely than men) will eventually enter a nursing care facility, or an equivalent congregate care facility. According to statistics from a 2004 National Nursing Home Survey (CDC, 2009), the lifetime risk of women entering a nursing home is estimated to be 52% versus men, at 30%. Subsequently, the issues surrounding residents of nursing home facilities will be predominantly those of older women (Cook, 1998). Therefore, as the feminization of our older population increases (United Nations, 1999), interest in gender-

specific issues should increase, as well. As such, research studies focused on America's graying and aging population, in general, should also include gender-specific studies geared toward issues facing older women (Charnie, 2002).

### *Living Environments*

When health and finances are in good condition, the majority of older persons prefer to live independently, remain in their own home, and age in place (Krout & Wethington, 2003). Projections from the NIAIC (2008) indicate approximately 45% of older persons will be living alone by the year 2020. Some older individuals, who currently live alone, are fortunate to have family members living nearby who can offer support and/or at least keep in touch on a regular basis (2008). However, with recent increased economic challenges and decreased family support, many older persons have been forced to look outside their familial and familiar environment to congregate facilities such as independent, assisted living, and/or skilled nursing facilities (Schwarz & Brent, 1999). As a result, according to Houser, Fox-Grage, and Gibson (2006), approximately 32,000 independent, assisted, and/or skilled nursing facilities are currently operating in the United States today, with a growing need increasing annually. Not surprisingly, in the United States, today, older women aged 65+ continue to make up the majority of individuals living in skilled nursing facilities, at approximately 65.7 % (CDC, 2009).

Gerontologists have long recognized two primary issues associated with the aging process: decreased gains and increased losses. Oswald and Wahl (2004) maintain that as we age, a changing dynamic of experienced gains and losses occur; where "losses" increase as "gains" decrease. Although a variety of losses and gains among older adults occur, they appear to become more prominent when considering place of residence, or living environment, is considered (Oswald & Wahl, 2004).



As our population ages and the life expectancy of women continues to increase, many older women will be facing critical issues concerning home environment, lifestyle, mobility, independence, etc. (Leith, 2006; Sykes, 1994). This is especially true after the death of a spouse. These lifestyle decisions for women become even more critical when faced with sudden financial changes and/or physical limitations. Consequently, decisions affecting lifestyle, mobility, and environment (such as personal residence, and/or potential relocation) should not be made lightly; yet oftentimes, they are made under extreme emotional duress (Leith, 2006; Sykes, 1994). As a result, when an older person is faced with the prospect of moving away from home and/or familiar neighborhoods, and relocating to an unfamiliar environment, such as a nursing home, feelings and attachment to place and home become more heightened.

Like many people in general, many older adults possess a deep emotional connection or attachment to their home, environment, and/or community. This connection to home and place is often referred to as “place attachment and identity” (Ponzetti, 2003). Place attachment can be viewed as one’s emotional connection to a particular place or location, which can include multidimensional interactions between personal understanding, feelings, and behaviors (Hidalgo & Hernandez, 2001; Ponzetti, 2003). According to Manheimer (2009) because we often give special meaning to our home, as we age, our home gives meaning in return. The idea of personal meaning and attachment to our home becomes even more critical when trying to understand and appreciate the numerous decisions and choices people must make throughout life (Ponzetti, 2003). While the theory of place attachment continues to be widely researched and dissected, many gerontologists, sociologists, and psychologists’ agree that the concept of place-attachment is multidimensional and as such, must be viewed from many different angles (Hidalgo & Hernandez, 2001; Scharlach, 2009). In a qualitative research study on place attachment and

rural communities, Ponzetti (2003) collected in-depth photographs and interviews with elderly residents, to better understand meaning and values. The results of his study reported 94% of participants felt at home in their community; with 88% very attached to their town (environment), and another 88% voicing sadness if they had to move.

Milligan (1998) regarded place attachment as two interconnected parts: the interaction of past experiences or memories with place; and the interaction of future, potential, or anticipated experiences and expectations associated with place (pp. 1-2). Still, Rubinstein and Parmelee (1992) viewed place attachment through the developmental tasks of the aging process, such as identity, purpose, and sense of continuity.

In his study on immigration, Wu (2002, pp. 267-275) highlighted the importance of home and place with the use of well-known phrases such as, *there's no place like home* and *home is where the heart is*. Cutchin (2003) identified aging and place attachment as a process; a process which links the emotional connection to home – to the desire to give meaning to life, which in turn shapes meaning as we age. Accordingly, in his study on aging-in-place, Cutchin introduced a theoretical model of place attachment, integrating home and community.

Although many older persons in general also experience feelings of attachment, Cutchin (2003) found older women, in particular, become more attached to their places and homes; by tying their feelings, attitudes, and memories to things that are familiar, such as neighborhood, friends, religious institutions, and long-established patterns. Eventually, however, these same attitudes, memories, and feelings of home and place conflict with the challenges and obstacles of increasing age. Consequently, when placed in a new environment or surrounding, many older people find themselves unable to replicate the intense feelings of home (Thomas & Blanchard, 2009). In addition, along with the strong memories, personal feelings, and attitudes associated

with one's home and place, is the intense desire to remain independent (AARP, 2007; Pynoos, Caraviello & Cicero, 2009). However, the reality remains: the decline in physical ability and/or lack of mobility often forces older women to give up a portion of their independence in lieu of security and safety; to live in various types of congregate living arrangements (Pynoos et al., 2009).

Pynoos and others (2009) believe one's attachment to place and home increasingly plays a more vital role, as we age (p. 26). Statistics from AARP (2007) revealed 91-95% of adults, age 65+, prefer to stay in their own home, if given the choice. However, as our population continues to age, so does the rate of disability; yet, unfortunately, most existing houses in the United States are not designed to meet the challenges and needs of our aging population (Pynoos et al., 2009). Although research shows how one's physical ability (or disability) is directly influenced by one's environment (Scharlach, 2009), the attraction to remain living in one's own home, or familiar place (thus preserve memories and meaning), continues to be a compelling desire among our older population.

Even when a person's home or environment becomes unsuitable and/or unsafe, literature still shows how one's personal feelings and attachment toward home and place continue to stimulate, impact, and influence one's desire to remain living at home (Cutchin, 2003; Scharlach, 2009). Unfortunately, this issue of environmental safety becomes even more critical with the fusion of our nation's rapid aging population and the current (existing) housing structures and communities, designed for yesterday's younger baby boom population, instead of today's emerging aging population (Pynoos, et al., 2009; Scharlach, 2009). Hence, as our population ages, so do our homes. These older structures not only require additional maintenance and responsibility, many older conventional homes are difficult to modify in order to help

accommodate for the physical challenges experienced by some of our aging population; thus again, forcing many older adults to consider relocation to an institutional-type dwelling designed specifically for their needs (Pynoos et al., 2009).

Years ago, there were few options available to those who required assisted care. The most common facilities available for older persons, who could no longer live independently, consisted of nursing homes, hospital based in-patient care, and/or senior citizen retirement centers. In the past twenty years, however, the range of retirement living and/or long-term care options for older persons has expanded (Barnes, 2005). Today, according to Barnes (2005), in addition to skilled nursing or hospital based care, the geriatric industry is offering a rich continuum of facilities and services; from in-home assistance to assisted living centers, from continuing care retirement communities (CCRC) and independent residential care homes (RCH) to hospice care, etc.

Thus, as the population of the United States ages, and our demographics shift from young to old, visibility in the demand, as well as in the trend of alternative living arrangements, will continue to increase (Spillman, Liu, & McGilliard, 2002).

### *Life Satisfaction and Mood*

A person's view of life satisfaction, according to Frisch (2006), often relies on a subjective comparison of circumstances, with a perceived standard. Similarly, according to Frey and Stutzer (2002), a person's level of satisfaction is often related to the discrepancy between one's circumstances and one's perception. According to specialists in the field (Diener, 2009; Frisch, 2006), the term life satisfaction has been used synonymously with other terms such as quality of life, happiness, subjective well-being, and psychological well-being. Whereas, according to Keyes, Shmotkin and Ryff (2002) and Linley, Maltby, Wood, Osborne and Hurling, (2009), the term subjective well-being often implies an affective, emotional component, while

the term psychological well-being relates to one's interaction with various existential concerns and challenges.

A review of the literature found many researchers utilizing and defining the terms life satisfaction and/or quality of life. For example, separate from material comfort, Buetell (2006) describes *life satisfaction* as it relates to one's subjective conditions, such as accomplishments. Veenhoven, (1991, 2000) views life satisfaction as the good life, while Kane (2003) and Frisch (2006) view life satisfaction, or quality of life, in terms of happiness, personal control, functional ability, etc. Consequently, according to Seligman (2002), because satisfaction of life is often a reflection of one's perception or sense of well-being, it also has the potential to become less susceptible to fluctuation of daily mood (Diener, Oishi, & Lucas, 2003).

In a British national survey focusing on the quality of life of older persons, aged 65+, Gabriel and Bowling (2004) reported the following six (quality of life) themes: living at home or familiar neighborhood; good social relationships; activities and hobbies; positive outlook; good health and mobility; and financial stability. In addition, in the same national survey, out of a total of 999, 80 survey respondents (40 men and 40 women) participated in post-baseline interviews, at 12 months and 18 months. Regarding the theme of home, 35% respondents reported pleasure and satisfaction from living in their own home, and stated it contributed to their overall quality of life. Regarding a familiar neighborhood, 41% said their neighborhood enhanced their quality of life, while 61% reported their relationship with neighbors contributed to their quality of life.

Measurement of well-being and life satisfaction, according to Subasi and Hayran (2004), can be especially helpful when evaluating the importance of environment within our older population. In a study focusing on the life satisfaction of older persons living in nursing homes, Subasi and Hayran (2004) reported, environment or place-of-residence to be a significant

predictor of one's satisfaction with life ( $p=.05$ ,  $p=0.001$ ). In the same study, along with one's environment or place-of-residence, the mean (life satisfaction) scores of older *active* persons were shown to be significantly higher than those who were not active ( $p=.03$ ). However, in a separate qualitative study exploring the effects of activities and perception of life satisfaction of 133 older adults living in 96 long-term care facilities in Massachusetts, McGuinn and Mosher-Ashley (2000) reported organized activities had little effect on perception of life satisfaction, yet self-generated activities seemed to have a more positive effect. However, McGuinn and Mosher-Ashley (2000) found gender to be a significant factor when looking at levels life satisfaction and participation in activities. Accordingly, females participated in more activities ( $M=2.05$ ) than did males ( $M=1.89$ ).

To differentiate and clarify between the many distinctions and definitions of the term life satisfaction, Sousa and Lyubomirsky (2001) found utilizing the terms life-domain satisfaction and life-global satisfaction useful. When referring to one's satisfaction with work, marriage, and/or income, the term life-domain satisfaction was utilized; however, when referring to one's comprehensive judgment of life, the term life global satisfaction was used (p. 668).

The term, *mood*, is often defined as a general attitude, prevailing emotion, and/or state or frame of mind (*American Heritage Stedman's Medical Dictionary*, n.d.) According to Lichtenberg et al., 1998, mood can be viewed as a balance between one's positive and negative experiences. In an article review, Carroll (2003) described mood as something penetrating the perimeter of perception. Elaborating further, Carroll believes, mood is often linked with emotion, although it differs in duration. However, unlike emotion, mood often continues or persists over time. Regardless of duration, definition, or fluctuation, Kahneman, Diener, and Schwarz (1999, as cited in the National Research Council, 2001) conclude, continued study of the variable,

mood, is compelling. As such, it is listed as one of five proposed measurements for research on issues of life satisfaction. In descending order, the five measurements are listed as follows: Objective Conditions; Subjective Well-being; Mood Levels; Emotional States; Biochemical Behaviors (National Research Council, 2001).

The measurements of mood and life satisfaction in older adults are also closely tied to Erikson's stages or models of human life-span development, especially the eighth stage: ego integrity vs. despair (Erikson, 1982). Although, during each developmental stage, certain tasks or potential crises are negotiated, the eighth stage offers older adults a chance to come to terms with their lives. Ego integrity (which lies on one end of the developmental spectrum) is related to one's acceptance of life as it has been lived, or one's willingness to accept responsibility for one's life. However, on the other side of the developmental spectrum lies the opposite attribute: despair. Despair often occurs when a person fails to successfully negotiate or resolve this task and results in feelings of pain, sorrow, or regret (Erikson, 1982).

According to the AoA (2009b), variables of mood and life satisfaction are commonly seen as critical factors affecting a healthy aging society; however, for older adults living in nursing home facilities these variables become more heightened or significant. Often, according to Lichtenberg et al., (1998), when older adults are forced by circumstances to relocate to alternative living environments, such as nursing homes, assisted living, or other types of long-term care facilities (thus effectively removing themselves from familiar environments, neighborhoods, family members, and/or friends), their perception of satisfaction of life and levels of mood are negatively affected. As a result, continued public policy and research in the field of gerontology should include a more specific focus regarding the impact one's living environment has on personal life satisfaction and mood.

*Existential Approach to Counseling*

Literature focusing on issues of mental health and our aging population seems to be well represented when related to the mental health needs of the caregivers of older persons, but not necessarily to older persons themselves (Smith, 2007). For example, a recent analysis of evidence-based interventions, by Gallagher-Thompson and Coon (2007), found substantial support, albeit related to caregivers of older persons, for treatments of distress, depression, and anxiety, as well as interventions enhancing coping skills and self-efficacy. However, according to the American Psychological Association (2004) and specialists in the field of gerontology (Qualls, Segal, Norman, Niederehe, & Gallagher-Thompson, 2002; Smith, 2007), literature focusing on the mental health needs of the individual older person (in general) and older women (in particular), is often underrepresented. As a result, not only are specific, psychological interventions, directly and effectively serving our aging population, warranted (Payne & Marcus, 2008), so too, are gender-specific psychological interventions.

Research suggests, within our older population, traditional medical model therapies (such as medication) and traditional counseling therapies (such as cognitive, behavioral, and psychodynamic) have been shown to be successful for alleviating symptoms of depression and anxiety (Ayers, Sorrell, Thorp, & Wetherell, 2007; Gatz & Fiske, 2003; McCurry, Logsdon, Teri, & Vitiello, 2007; Nordhus & Pallesen, 2003; Pinqart & Sorensen, 2001). However, instead of just alleviating symptoms, many alternative therapies, with an emphasis on enhancing well-being, emotional awareness, and expression, strive to do more such as increase memory and boost immune function (Smith, 2007). Consequently, when working with older persons, traditional standard (medical model) treatments may need to be modified to include alternative therapies, as well (Duffy, 1999).



According to Payne and Marcus (2008), there is an increased need for mental health interventions within our aging population. Consequently, because many older adults often experience increased isolation and loneliness, a group approach to counseling provides “a much needed sense of social interaction” (Payne & Marcus, 2008, p. 269). In a meta-analysis of 44 studies with pretest/posttest designs, Payne and Marcus (2008) found the use of group therapy to be extremely beneficial to older adults, with an effect size of .42 (95% CI). Although the oldest (of older adult) group members appeared to benefit less than the younger (older adult) group members, overall group counseling for older adults was shown to be forceful, with average effect size (for pre–post studies) similar to groups with younger adults and adolescents.

Despite the appearance of a busy environment, and despite living among numerous people, many residents of nursing home facilities, or other types of long term care facilities, often experience feelings of isolation and depression, along with periods of adjustment (Molinari, 2003). Consequently, according to Molinari, the group process can be an effective and natural fit for older persons living in residential care facilities. However, research on psychotherapy outcomes suggests the approach and/or format of therapy itself, does not necessarily lead to positive therapeutic outcomes.

Although the effectiveness of psychotherapy in general has been well researched and documented over the past forty years, the validity and effectiveness of therapy has been limited to four common factors (Lambert, 1992; Lambert & Bergin, 1994). The four common factors of all therapeutic improvement are identified as follows: 1) 40% of improvement is the result of the strengths of the client, the environment, and chance; 2) 30% - the result of the therapeutic relationship; 3) 15% - the result of the client’s and therapist’s belief in the counseling process, expectancy and hope, and a placebo effect; and, 4) 15% - result of the therapeutic approach

(Lambert, 1992; Lambert & Bergin, 1994). Likewise, Cuijpers, van Straten, and Andersson (2008) found in a study comparing differential outcomes of numerous therapeutic interventions (for depression), very few indications that one treatment intervention differed significantly from another. Thus, they acknowledged a possible explanation could be the result of “common, non-specific factors; such as, the therapeutic alliance and belief in the treatment” (p. 909). However, regardless the lack of indications or the small (15%) improvement identified with the therapeutic approach, group counseling has been shown to be an effective and efficient approach for older adults by facilitating a sense of belonging, improving social skills, and improving behavior.

### *Existential Therapy*

“Existential Therapy” (ET), is best described as a “philosophical approach to the counseling process” (Corey, 2005, p. 131), and emphasizes a person’s freedom to choose. Continuing from this perspective, the existential approach to group counseling can be viewed as a way of thinking, as well (Corey, 2008). In addition, while an existential counseling group as a whole can represent a sample or “microcosm of the participant’s world” (p. 218), the primary group focus remains concentrated on issues surrounding four ultimate human concerns defined by Yalom (2005) as death, freedom, existential isolation, and meaninglessness. Consequently, the expression of Yalom’s four human existential concerns becomes a critical component of group therapy. Therefore, it is also in this (existential group) context, where older women, living in skilled nursing home facilities, can be offered therapeutic interventions and support to help address life’s existential issues of isolation, purpose or meaning, lack of freedom, and ultimate death; thereby impacting one’s satisfaction with life and/or mood levels.

In an existential group therapy approach, participants (such as, older women living in skilled nursing facilities) not only have opportunities to discover themselves, but also have

opportunities to expand on the various existential issues of self-awareness, meaning, and purpose in life (Corey, 2008). Since the primary therapeutic goal of an existential group is to help participants come to terms with various personal decisions, struggles, and challenges in life (Corey, 2005), this approach appears to be even more beneficial to residents living in congregate facilities, such as a skilled nursing home, where issues of loss, personal freedom, identity, purpose and meaning, are amplified. As a result, the existential group counseling approach can offer participants an opportunity to reclaim control of feelings and come to terms with life, while at the same time offer participants an opportunity to find continued meaning, identity, and purpose in life.

Irvin Yalom (2005) identified and expanded on the group existential theme through a complex connection of human experiences and defined eleven therapeutic factors as “necessary agents of change during the group process” (p. 1). The following eleven therapeutic factors are the foundation to group therapy (Yalom, 2005):

1. Instillation of hope
2. Universality
3. Imparting information
4. Altruism
5. Corrective recapitulation of the primary family experience
6. Development of socializing techniques
7. Imitative behavior
8. Interpersonal learning
9. Group cohesiveness
10. Catharsis

### 11. Existential factors.

Out of the eleven therapeutic factors, Yalom (2005) considers interpersonal learning, group cohesiveness, and catharsis to be especially important to the group process. Consequently, for older women living in skilled nursing facilities, participation in group counseling can be a viable therapeutic approach to help increase life satisfaction and mood levels, by alleviating isolation, facilitating development and growth, and enhancing social skills and communication.

In a qualitative analysis on the effects of an intervention focusing on existential group therapy and quality of life, Ventegodt et al. (2004) surmise that the use of existential group therapy offers participants an effective means of healing body, mind, and soul. Ventegodt and coauthors reported in the discussion section that the use of a quantitative method of evaluation, such as a quality of life questionnaire, would have proved valuable, they still chose to use a qualitative method instead, to better illustrate the “experience of personal transformation, shift of life perspective, and the development of a philosophy of life” (p. 130), among participants.

Although the use of group therapy, with older adults, has been a popular approach since the 1950’s, and previous studies have shown it to be effective, there is still limited evidence available, examining the effects of various group therapy treatment interventions for older adults. In the past, according to Poggi and Berland (1985), some mental health care professionals were reluctant to treat older clients; they either felt powerless, or they feared the older client might die during treatment. Today however, the reluctance to treat, and/or the luxury to choose whether to treat, or not treat the older client (within the field of mental health), is not always an option. The shift in our nation’s demographics from young to old, along with the overall increase in the numbers of older persons, demands increasing attention from today’s practicing mental health professionals (Lichtenberg, 1994). In addition, seen from the perspective of Erikson’s (1982)

developmental life span approach and Yalom's (2005) human existential concerns of loss and abandonment, especially when related to various aspects and challenges associated with aging, the need to treat our older population becomes critical (Bush, 2009). Consequently, the group approach to counseling therapy can be a viable mode of operation to best service the increasing aging population within our society, while addressing the various aspects and challenges of aging (Bush, 2009; Knight, 2004).

### *Group Art Therapy*

As we age, basic natural changes in the brain, along with pathologic changes (i.e., stroke) and neurodegenerative disorders, such as dementia and Alzheimer's disease, greatly impact not only overall physical function, but also the quality of life, well-being, and mental health (Lerner, 2007). Consequently, addressing these changes and challenges can be formidable, for both the mental health professional and the older client, especially if the ability to communicate becomes impaired. However, mental health professionals such as Johnson and Sullivan-Marx (2006), recommend the use of art and art therapy as a viable and effective approach when working with an older population, for it offers a unique, nonverbal, and alternative form of communication, especially for clients with language impairment (p. 310). For example, in order to externalize the process and facilitate meaning, many professional art therapists and other mental health professionals, according to Riley (2004) utilize art as a visual means of communication (Arrington, 2001; Keeling & Bermudez, 2006).

Although, according to Saunders and Saunders (2000), the advantages of art therapy are well documented, the majority of studies reporting on the effectiveness of art therapy are based on qualitative measures instead of quantitative evaluations. However, in 2001, Cohen et al. (2006) conducted a multisite study measuring the impact of fine-arts participation on the overall

health and mental health of older adults. Based on interim results, using a quasi-experimental design with 300 older adults (age 65-100 years) randomly assigned to either an arts group or control group, Cohen, et al. (2006) found those participating in the arts group experienced increased mood levels, increased activity levels, decreased depression scores, and increased levels of independent functioning. Further positive effects of arts participation, such as lower numbers of doctor visits, lower rates of medication usage, and increased morale, were also reported. Cohen, et al. noted however, “because of the exploratory nature of this study, differences between group statistics were reported at  $p < .10$  level of significance” (p. 730). Regardless, in examining the impact of art on the health and well-being of older adults, Cohen et al., stated “we have witnessed health promotion and prevention effects. Moreover, through involvement in a high-quality arts program, participants, with an average age greater than life expectancy, reflect a reduction in risk factors driving the need for long-term care” (p. 733).

In another experimental study, designed to investigate the benefits of a short-term art intervention targeting quality of life and cognitive functioning in older adults, Noice, Noice, and Staines (2004) found, after four weeks of intervention, significant differences with participants receiving visual arts training ( $p=0.003$ ) and participants receiving theater training ( $p=0.002$ ) on both cognitive functioning and psychological well-being measures, as opposed to participants in the control group. Likewise, results from a study examining the effects of a visual arts discussion group, Wikstrom (2002) also reported positive findings, with participants in the visual arts discussion group demonstrating significant improvement in social interaction (compared to those in the matched control group).

In an attempt to analyze the effectiveness of various therapeutic activities with persons with Alzheimer’s disease, Marshall and Hutchinson (2001) reviewed the research methods and

activities of 32 studies, including case, descriptive, quasi-experimental, qualitative, and experimental studies. The results from one of the descriptive studies (with eight older participants attending a senior day-psychiatric program) found the use of group art therapy produced a positive effect on participants, by increasing interaction, expression of emotion, and reminiscence (Marshall & Hutchinson, 2001). As an extension of a pilot investigation, Kinney and Rentz (2005) evaluated the well-being of twelve individuals and the effects of a specific art program (designed for persons with early and middle stages of dementia) called “Memories in the Making.” Consequently, among the various domains of well-being, Kinney and Rentz (2005) found an increase in interest, attention, self-esteem, and normalcy, with participants involved in the art program, as compared to participants involved in traditional senior-center activities. Conversely, no statistical differences were reported for negative effect, or sadness, between the art activity program and other activities.

Although the professional field of art therapy is relatively new, a brief history, according to Malchiodi (2003), shows its roots are deep and extensive. Throughout the centuries, humans have long communicated and expressed themselves through creativity and art, with the use of symbols, masks, robes, rituals, hieroglyphics, cave drawings, etc. In the field of mental health, the use and power of art was documented over one hundred years ago, as an effective means of communication, especially when working with mental illness and trauma (Malchiodi, 2007).

From the 1930’s through 1960’s, the Houston Menninger Clinic (originally located in Kansas) was considered a leading clinical and research institute in the art therapy movement (Menninger, 2010). The Menninger Clinic implemented one of the original art therapy programs in the United States and built upon it by adding an artists-in-residence program. Later, as journal publications increased (highlighting the use of the arts in psychotherapy), Master’s degree

programs were introduced, credentialing, and the founding of the American Art Therapy Association in 1969, the profession of art therapy and the role of the art therapist evolved (Malchiodi, 2003; Rubin, 1999).

Although numerous qualitative studies exist in the field of art therapy, quantitative, randomized, controlled studies are still limited, in comparison. In 2001, a clinical trial utilizing art interventions with hospitalized children and post-traumatic stress disorder, found a reduction in acute stress symptoms in children receiving the art therapy intervention, as opposed to children in the experimental group, however; no statistically significant differences in reduction of post-traumatic stress symptoms were observed (Chapman, Morabito, Ladakakos, Schreier, & Knudson, 2001). In a randomized, controlled investigation examining the use of mindfulness-based art therapy (MBAT) with women diagnosed with cancer, Monti et al. (2006) found encouraging data regarding art therapy's "potential for reducing symptoms of distress and improving key aspects of quality of life" (p. 371). For example, comparing women from the wait-list control group to women in the experimental group (who received an eight-week art intervention), Monti et al. (2006) demonstrated statistically significant differences in two targeted subscales: depression,  $p=0.001$ ; and anxiety,  $p=0.022$ .

In an article arguing the emotional needs of the elderly, Johnson and Sullivan-Marx (2006) discussed how the use of art and art therapy helped address some of the developmental tasks older people encounter. For example, with a previously agitated client diagnosed with Alzheimer's disease, the researchers found the creation of art (through structure and repetition) produced a calming effect (Johnson & Sullivan-Marx, 2006). However, in addition to producing a sense of calm, as well as a sense of pride in one's completed work of art, Kaplan (2000)



maintained the use of art and the process of art making beneficial to the client; by helping assess cognitive and developmental deficits.

Art therapy, with its unique, nonverbal form of communication can be especially beneficial to older persons living in congregate-type living facilities; for the process, alone, offers participants an opportunity to exercise control, choice, and social connections (Johnson & Sullivan-Marx, 2006; Weisberg & Wilder, 2001). Moon (2003), an existential art therapist, believes the use of art therapy offers participants a dynamic means of communication, imagery, and expression; while focusing on universal existential themes, such as love, joy, suffering, and meaning and purpose in life. In addition, because art, and the process of creating art involves many stages, and because the various stages of art, in turn, can imitate various stages of life, the use of art and art therapy offers participants a unique vehicle for reviewing and reflecting on life (Moon, 1995, 2003). Throughout his professional life, Moon (1995, 2003) recognized the power of art, with its ability to connect the physical (i.e., materials) with life. As a result, Moon is a strong proponent of art's ability to provide effective and creative avenues for enhancing quality of life (Moon, 1995, 2003).

In 2007, Bell and Robbins conducted a study involving 50 adults (taken from a convenience sample of the general population) comparing a “producing” art group, with a “viewing” art group. They hypothesized, by producing art (Group Produce) and viewing art (Group View), negative mood and anxiety would decrease. The criterion instruments used to measure the dependent variables of mood and state-trait anxiety were: the *Profile of Mood States (POMS-B)*, McNair, Lorr, & Droppleman, 1971) and the *State-Trait Anxiety Inventory (STAI)*, Spielberger, 1983). Results from the study showed ‘Group Produce’ exhibited a greater reduction in negative mood, than ‘Group View’ on all three measures. For each measure, there was a

statistically significant group-by-time interaction: Mood Disturbance,  $F=11.2$ ,  $df=1,48$ ,  $p<.005$ ; State Anxiety,  $F= 66.4$ ,  $df=1,48$ ,  $p<.001$ ; Trait Anxiety,  $F= 23.7$ ,  $df=1,48$ ,  $p<.001$ ). These results are consistent with the primary premise of art therapy: that the process of making art produces general mood enhancing properties (Nainis et al. 2006).

Rusted, Sheppard, and Waller (2006) conducted an experimental study of 45 older adults comparing the immediate and long-term effects of both art therapy groups and recreational therapy groups. While specific criteria included a diagnosis of mild to severe dementia, plus attendance at day-care or residential facilities, the aim of the study was to determine if the use of art therapy would produce significant positive changes in mood and cognition, more than recreational therapy. Within-session changes in mood, mental acuity, physical competence, anti-social, cooperative and agitated behavior scales were completed at the end of each session. Over the 40-week time frame, participants in the art therapy group showed session-to-session changes in responsiveness. Paired sample t-tests for art and activity groups, at baseline and at 40 weeks, showed an increase over time for the art therapy group. As a result, positive effects of art therapy participation contrasted with the effects of recreational participation:

- Elderly persons (with dementia) showed positive changes in mood and sociability in response to regular periods of small group work.
- Art Therapy sessions produced benefits over and above those observed in response to similar time spent in recreational activities.
- The benefits of art therapy extended to improved sociability in the wider daycare setting.

In the comprehensive guide to art therapy, Landgarten (1981) examined various ways in which the use of art therapy addressed the emotional needs of the older population. By

stimulating the thought process, encouraging creativity and self-expression, and by providing a sense of dignity, Landgarten found the emotional needs of older persons, such as issues of identity, role changes, dependence, and death, were well addressed through the therapeutic use of art. More recently, McNeilly (2005) claimed the use of art therapy helped participants reach beyond verbal language, by awakening the senses and provides participants a dynamic opportunity to fully engage in the whole sensory experience (McNeilly, 2005, p. 124).

Because of limited mobility, living environment, and/or isolation, many older adults lack adequate emotional support (Hill, 2003). According to Johnson and Sullivan-Marx (2006) this lack of support became immediately obvious, when they explored the developmental tasks of the elderly in relationship to making art. Johnson and Sullivan-Marx found the emotional needs of older persons were often overlooked, in lieu of more obvious physical needs (2006). However, involvement and sharing in a therapeutic group, such as art therapy, has been shown to be emotionally, spiritually, and physically beneficial (Hill, 2003). Furthermore, according to Moon (2003), along with visual imagery, graphic metaphors, and the creative, active and physical means of expression, participation in an art therapy group has been shown to facilitate communication, increase socialization skills, and increase overall quality of life.

In an article exploring the themes of empathy, McNiff (2007) revealed how the group art therapy process (making art together) helped facilitate healing and transformation. He concluded that the use of art therapy, in a mindful and supportive group environment, had the ability to empower participants to overcome feelings of isolation. Although art therapy's versatility allows it to be used with participants of any age, and can be adapted to both the individual and group setting, Davis-Basting (2006) believes the use of art therapy offers older persons, in particular, a unique sense of hope; for it can provide a way to look at self from a detached viewpoint

(Menninger, 2010). Consequently, as the older population continues to face increasing losses and challenges, such as independence, choice, and/or declining health, the use of group art therapy can provide participants an alternative means to facilitate support, communication, and coping skills; especially with the additional opportunity to share and express satisfaction in their art work (Johnson & Sullivan-Marx, 2006). The therapeutic process of making art, according to Argyle and Bolton (2005), can be powerful yet soothing and calming (Graham-Pole, 2000). It can “enable expression of the otherwise inexpressible” (Argyle & Bolton, 2005, p. 341). The creative process of art therapy offers participants a chance to experiment with new ways of seeing and being, while various art therapy interventions (such as, masks, thematic painting, and doll-making, etc.) help facilitate reflection, communication, and cognition (Malchiodi, 1999).

#### *Group Life Stories Narrative Therapy*

In 1979, Joan Didion, American journalist, author, and essayist, began the first chapter of her book, *The White Album*, with the following sentence: “We tell ourselves stories in order to live” (p. 11). Through her own lens, while searching for purpose and meaning in life, Didion tells a personal story filled with diverse experiences, troubled times, and pivotal moments; and although she has long been considered a masterful storyteller, Kenyon (2003) believes, as humans, we are all masterful storytellers and as such, we all have unique stories to share, create, and discover (p. 31).

Although empirical research surrounding the use of narrative therapy within our aging population, is somewhat limited in scope, Gardner and Poole (2009), believe research in this area continues to expand and improve. While utilizing a biographical-narrative approach with Holocaust survivors, Rosenthal (2003) argued in favor of storytelling, as an intervention, especially for its healing potential, while Kenyon (2003) utilized storytelling for its countless

opportunities to facilitate reminiscence and reflection. According to Rennie (1994), storytelling can be more powerful than its dialogue would suggest (p. 234). Consequently, the narrative life stories approach to counseling provides older persons with a therapeutic meaningful approach to better understand themselves more fully (Holst, Edberg, & Hallberg, 1999; Kenyon, 2003; Rennie, 1994).

Narrative therapy, developed within the traditional approach of family therapy, is philosophically grounded in post-structuralism (i.e., having not just one, single purpose or meaning) and is commonly viewed as an alternative approach to the traditional or conventional counseling therapies (Besley, 2002; Nylund & Nylund, 2003; Gardner & Poole, 2009). Influenced by a myriad of disciplines from areas of anthropology and sociology to psychology and literature, narrative therapy complements the principles and practices of other alternative therapies, such as art therapy (Malchiodi, 2003); however, the primary approach, or means of communication with narrative therapy, is verbal (i.e., storytelling).

In a randomly assigned, pretest/posttest study of 43 adults (age 65 to 93), examining the effects of life review on depression, Serrano, Latorre, Gatz, and Montanes (2004) reported improvement in depression scores, as measured by the Center for Epidemiologic Studies Depression Scale (CES-D). In addition, posttest results found, not only fewer depressive symptoms (in the treatment group vs. non-treatment group), but also an increase in life satisfaction scores, as measured by the Life Satisfaction Index-A (LSIA).

A case study of an older woman experiencing depression and decreased physical functioning, presented by Kropf and Tandy (1998), described the use of narrative storytelling as a positive and life affirming experience. In their review, Kropf and Tandy claimed the use of

narrative therapy offered, to their client, not only a new opportunity to reexamine life, but also an opportunity to reexamine their perceived life story.

Pioneers and colleagues in the field of narrative therapy, such as White, Epston, Freedman, Nylund, and Madigan (Nylund & Nylund, 2003), believe humans live life according to their stories. Consequently, the use of storytelling, or the narrative, has the “tremendous potential to shift individual lives in preferred directions” (p. 393). By externalizing the personal story, participants in narrative therapy can separate the issue, or problem, from self; thus opening a space to recreate or re-author” their own lives (Nylund & Nylund, 2003, p. 389). According to Johnson (2003), narrative storytelling provides participants a unique opportunity to better review, communicate, connect, and understand their lives. Kenyon and Randall (2001) argue the use of storytelling, or narrative therapy, offers participants an engaging and aesthetic way to review life, thus ultimately, providing a better way to understand and make meaning, as well.

In a review of narrative therapy literature, Caldwell (2005) argued the use of storytelling as an ideal intervention in the field of gerontology. When used in a group format, the use of the narrative and storytelling also appeared to be successful; for it offered fellow group members a chance to participate as audience members, while championing or supporting the lead character (van der Velden & Koops, 2005; Gardner & Poole, 2009). In a systematic review of eight intervention studies and the use of life stories in institutional care settings, Moos and Bjorn (2006) found life stories and reminiscence to have a strong positive effect in self-esteem, integration of the self, and in social interaction; however, certain attributes, such as large group size, were shown to reduce the beneficial effects in two of the eight reported evaluations. In all, according to Moos and Bjorn “enhanced interaction, regardless of whether the evidence was qualitative, quantitative, or anecdotal was reported” (p. 448).

Most therapeutic counseling involves some form of life review, reminiscence, and recall (Hyer, Sohnle, Mehan, & Ragan, 2002). By helping place memories in context, reminiscence and life review can be extremely beneficial for self-understanding, especially during times of transition, grief, or illness. The process of narrative life review, reminiscence, and storytelling, according to Kenyon (2003), can help participants develop and maintain a sense of identity, as well as express “what is meaningful (or meaningless) to us in life” (p. 30). From the perspective of gerontology, the use of reminiscence and review offers participants a chance to relive their personal story (Kenyon, 2003).

In a randomized controlled trial examining the effects of a reminiscence program on well-being/ill-being (WIB) and social engagement (SES), in nursing home residents (with dementia) Lai, Chi, and Kayser-Jones (2004) found significant positive changes in both WIB and SES outcomes, immediately post intervention, however; six weeks post intervention, no significant differences were found in WIB. As a result, Lai et al. argue in favor of a continuous, ongoing program to provide long-term and lasting benefits.

In an attempt to discover purpose and meaning in life, Singer (2004) believes we all have unique stories to tell, with key episodes, wisdom, and self-defining memories, which are essential to one’s past, present, and future. According to Hyer et al. (2002), as humans, we strive to attach meaning or purpose to our lives, while organizing and anticipating our interactions with the world. Consequently, as a process, the use of the narrative life story allows one to creatively revisit the past, while at the same time, adhere to a sense of coherence, meaning, and control. This type of intervention, or treatment approach, can be potentially useful in long-term care facilities. For example, in a small, randomly separated, pre and post test design, examining the use of narrative, positive-core memories (PCM) with residents in a long term care facility, Hyer

et al. (2002) found the use of a positive narrative to be significant in affecting positive mood states, as measured by the *Profile of Mood States [POMS-B]* (McNair, Lorr, Heuchert, & Droppleman, 2003). They found the use of reminiscence and life stories offered an additional integrative quality resulting in a more coherent narrative (Hyer et al., 2002).

As the wife of the late, well-known developmental psychologist, Erik Erikson, Joan Erikson was well versed in her husband's theories and stages of psychosocial development. In the revised, extended version of Erikson's original book, *The Life Cycle Completed*, Joan Erikson (Erikson, 1982) comments on the privilege of growing old. She believes the privilege allows one to relive a long life, albeit, in retrospect (Erikson). Granted, while on one side of the equation looking back can be limited, narrow, cluttered, or steep; the other side of the equation provides a retrospective view offering enlightenment, discernment, and insight (Erikson). Focusing on the retrospective view of life, Kenyon, Clark, and de Vries (2001), use life stories as a metaphor, by providing assumptions, implications, and issues to help solidify and justify the use of storytelling with older adults, with the implied purpose of improving quality of life. Kenyon et al. (2001) believe the questions older persons have about life, and what makes life worthwhile, can only be answered by asking them (p. viii).

In 2001, Kenyon and Randall (2001) examined numerous ways in which the narrative operates, and offered the following five basic assumptions (pp. 3-18):

1. Viewed from an existential perspective, storytelling and humanity go hand-in-hand within three dimensions: affective, cognitive, and voluntary. Consequently, although often seen as a work-in-progress, as humans, we become the authors (hence: *story*) of our own lives. (p. 4)



2. As humans, we are open to change; therefore, our stories consist of facts as well as elements of possibilities.
3. From a narrative point of view, we are connected to our stories through the nature and meaning of time. As a result, there is both *clock time* and *story time*.
4. As stories, our lives have four interrelated levels. (p. 7).
  - Structural (the policies of society)
  - Socio-cultural (cultural, ethnic, and gender)
  - Interpersonal (relationships)
  - Intrapersonal (meaning and understanding)
- 5) Although mystery, absurdity, and obscurity often surround our stories, we realize our lives are better understood in terms of the narrative metaphor.

For our aging population, according to Davis-Jones and Beck-Little (2002), literature suggests the use of narrative life stories and reminiscence can be a valuable and effective treatment intervention for reducing depression, improving self-esteem, promoting social interactions, and increasing life satisfaction. Kenyon (2003) strongly believes narrative life stories are some of the most intimate possessions we own, however, he cautions, not everyone feels comfortable engaging in personal storytelling or reminiscent activities, especially during certain periods of life. Consequently, and similar to more traditional counseling therapies, ethical issues abound, especially during times of immediate trauma. Nonetheless, with sensitivity, care, and genuine story-listening mode, meaningful story-telling encounters, with older persons, can help facilitate understanding, acceptance, and wisdom (Kenyon, 2003).

*Summary*

This chapter focused on the research and literature relevant to this study. It included a review of existing research and literature describing Art Therapy and Life Stories Narrative Therapy, on the life satisfaction and mood.

Chapter III presents the research design, setting, and assignment of the two experimental counseling groups in two separate nursing home facilities. Additionally, the independent and dependent variables, research questions, hypotheses, and data analyses for evaluating the outcome effects of two group counseling interventions, Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT), on life satisfaction and mood of older females living in skilled nursing home facilities, are also presented.

### CHAPTER III

#### METHODS

##### *Introduction*

This chapter covers the methods and procedures used to describe the participants, collect and analyze the data, and test the hypotheses developed for evaluating the effects of Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT) on levels of life satisfaction and mood of older women living in skilled nursing home facilities.

Including the preliminary, ninety-minute (information) session offered to all group participants, both Experimental Group I GAT and Experimental Group II GLSNT received a total of 12 hours of group counseling intervention. A pretest was used to establish baseline information on the following dependent variables: the participants' levels of life-satisfaction and mood disturbance. A posttest (conducted during the final group session) was used to determine the effects of the interventions on the two dependent variables. It was hypothesized; there would be no significant differences, at the completion of the study, in levels of life satisfaction and mood disturbance between participants in Experimental Group I (GAT) and participants in Experimental Group II (GLSNT).

##### *Research Design*

This quasi-experimental pretest-posttest design (Hadley & Mitchell, 1995) compared the outcomes of two group therapy interventions, Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT) on levels of life satisfaction and mood. Group participants consisted of older women, age 65 years +, who were mobile (with or without assistance), communicative, and living in two Metropolitan Detroit based skilled nursing care facilities, for a minimum of three months. Group participants completed two pre-study instruments and one demographic

form. Although residential restrictions prevented random selection of individual participants to treatment, random assignment of experimental treatment to the two nursing home groups was made possible through the flip of a coin; where heads equaled Experimental Group I, Group Art Therapy (GAT) and tails equaled Experimental Group II, Group Life Stories Narrative Therapy (GLSNT). At the completion of the study all participants completed two post-study instruments.

This study yielded pre-and-post experimental information to be compared between groups (Between Groups) as well as within groups (Within Groups). Figure 1 details the research design.

Figure 1 Research Design			
Participants	Pretest	Treatment	Posttest
Experimental Group I: Group Art Therapy intervention with older women residing in skilled nursing home facilities.	R – O <sub>1</sub>  Life Satisfaction and Mood	T <sub>1</sub>  Group Art Therapy	O <sub>2</sub>  Life Satisfaction and Mood
Experimental Group II: Group Life Stories Narrative Therapy intervention with older women residing in skilled nursing home facilities.	R-O <sub>3</sub>  Life Satisfaction and Mood	T <sub>2</sub>  Group Life Stories Narrative Therapy	O <sub>4</sub>  Life Satisfaction and Mood

### *Variables*

#### *Independent Variable*

The independent variables for this study were random assignment of two experimental treatment conditions to two groups, Experimental Group I, Group Art Therapy (GAT) or Experimental Group II, Group Life Stories Narrative Therapy (GLSNT).

### *Dependent Variable*

The dependent variables were participants' levels of life satisfaction, as measured by the *Satisfaction with Life Scale (SWLS)*, Diener, Emmons, Larson, & Griffin, 1985) and mood disturbance, as measured by the *Profile of Mood States (POMS-B)*, McNair et al., 2003)

### *Setting*

Two Bortz Skilled Nursing Care facilities, located in the metropolitan Detroit, Michigan area served as settings for this study. According to Smythe (personal communication, August 4, 2010) Bortz Nursing Care facilities are granted licenses by the State of Michigan, Bureau of Health, Department of Consumer and Industry Services (CIS). They are one of the largest, privately owned, family operated nursing care facilities in the United States. Their mission is to “enhance the well-being and quality of life of its residents, while providing superior care and security to those who can no longer care for themselves” (P. M. Law-Hopkins, personal communications, October 20, 2010). Two-out-of-four Metropolitan Detroit based Bortz facilities, Redford Geriatric Facility and Cranbrook Nursing Facility, were randomly selected to serve as settings for this research study. Approval to conduct the research study was granted by the Human Investigative Committee at Wayne State University and by the Vice President of Operations for the Bortz Skilled Nursing facilities. The letter of approval is listed in Appendix A.

### *Participants*

Group participants consisted of volunteer, female nursing home residents (with a minimum residency of three months), who were cognitively and physically able to participate in either group art therapy or group life stories narrative therapy intervention. Cognitive ability was determined by utilizing a minimum assessment score of 8 (moderate impairment) out of a possible 15 (intact cognition) of the *Brief Interview for Mental Status (BIMS)-Nursing Home*

*Comprehensive Assessment, Minimum Data Set (MDS-3.0)* [Supplemental material] (U.S. Department of Health and Human Services [HHS], 2010), conducted by a member of the Bortz nursing staff, prior to the study.

To be included in the study, participants had to be physically able to participate, with minimal assistance, and: 1) have resided in the facility for at least three months; 2) be of age 65 years or older; 3) able to communicate; and 4) mobile (with or without assistance). Excluded from this study were women residents who: 1) were unable to communicate effectively with other group members; 2) confined to their bedrooms; 3) diagnosed with late stage cognitive disorders; 4) under the age of 65; and 5) resident less than three months. Participants were recruited through the researchers' presentation, residential recruiting flyer, and assistance from facility staff members.

Information about the research study, and the two group interventions, were provided via personal announcements by the researcher and staff members, as well as through a distributed flyer (see Appendix A). The flyer also included the title of the study, contact information, and the day and time of each group therapy session. Interested participants were asked to inform the researcher, a member of the nursing staff, or sign their name to a volunteer participation form, maintained by the nursing staff.

The initial sample included 20 volunteers; however, three individuals were unable to complete the study. Seventeen older females, age 65+, living in two Metropolitan Detroit based skilled nursing facilities for a minimum of three months, completed this study. The age of participants ranged from 65 to 92, with a mean of 80. Eighty-two percent of group members were African American while 76% were widowed. Experimental Group I, GAT included seven participants and Experimental Group II GLSNT included ten participants.

### *Preliminary Procedures*

Participants in this research study were recruited on a volunteer basis. The researcher held the initial ninety-minute session (at two separate facilities) with the volunteers who signed the participation form. During the first session, researcher and volunteer participants were introduced. Information regarding guidelines, purpose, and expectations of the study, as well as issues of confidentiality, were discussed. Participants were informed of any potential risks, as well as overall benefits of participating in a research study; along with information on group art therapy, group life stories narrative therapy, testing procedures, meeting dates, and room location. While reading along, participants were read aloud the informed consent and were subsequently asked to sign the document. Assistance was provided, when needed.

For purposes of data identification, as well as an assurance of anonymity and confidentiality, participants were asked to choose a personal four-digit number; such as four digits of a phone number, to be used throughout the duration of the study. Participants were informed they could withdraw from the group at any time, without penalty or prejudice. They were also provided with information regarding individual counseling opportunities, available (at no cost), to any group member who became upset or agitated during the group counseling sessions.

After discussion of benefits, procedures, and confidentiality, etc., participants were asked to complete a short, personal, demographic questionnaire form, as well as two pretest criterion instruments. Clarification questions from participants were permitted at this time while assistance with pretest questionnaires was provided, if needed (with the use of repetition and simple clarification of items appearing on the criterion instrument). Expansive explanation or elaboration however, was not given.

Two criterion instruments *SWLS* (Diener et al., 1985) and *POMS-B* (McNair et al., 2003) were used to establish baseline information for the two dependent variables, life satisfaction and mood disturbance. Following completion of all paperwork, group members were informed of the day and time of next group session as well as the type of intervention received. Because of limitations restricting travel among nursing home residents, random selection and assignment of participants to the two experimental treatment conditions was not possible, however; random assignment of the two experimental treatment conditions, to the two separate nursing home groups, was made possible through the flip of a coin; where ‘Heads’ represented Experimental Group I Group Art Therapy and ‘Tails’ represented Experimental Group II Group Life Stories Narrative Therapy.

At the conclusion of the study, all participants completed the two criterion instruments, *SWLS* (Diener et al., 1985) and *POMS-B* (McNair et al., 2003), to determine the outcome effects of the two group counseling interventions on the dependent variables. Participants were given the opportunity to ask questions and seek closure. All participants received a total cash compensation gift of \$20.00 (as a token of gratitude) and a personalized ‘Certificate of Appreciation’ (see Appendix E).

#### *Experimental Treatment Procedures*

The purpose of this study was to determine if the use of Group Art Therapy (GAT) was a more effective therapeutic intervention (enhancing levels of life satisfaction and mood of older women residing in skilled nursing home facilities) than the use of Group Life Stories Narrative Therapy (GLSNT). The final outcome of the two group therapy interventions (GAT and GLSNT) were compared in terms of pre-to-post score changes in levels of life satisfaction and



mood disturbance as measured by the *SWLS* (Diener et al., 1985) and *POMS-B* (McNair et al., 2003).

Including the initial preliminary, ninety-minute (information-gathering) session, held day one of week one, members of each therapy group participated in a total of eight (bi-weekly, ninety-minute) sessions for a total of twelve hours of group therapy intervention over a four-week period. The following two sections describe the group treatment interventions.

#### *Experimental Group I, Group Art Therapy (GAT)*

Members in Experimental Group I participated in a total of eight, Group Art Therapy intervention sessions (including the initial, preliminary information-gathering session) over a four-week period. Each group art therapy session ran approximately ninety minutes and was held twice weekly.

At its most basic level, art therapy, according to the American Art Therapy Association (AATA, 2010), is the therapeutic use of making art. It was founded on the understanding that the process of art making is healing and life enhancing. As such, thus, it can become an effective alternative intervention facilitating hope, meaning, and change (AATA, 2010). According to Brown (1996), the use of art, especially during the group process, provides an additional means of communication by offering different modes of expression. Group Art Therapy can be a dynamic intervention, especially when working with older populations. In addition to a creative means of communication, the art therapy group provides camaraderie and opportunities for increased socialization and self-discovery. In addition, through the therapeutic process of making art older adults have an opportunity to come to terms with the various existential challenges, dilemmas, and limitations of growing older (Moon, 2003).

The following group art therapy interventions (see Figure 2) provided opportunities for exploring participants' worlds (i.e., physical world, social world, and private world), as well as opportunities to examine existential issues and concerns such as death, isolation, loss of freedom, and purpose. Additionally, within the existential setting, the group art therapy sessions also provided an opportunity for participants to utilize imagery as a means to explore the eighth stage of Erikson's psychosocial model of development: Integrity vs. Despair (Erikson, 1982). Like various stages of life, art, too has many stages. Consequently, through the process of making art a vehicle for life review and reflection was created (Moon, 2003).

Each intervention session began with a brief 'settling-in' period and various relaxation techniques. It was important for group members to feel safe, relaxed, and comfortable. Over the four-week intervention period, group members reflected on past events while trying to understand and/or recognize specific decisions or meanings (of which they may not have been aware, previously). Through various art interventions, group participants were guided through different developmental stages (either chronologically or thematically), while considering various existential aspects of life, such as; death, grief, hardship, fear, relationships, work, family, and accomplishments, etc. (Dynes, 2006).

The following Group Art Therapy (GAT) Counseling Session Summaries (Figure 2) highlight the various art therapy directives utilized during the seven art therapy intervention sessions, after the initial information and pretest session #1. The directives were adapted from Landgarten (1981) and Darley and Heath (2008).

Figure 2 Experimental Group I, Group Art Therapy (GAT) Counseling Session Summary 2  
Format of Group Art Therapy (GAT) Interventions

Session 2

Theme: Icebreaker/Introduction

- Welcome members to the group:
  - Set a warm and welcoming tone.
  - Allow group members time to settle in, get comfortable, and relax.
  - Thank members again, for their time and participation.
  - Allow time for members to voice questions and concerns.
  - Remind members about respect, confidentiality, and consideration.
    - Guidelines for Researcher/Counseling Therapist
      - i. Be attentive: Display genuine interest
      - ii. Use appropriate and encouraging comments
      - iii. Empathy
- Introduce Icebreaker:
  - Creating, designing, and coloring name-card
  - iv. Introductions: name, place of birth, favorite childhood food.
- Objective:
  - Getting acquainted
  - Stimulate creativity, socialization, and memory recall.
- Goal:
  - Engender a sense of community, fun, and relaxation.
- Materials:
  - Cardstock paper, markers, colored pencils, crayons.
- Intervention:
  - Researcher instructs group members to fold card stock in half – length wise – and write name on front in bold letters (assistance offered if needed). Group members are asked to design or decorate a unique name-card, as they like. Members are then asked to introduce themselves and share a little about themselves. This initial art therapy directive is designed simply to facilitate introduction while alleviating any concerns or anxiety about artistic ability.
- Process Criteria:
  - Group members are never left unattended and are assisted by an attendant from Bortz nursing facility. The researcher will encourage listening, sharing, and the creative process of the intervention.
- Outcome Criteria:
  - Introductions, creating a welcoming and safe environment, comfort and creativity.

Figure 2 Experimental Group I, Group Art Therapy (GAT) Counseling Session Summary 3  
Format of Group Art Therapy (GAT) Interventions

Session 3

Theme: Metaphors and Thematic Painting

- Welcome members back to the group:
  - Allow group members time to settle in, get comfortable, and relax.
  - Allow time for members to voice questions and concerns about previous week.
- Introduce Art Therapy directive:
  - Thematic Painting and Metaphors.
- Objective:
  - Discuss theme of seasons and change, weather, and related metaphors (autumn/autumn years; rain/hardship, change of colors/ phases, winter/blanket, etc.).
- Goal:
  - Restore and/or add to one's self-identity as well as help group members interpret images of various life stages.
- Materials:
  - 18x24 inch thick paper, non-toxic tempera paint, brushes, and water.
  - Smocks or aprons, paper towels, cups, and plastic tablecloths.
- Intervention:
  - Participants will be asked to paint any image(s) that come to mind from reflecting on seasons of life, stages, colors, and metaphors. The researcher will spend approximately 5-10 minutes with materials, instructions, and demonstration. After approximately 30 minutes of painting, the group members will discuss images, process, feelings, ideas, etc.
- Process Criteria:
  - Group members are never left unattended and are assisted by an attendant from Bortz nursing facility. The researcher will continue to encourage listening, sharing, and creative aspects of the intervention.
- Outcome Criteria:
  - Participants will have an opportunity to work with paint to create a product. They will reflect on memories, share thoughts and feelings.

Figure 2 Experimental Group I, Group Art Therapy (GAT) Counseling Session Summary 4  
Format of Group Art Therapy (GAT) Interventions

Session 4

Theme: Rain Sticks/Thematic Sculpture

- Welcome members back to the group:
  - Allow group members time to settle in, get comfortable, and relax.
  - Allow time for members to voice questions and concerns about previous week.
- Introduce Art Therapy directive:
  - Rain Sticks/Thematic Sculpture.
- Objective:
  - Participants will engage in exploration of objects and materials while creating something out of raw materials.
- Goal:
  - To enhance memory, orientation, movement, and communication.
- Materials:
  - Non-toxic paint, colorful yarn, colorful tissue paper, and aluminum foil.
  - Scissors, glue, dried beans (lentils), rice, or small pasta pieces.
  - Individual six-inch cardboard tubing
- Intervention:
  - Researcher will summarize previous week's session and reorient group to the theme of autumn, rain, changes, etc, while explaining current directive: The Rain Stick/Thematic Sculpture. Participants will be shown an example of a Rain Stick and hear the sounds emanating from the completed musical instrument.
- Process Criteria:
  - Group members are never left unattended and are assisted by an attendant from Bortz nursing facility. The researcher will continue to encourage conversation, process, sharing, gross and fine motor skills.
- Outcome Criteria:
  - While creating a personal rain stick (to be used in the following session), group members will be asked to recall events from previous sessions, reflect on life experiences, and encouraged to share and socialize.

Figure 2 Experimental Group I, Group Art Therapy (GAT) Counseling Session Summary 5  
Format of Group Art Therapy (GAT) Interventions

Session 5

Theme: Utilizing (handmade) Rain Sticks and Movement

- Welcome members back to the group:
  - Allow group members time to settle in, get comfortable, and relax.
  - Allow time for members to voice questions and concerns about previous week.
- Introduce Art Therapy directive:
  - Rain Sticks and Movement
- Objective:
  - Group members will engage in movement (with music) and through the individual rain stick instrument created in the previous sessions. The movement and music will stimulate thoughts and feelings as well as, enhance quality of life.
- Goal:
  - To increase feelings of self-esteem, self-worth, and socialization, while using the personal musical instrument, and to increase cognitive functioning through stimulation and repetition of task.
- Materials:
  - Completed handmade rain stick and music (chosen previous week by group).
- Intervention:
  - Researcher will explain the process, music, movement, and rain stick and encourage movement, while alternating with the use of each participant's rain stick.
- Process Criteria:
  - Group members are never left unattended and are assisted by an attendant from Bortz nursing facility. The researcher will encourage movement, conversation, and gross motor coordination.
- Outcome Criteria:
  - Participants will assess memories and be physically stimulated by movement, rhythm, and music. Participants will also demonstrate creativity, feelings of accomplishment, and feelings of self-worth.

Figure 2 Experimental Group I, Group Art Therapy (GAT) Counseling Session Summary 6  
Format of Group Art Therapy (GAT) Interventions

Session 6

Theme: Masks

- Welcome members back to the group:
  - Allow group members time to settle in, get comfortable, and relax.
  - Allow time for members to voice questions and concerns about previous week.
- Introduce Art Therapy directive:
  - Masks
- Objective:
  - Through masks, participants will engage in self-expression, fantasy, wishes, and concerns.
- Goal:
  - To encourage play, communication, and expression of emotions, thoughts, and dreams. To increase cognition, memories, and creativity.
- Materials:
  - Store bought plastic whole facemask and/or half facemask.
  - Colored tissue paper, foil, glue, string, glitter, ribbon, buttons, feathers, etc.
- Intervention:
  - Researcher will discuss the concept, use, and ritual of masks. Group members will be encouraged to have fun, experiment, be creative and spontaneous. Discussion will follow while each participant tries on mask (and thus, new persona).
- Process Criteria:
  - Group members are never left unattended and are assisted by an attendant from Bortz nursing facility. The researcher will encourage a festive atmosphere filled with color, creativity, and self-expression.
- Outcome Criteria:
  - This is a very exciting activity. Masks encourage make-believe and play. Group members will be engaged and energized as they go through the art process, discuss various choices, and try on new personas. In addition, participants will demonstrate greater feelings of identity, understanding, and group cohesiveness.

Figure 2 Experimental Group I, Group Art Therapy (GAT) Counseling Session Summary 7  
Format of Group Art Therapy (GAT) Interventions

Session 7

Theme: Life is a Puzzle

- Welcome members back to the group:
  - Allow group members time to settle in, get comfortable, and relax.
  - Allow time for members to voice questions and concerns about previous week.
- Introduce Art Therapy directive:
  - Life is a Puzzle
- Objective:
  - Group members will expand on ideas of creativity, cognitive thought, uniqueness and group socialization. Participants will select a large puzzle piece (previously cut from foam core board), share an experience, and create an image to match story.
- Goal:
  - To honor uniqueness while enhancing group cohesiveness, reduce feelings of isolation, and promote understanding and empathy.
- Materials:
  - Foam core puzzle piece, markers, colored pencils, crayons, and trimmings.
- Intervention:
  - Researcher will explain the art directive and instruct participants on how to approach the puzzle piece. Discussion will follow regarding the significance of the individual/unique puzzle piece as well as the completed puzzle/group cohesiveness.
- Process Criteria:
  - Group members are never left unattended and are assisted by an attendant from Bortz nursing facility. The researcher will encourage shared feelings, discussion, creativity, and group participation.
- Outcome Criteria:
  - Participants will assess thoughts and feelings of both current and past experiences. In addition, they will demonstrate feelings of personal identity along with group identity and cohesion.



Figure 2 Experimental Group I, Group Art Therapy (GAT) Counseling Session Summary 8  
Format of Group Art Therapy (GAT) Interventions

Session 8

Theme: Final Session – Closure, Posttest Instruments, Certificates, Gift

- Welcome members to final group session
  - Allow group members time to settle in, get comfortable, and relax.
  - Remind group members this is final session.
- Introduce short art therapy directive and posttest instruments:
  - Endings/Closure
  - Small clay object as gift to group member.
- Objective:
  - Group members will experience a sense of closure (in safe environment), accomplishment, purpose, pride, and dignity.
- Goal:
  - To encourage and provide a safe environment for closure and resolution.
  - To encourage and provide a sense of accomplishment, feelings of self-worth.
  - To extend gratitude and appreciation to fellow members.
  - To complete posttest instruments.
  - For researcher to extend gratitude and appreciation for participation.
- Materials:
  - Self-drying, non-toxic clay polymer material in multiple colors.
- Intervention:
  - Participants will be asked to create a small object (flower, animal, etc.) out of non-toxic clay polymer and present it as a gift to the group member sitting on left. Participants will be invited to share something special about their experience.
  - Participants will be encouraged to ask questions. They will be asked to organize thoughts and express feelings about the past sessions, as well as thoughts and feelings with current/final session. Researcher will discuss endings and the many ways we say goodbye to others
- Researcher will administer posttest instruments: *Satisfaction with Life Scale (SWLS*, Diener et al., 1985) and *Profile of Mood States*, Brief form (*POMS-B*, McNair et al., 2003).
- Process Criteria:
  - Researcher will aid and assist those who require assistance. Researcher will remind group members the importance of their participation and will personally thank each participant with a personalized Certificate of Appreciation and a cash gift of \$20.00.
- Outcome Criteria:
  - Closure is significant. It is important for participants to be able to express themselves about the pros and cons of their participation and sessions, as well as express feelings about their group experience. Each participant will be offered an opportunity to share a positive moment with another group member.

*Experimental Group II, Group Life Stories Narrative Therapy (GLSNT)*

Members in Experimental Group II participated in a total of eight Group Life Stories Narrative Therapy counseling intervention sessions (including the initial, information-gathering session) over a four-week period. Each Group Life Stories Narrative Therapy session lasted approximately ninety minutes in duration, and was offered twice weekly.

Group Life Stories Narrative Therapy involved a process of review, reminiscence, storytelling, and story listening. Kenyon (2003) asserts the narrative (i.e., storytelling) takes on a unique spiritual, or existential, quality when participants express meaning in life. Although primarily thought of as a collaborative process, the premise of narrative therapy is based on the belief that while our identity is created in one context (social), it is revealed through another (stories) (Gardner & Poole, 2009). A review of life stories and experiences, especially for older people (Haight & Haight, 2007), takes on an existential quality by helping participants, or group members, facilitate meaning and purpose in life. As a result, the aim of the Life Stories Narrative Therapy group interventions was to offer participants an opportunity for self-discovery, through reflection and examination of one's life story. Consequently, the life story-narrative review process provided an opportunity (for group participants) to come to terms with prior decisions and choices, while facilitating an acceptance of responsibility.

The following structured life stories narrative therapy sessions were enhanced by Erikson's eight stages of psychosocial development. While reviewing various stages, a primary focus was on the eighth stage of Mature Adulthood - 65+ years (Erikson, 1982). Erikson's eighth stage of psychosocial development highlights the concept of Integrity (accepting responsibility) vs. Despair (regrets). Although life stories narrative therapy helped provide participants with an opportunity to reconnect with the past, one of the goals of the intervention was to help

participants reach Integrity, or acceptance of one's life, as it was lived; while another goal was to help facilitate meaning and purpose in life (Haight & Haight, 2007). In addition to accepting one's life and facilitating purpose and meaning, the use of life stories narrative therapy also yields, according to Haight and Haight, other therapeutic benefits, such as: "reduced depression, greater life satisfaction, reconnection, self-acceptance, bonding, catharsis, relationships, and peace" (p. 18).

Figure 3 highlights the seven Group Life Stories Narrative Therapy (GLSNT) counseling session summaries and the various narrative directives used during the bi-weekly group counseling interventions, after the initial information and pretest session #1. The following directives were adapted from Birren and Deutchman (1991), and Birren and Cochran (2001) and Haight and Haight (2007).

Figure 3 Experimental Group II, Group Life Stories Narrative Therapy Counseling Session Summary 2, Format of Group Life Stories Narrative Therapy (GLSNT) Interventions

## Sessions 2

### Theme: Icebreaker

- Welcome members to the group:
  - Set a warm and welcoming tone.
  - Greet each new member; make nametags.
  - Allow group members time to settle in, get comfortable, and relax.
  - Allow time for members to voice any concerns.
    - Guidelines for Researcher/Counseling Therapist:
      - i. Be attentive: Display genuine interest
      - ii. Use appropriate and encouraging comments
      - iii. Empathy
- Introduce Icebreaker:
  - Name, Place of Birth, Favorite childhood food.
- Objective:
  - Getting acquainted
  - Encourage interaction while stimulating the process of life stories, reminiscence, and review.
- Goal:
  - To begin the process of review/reconnection with the past in a nonthreatening way.
- Materials:
  - Flip chart; nametags;
  - Plain paper, pencils, and markers.
- Intervention:
  - Researcher asks participants to first think about a favorite food from childhood. Group participants are asked to pair up with a person on either their right or left. After approximately five-to-ten minutes (to interview each other), each participant will introduce her partner to the group, by name, birthplace, and the favorite food memory shared.
- Process Criteria:
  - Group members are never left unattended and are assisted by an attendant from Bortz nursing facility. The researcher will encourage interaction and discussion as well as encourage the life review process.
- Outcome Criteria:
  - Increased socialization. This experiential allows group members a chance to bond, share in the conversation, understand one another, focus, and potentially trigger memories.

Figure 3 Experimental Group II, Group Life Stories Narrative Therapy Counseling Session Summary 3, Format of Group Life Stories Narrative Therapy (GLSNT) Interventions

Session 3

Theme: Igniting Senses

- Welcome members back to group:
  - Greet each member by name; hand out nametags.
  - Allow time to settle in, get comfortable, and relax.
  - Summarize and Address any questions from week one.
- Introduce theme: Clustering – a brainstorming exercise
- Objective:
  - Stimulate recall
  - Association of memories through words, images, smells, sounds, etc.
- Goal:
  - Problems of Focus
  - Opening up thinking; letting in feelings.
  - Engaging senses
- Materials:
  - Flip Chart
  - Writing materials
- Intervention:
  - Hand out an orange to each participant. Write the word ‘orange’ in the middle of flip chart.
  - Brainstorm with group for associations with the color orange.
  - Encourage participants to use all senses.
    - Sounds
    - Taste
    - Smell
    - Touch/textures
  - Share sensations that were important (as a child)
- Process Criteria:
  - Group members are never left unattended and are assisted by an attendant from Bortz nursing facility. The researcher will encourage participants to share (what they are comfortable sharing), listen attentively while others speak, and offer supportive feedback and comments.
- Outcome Criteria:
  - Participants continue socialization skills while becoming more insightful and understanding. Participants draw on all five senses as they share sensations of childhood; i.e., smell of freshly mowed grass in the summer, the touch of an orange peel.

Figure 3 Experimental Group II, Group Life Stories Narrative Therapy Counseling Session Summary 4, Format of Group Life Stories Narrative Therapy (GLSNT) Interventions

#### Session 4

#### Theme: Childhood and Earliest Memory

- Welcome members back to group:
  - Greet each member by name; hand out nametags.
  - Allow time to settle in, get comfortable, and relax.
  - Stress the issue of confidentiality:
    - Trust in other group members is essential.
    - Participants must feel safe sharing stories.
  - Summarize and Address issues from previous session.
- Introduce narrative life stories directive:
  - Start with safe/non-threatening question
    - Questions addressing earliest memory (and first stage of life).
    - Think back as far as you can.
- Objective:
  - Trust vs. Mistrust
  - Autonomy vs. Shame and Doubt
  - Stimulate memory and detail
- Goal:
  - To report anything that comes to mind. Memory does not need to be personal.
- Materials:
  - Large plain paper, pencil, pen, and marker.
- Intervention:
  - What is the very first thing you can remember in your life? Go back as far as you can. Did you have siblings; cousins; aunts; uncles, etc.? Did you have a best friend? Were you ever afraid? Was church important in your life?
  - Researcher utilizes anecdotes from life to prompt reflection and memories:
    - Be attentive, supportive, and accepting
- Process Criteria:
  - Group members are never left unattended and are assisted by an attendant from Bortz nursing facility. The researcher will continue to encourage discussion while creating a warm, understanding, and open climate. It is critical to regard group members with warmth and understanding.
- Outcome Criteria:
  - Participants begin to recall childhood as well as make choices on what to share and talk about. Hearing others' stories helps retrieve memories. Sharing of stories can help participants become more aware of strengths. Trust and comfort continue to grow.

Figure 3 Experimental Group II, Group Life Stories Narrative Therapy Counseling Session Summary 5, Format of Group Life Stories Narrative Therapy (GLSNT) Interventions

### Session 5

#### Theme: Adolescence

- Welcome members back to group;
  - Greet each member by name; hand out nametags.
  - Allow time to settle in, get comfortable, relaxed.
  - Summarize and Address any questions from previous week.
- Introduction:
  - Reinforce trusting relationship
  - Dialogue about late childhood and adolescence
- Objective:
  - Focus is on late childhood and adolescence
    - Initiative vs. Guilt
    - Industry vs. Inferiority
- Goal:
  - Improving memory; socialization; listening skills.
- Materials:
  - Large plain paper, pencil, pen, and marker
- Intervention:
  - Successful Firsts. When you were young, what projects did you enjoy working on, or what did you enjoy doing around the house? What was school like for you?
- Process Criteria:
  - Group members are never left unattended and are assisted by an attendant from Bortz nursing facility. Researcher will utilize counseling skills by caring, responding, and reflecting.
- Outcome Criteria:
  - To help participants facilitate personal recall and to affirm uniqueness, accomplishments, and success.

Figure 3 Experimental Group II, Group Life Stories Narrative Therapy Counseling Session Summary 6, Format of Group Life Stories Narrative Therapy (GLSNT) Interventions

### Session 6

Theme: Evaluation and Unfinished business

- Welcome members back to group;
  - Greet each member by name; hand out nametags.
  - Allow time to settle in, get comfortable, relaxed.
  - Summarize and Address any questions from previous week.
- Introduction:
  - Focus is on young adulthood
    - Identity vs. Role Confusion
    - Intimacy vs. Isolation
- Objective:
  - Closure on childhood memories
  - Examining past decisions and the influence on life
  - Recall adult memories
  - Achieve clarity
- Goal:
  - Improving memory; socialization; listening skills.
- Materials:
  - Large plain paper, pencil, pen, and marker
- Intervention:
  - Recall past; allow for differences; Focus on important decision made at this time. Did these decisions influence the course of their life?
- Process Criteria:
  - Group members are never left unattended and are assisted by an attendant from Bortz nursing facility. The researcher will encourage conversation, and participation, practice good listening skills, and offer unconditional positive regard.
- Outcome Criteria:
  - To help participants reconcile decisions and events by reframing old conclusions and ultimately paint new positive image of self.



Figure 3 Experimental Group II, Group Life Stories Narrative Therapy Counseling Session Summary 7, Format of Group Life Stories Narrative Therapy (GLSNT) Interventions

### Session 7

#### Theme: Integration

- Welcome members back to group;
  - Greet each member by name; hand out nametags.
  - Allow time to settle in, get comfortable, relaxed.
  - Summarize, Clarify, and Address any questions from previous week and remind group members this is the next to last session.
- Introduction:
  - Focus is on adulthood
    - Integrity vs. Despair
- Objective:
  - Review Significant Successes
  - Examine, evaluate, and consider past experiences
- Goal:
  - Sum up life's parts: envision your whole life,
  - Help participant understand and accept life as it was lived.
- Materials:
  - Large plain paper, pencil, pen, and marker
- Intervention:
  - Enumerate the good things; relish long-forgotten achievements; show how bad times brought you through to the good. Reframe life by creating acceptable image
- Process Criteria:
  - Group members are never left unattended and are assisted by an attendant from Bortz nursing facility. Help facilitate understanding and acceptance of where participants have been and why. Utilize counseling skills and listening skills.
- Outcome Criteria:
  - To help participants to get "unstuck" and help them look ahead. Help provide insight and strength. Summarize life review. Integration.

Figure 3 Experimental Group II, Group Life Stories Narrative Therapy Counseling Session Summary 8, Format of Group Life Stories Narrative Therapy (GLSNT) Interventions

### Session 8

Theme: Closure – Final Group Session, Posttest Instruments, Certificates, and Gift

- Welcome members back to group; Allow time to settle in, get comfortable, and relax.
- Introduction:
  - Endings/Closure
- Objective:
  - Group members will experience a sense of closure, accomplishment, increased purpose, pride, and dignity.
- Goal:
  - Tie up loose ends; provide safe environment for closure and resolution.
  - To complete posttest instruments.
  - To extend gratitude and appreciation for participation
- Intervention:
  - Researcher will discuss endings and the many ways we say goodbye to others. Participants will be encouraged to ask questions and express thoughts and feelings regarding previous sessions and final session. They will be encouraged to continue with social connections.
- Process Criteria:
  - Researcher will aid and assist those who require assistance. Researcher will remind group members the importance of their participation and will personally thank each participant with a personalized Certificate of Appreciation and a cash gift of \$20.00.
- Outcome Criteria:
  - Closure is significant. It is important for participants to be able to express themselves about the pros and cons of their participation and group sessions, as well as express feelings about their personal group experience. Each participant will be offered an opportunity to share a positive moment with another group member.

### *Criterion Instruments*

The following criterion instruments were used in this research:

*Demographic Questionnaire (Ryan, 2010)*

All study participants were instructed to complete a short, self-report Demographic Questionnaire (Ryan, 2010) on the first day of each group therapy session. Demographic items

included on the questionnaire were age, racial/ethnic category, marital status, education level, status of health, status of mobility, and previous levels of participation in extracurricular activities. Forced-choice responses were utilized to provide consistency.

*Satisfaction with Life Scale (SWLS, Diener et al., 1985)*

The *SWLS* (Diener et al., 1985) is a 5-item self-report scale designed to measure the cognitive component of global subjective well-being. The short, five-minute instrument used participants' own judgment of satisfaction with life and refers to the discrepancy or balance between one's life achievements and expectations. Group participants were instructed to rate five statements using a 7-point Likert scale, where a 1=strongly disagree, 2=disagree, 3=slightly disagree, 4=a neutral state (neither agree nor disagree), 5=slightly agree, 6=agree, and 7=strongly agree. No specific training or equipment was required to administer the *SWLS* (Diener et al., 1985). The items were summed to obtain a total score for life satisfaction. As a result, scores ranged anywhere from 5-35, with higher scores indicating higher levels of satisfaction with life. Fox, Stathi, McKenna, and Davis (2007) conducted a study on the physical activity and mental well-being of older adults. They reported a weak ( $r=0.20-0.28$ ) relationship between activity expenditure and time spent in activity to quality of life, subjective well-being and physical self-perceptions. Several mental health indicators were weakly and negatively related to time spent sedentary. Preliminary reliability of instruments appropriate for quality of life research was also provided.

Test-retest reliability for the *SWLS* (Diener et al., 1985) was established over a two-month period using five items selected from a pool of 48 based on results from factor analysis. Internal consistencies for this test reported an alpha coefficient of .87, while the correlation of .82 between test-and-retest scores showed stability (Diener et al., 1985). Test-retest validity for

the *SWLS* (Diener et al., 1985) was established using the following nine measures of subjective well-being: General life, social life, sexual life, relationships, self, physical appearance, family life, school life, and job (Alfonso, Allison, Rader, & Gorman, 1996). The scores on the *SWLS* (Diener et al., 1985) were related to independent ratings of life satisfaction among older adults.

*Profile of Mood States-Brief (POMS-B, McNair et al., 2003)*

The *POMS-B* (McNair et al., 2003) is a 30-item self-report inventory well suited for older persons. The *POMS-B* (McNair et al., 2003) measures both positive and negative aspects of following six identified mood-states or subscales of mental health:

- Tension – Anxiety
- Depression – Dejection
- Anger – Hostility
- Vigor – Activity
- Fatigue – Inertia
- Confusion – Bewilderment

The selected 30-items used for the *POMS-B* (McNair et al., 2003) assessment had the highest mean factor loadings from six studies used in the development of the original 65-item *Profile of Mood States* (McNair, Lorr, & Droppleman, 1971) instrument. Participants rated their levels of mood during one-of-three time frames (i.e., during the past week – including today; right now; and other) using a 5-point Likert Scale with 0=not at all and 4=*extremely*. Normative data were based on the time frame of during the past week – including today, with higher scores on the *POMS-B* (McNair et al., 2003) relating to higher levels in negative mood (i.e., mood disturbance). The *POMS-B* (McNair et al., 2003) inventory was presented in a “QuikScore” paper-and-pencil format and automatically transferred respondent’s answers through the top page

to the concealed scoring page. It was designed for recording, scoring, and profiling answers without the use of conversion tables or scoring stencils. In a study of nursing home residents and community-dwelling elders Gueldner, et al. (2001), compared the *Profile of Moods (POMS)*, McNair, Lorr, & Droppleman, 1981) and *Life Satisfaction Index A (LSIA)*, Neugarten, Havighurst, & Tobin, 1961) scores. Results confirmed female nursing home residents had lower scores ( $p=.05$ ) on subscales (anger, vigor, and confusion) of *POMS* (McNair, et al., 1981) than either of their male counterparts. Conversely, male nursing home residents reported lower mean score on fatigue, than either the female nursing home residents, or the normative males ( $p=.05$ ).

An internal consistency rating for the *POMS-B* (McNair et al., 2003) was reported at 0.76 to 0.95, Cronbach alpha rating. In addition, the *POMS-B* (McNair et al., 2003) was correlated with the *Psychological Well-Being Scale* (Ryff, 1989) with a calculated -0.68 rating (McNair et al., 2003).

#### *Group Counseling Session Summary (GCSS, Ellington, 1997)*

The *Group Counseling Session Summary (GCSS)*, Ellington, 1997) was adapted from a counselor training and supervision instrument used at the Wayne State University, College of Education, Counseling and Testing Center. This instrument contained six brief questions and provided information concerning group themes, members' roles, significant patterns, interventions, session development, and goals and plans for ensuing sessions. The group leader completed one form following each group therapy intervention session, for personal reference only.

#### *Research Question and Hypotheses*

A quasi-experimental, two-treatment group design was employed to examine the pre and posttest data of two group counseling therapy interventions, Group Art Therapy (GAT) and

Group Life Stories Narrative Therapy (GLSNT), on the dependent variables, life satisfaction and mood disturbance, of older women living in two Metropolitan Detroit based skilled nursing home facilities. This study strived to answer the following two research questions:

1. Will Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT) be equally effective in increasing levels of Life Satisfaction (LS) of older women, age 65+, living in two Metropolitan Detroit based skilled nursing home facilities?

H<sub>01</sub>: There is no significant difference in mean scores on Life Satisfaction (LS) between older women, age 65+, participating in Experimental Group I, Group Art Therapy (GAT) and older women, age 65+, participating in Experimental Group II, Group Life Stories Narrative Therapy (GLSNT).

Null Hypothesis  $\mu_1 = \mu_2$

Alternative Hypothesis  $\mu_1 \neq \mu_2$

Instrument: *Satisfaction with Life Scale (SWLS)*, Diener et al., 1985).

2. Will Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT) be equally effective in decreasing levels of Mood Disturbance (MD) in older women, age 65+, living in two Metropolitan Detroit based skilled nursing home facilities?

H<sub>02</sub>: There is no significant difference in mean scores on Mood Disturbance (MD) between older women, age 65+, in Experimental Group I, Group Art Therapy (GAT) and older women, age 65+, in Experimental Group II, Group Life Stories Narrative Therapy (GLSNT).

Null Hypothesis  $\mu_1 = \mu_2$

Alternative Hypothesis  $\mu_1 \neq \mu_2$

Instrument: *Profile of Mood States (POMS-B)*, McNair et al., 2003).

### *Data Analysis*

The collected data analyzed from both pre and post test instruments determined the differential effects of participating in Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT). Statistical analyses were conducted using *IBM-SPSS Statistical Program for Windows*, Version 19.0 (IBM Corporation, 2010) with an alpha level of  $p < .05$ . Descriptive statistics and frequency distributions for demographic characteristics such as age, race, education, marital status, health and mobility status, and activity levels provided a descriptive profile of the sample.

To determine if the two groups come from populations of equal variance, a Levene's test for equality of variance was performed, prior to *t*-Test. To determine if random assignment of treatment-to-group was successful, a *t*-Test for independent samples by treatment group was used. If no significant differences were found for the pretest scores of the two dependent variables, life satisfaction and mood, baseline equality was assumed and random assignment of treatment-to-group was successful. If significant differences were found, then baseline equality was not met and random assignment of treatment to group was not successful.

To determine if differential effects existed between the two group treatment interventions on life satisfaction and mood disturbance in older women residing in skilled nursing home facilities, a Univariate Analysis of Covariance (ANCOVA) with group membership as the fixed independent variable was utilized to compare posttest scores with pretest scores as covariates. Mean scores were compared to determine which group had the highest increase in levels of life satisfaction and highest decrease in levels of mood disturbance. A Paired-Samples Test was conducted to determine whether the treatment intervention caused any real change (differences) within each group. The non-parametric Wilcoxon Signed-Rank Test,

with exact p-values, was utilized to further investigate significant differences. Analyses provided an opportunity to determine change from pretest to posttest, as well as an opportunity to determine if change resulted from treatment intervention. For the null hypothesis to be rejected in favor of the alternative, measures for the dependent variables had to be statistically significant. The statistical analysis for each hypothesis is presented in Figure 4.



Figure 4 Statistical Analyses Chart

Research Question	Variables	Statistical Analysis
<p>1. Will Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT) be equally effective in increasing levels of life satisfaction of older women, age 65+, living in skilled nursing home facilities?</p> <p>H<sub>01</sub>: There would be no significant differences in mean scores on levels of Life Satisfaction between Experimental Group I, Group Art Therapy (GAT) and Experimental Group II, Group Life Stories Narrative Therapy (GLSNT).</p>	<p><u>Independent Variable:</u> Group Assignment: Experimental Group I: Group Art Therapy (GAT) Experimental Group II: Group Life Stories Narrative Therapy (GLSNT)</p> <p><u>Dependent Variables:</u> Posttest scores on the <i>SWLS</i> (Diener et al., 1985)</p> <p><u>Covariates:</u> Pretest scores on the <i>SWLS</i> (Diener et al., 1985)</p>	<p>A Univariate Analysis of Covariance (ANCOVA) with group membership as fixed independent variable was used to compare post scores with pre scores as covariates.</p> <p>Mean scores were compared to determine which group had highest levels of Life Satisfaction following the 12 hours of treatment intervention, over a four-week period.</p> <p>A Paired Samples Test was used to determine whether or not a group saw significant differences in Life Satisfaction.</p>
<p>2. Will Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT) be equally effective in decreasing levels of mood disturbance of older women, age 65+, living in skilled nursing home facilities?</p> <p>H<sub>02</sub>: There would be no significant differences in mean scores on levels of Mood Disturbance between Experimental Group I, Group Art Therapy (GAT) and Group II, Group Life Stories Narrative Therapy (GLSNT).</p>	<p><u>Independent Variable:</u> Group Assignment: Experimental Group I: Group Art Therapy (GAT) Experimental Group II: Group Life Stories Narrative Therapy (GLSNT)</p> <p><u>Dependent Variables:</u> Posttest scores on the <i>POMS-B</i> (McNair et al., 2003)</p> <p><u>Covariates:</u> Pretest scores on the <i>POMS-B</i> (McNair et al., 2003)</p>	<p>A Univariate Analysis of Covariance (ANCOVA) with group membership as the fixed independent variable was used to compare post scores with pre scores as covariates.</p> <p>Mean scores were compared to determine which group had lowest levels of Mood Disturbance following the 12 hours of treatment intervention, over a four-week period.</p> <p>A Paired Samples Test was used to determine whether or not a group saw significant differences (decreased scores) in Mood levels.</p>

*Summary*

Chapter III described the method of assigning the treatment conditions to one of the two experimental groups, the research setting, and description of participants, various treatment procedures, and criterion instruments used during this study. Chapter III also presented a description of the research design, research question and statistical hypotheses, and data analyses utilized. Chapter IV presents the results and a description of the findings.

## CHAPTER IV

### RESULTS

This chapter describes the sample, demographics, research questions, statistical hypotheses, and data analyses. It is followed by the results of two group therapy interventions on levels of life satisfaction and mood of older women residing in skilled nursing home facilities.

#### *Demographic Characteristics*

The sample consisted of 17 women, age 65+, from two Metropolitan Detroit based nursing home facilities. The overall minimum/maximum age was 65-92, while the overall mean age was 80 ( $SD=9.59$ ). Seven women in Experimental Group I, Group Art Therapy (GAT) and 10 women in Experimental Group II, Group Life Stories Narrative Therapy (GLSNT) completed the study. Table 1 presents the distribution of age by treatment group.

Table 1

#### *Distribution of Age by Treatment Group Assignment*

Treatment Group	Mean Age	N	Std. Deviation	Minimum Age	Median Age	Maximum Age
Experimental Group I: GAT	75	7	8.6	66	71	88
Experimental Group II: GLSNT	83	10	8.6	65	86	92
TOTAL	80	17	9.6	65	82	92

For descriptive purposes only, cross tabulations were conducted on additional demographic characteristics (self-reported) on the *Demographic Form* (Ryan, 2010).

The results of these tabulations are presented in Table 2.

Table 2

*Demographic Characteristics by Treatment Group*

Demographic Characteristic	Category	Treatment Group		
		Group I GAT	Group II GLSNT	Total
Marital Status	Single	1 (14%)	0 -	1 (6%)
	Divorced/Separated	0 -	2 (20%)	2 (12%)
	Widowed	5 (72%)	8 (80%)	13 (76%)
	Other	1 (14%)	0 -	1 (6%)
	Total	7 (100%)	10 (100%)	17 (100%)
Ethnicity	African American	6 (86%)	8 (80%)	14 (82%)
	Native American	0 -	2 (20%)	2 (12%)
	Other	1 (14%)	0 -	1 (6%)
	Total	7 (100%)	10 (100%)	17 (100%)
Level of Education	Less than H. S. Diploma	3 (43%)	3 (30%)	6 (35%)
	High School Diploma	3 (43%)	6 (60%)	9 (53%)
	Associate Degree	1 (14%)	1 (10%)	2 (12%)
	Total	7 (100%)	10 (100%)	17 (100%)
Health Status	Poor	1 (14%)	1 (10%)	2 (12%)
	Average	6 (86%)	5 (50%)	11 (65%)
	Good	0 -	4 (40%)	4 (23%)
	Total	7 (100%)	10 (100%)	17 (100%)
Mobility Status	Poor	1 (14%)	0 -	1 (6%)
	Average	4 (57%)	9 (90%)	13 (76%)
	Good	2 (29%)	1 (10%)	3 (18%)
	Total	7 (100%)	10 (100%)	17 (100%)
Extra Curricular Activities	1-4 Activities	2 (29%)	2 (20%)	4 (23%)
	5-10 Activities	2 (29%)	2 (20%)	4 (23%)
	All Activities	3 (42%)	6 (60%)	9 (54%)
	Total	7 (100%)	10 (100%)	17 (100%)

Overall, 76% of participants reported their marital status as widowed. In Experimental Group I, GAT 72% reported marital status as widowed, while in Experimental Group II, GLSNT, 80% reported widowed.

Eighty-two percent of all group participants reported their ethnicity as African American. In the Experimental Group I, GAT, 86% reported ethnicity as African American, while in Experimental Group II, GLSNT, 80% reported ethnicity as African American.

Overall, 53% of participants reported their highest level of formal education as having received a High School Diploma or GED; 35% reported less than high school diploma, while 12% reported receiving an Associate Degree. In Experimental Group I, GAT, 43% of participants reported receiving a High School Diploma, while an equal number reported less than a High School Diploma. In Experimental Group II, GLSNT, 60% of participants reported receiving a High School Diploma, while 30% reported less than a High School Diploma.

Sixty-five percent of all group participants (self-reported) their health status as average, while a total of 23% reported health status as good. In the mobility category, 76% of all participants reported their status as average, while an additional 18% reported their mobility as good (even though the majority of all participants had significant health issues and/or significant mobility issues).

Overall, 54% of participants engaged in all activities during the past year, while 23% participants engaged in 1-4 activities, and an equal amount reported participation in 5-10 activities.

#### *Pretest Analysis*

To test whether the two groups came from populations of equal variance, a Levene's test was performed for both measures, prior to the *t*-test. Table 3 presents the pretest statistics for the two dependent variables, by treatment group.

Table 3

*Pretest Dependent Variable Statistics by Treatment Group*

	Treatment Group	N	Mean	Std. Deviation	Std. Error Mean
SWLS Pre Score	Experimental Group I, GAT	7	14.43	8.28	3.13
	Experimental Group II, GLSNT	10	21.50	5.84	1.85
POMS Pre Score	Experimental Group I, GAT	7	22.43	18.23	6.89
	Experimental Group II, GLSNT	10	5.58	8.55	2.70

For the dependent variable, *SWLS* (Diener et al., 1985), the pretest mean score for Experimental Group I, GAT, was 14.43 ( $SD=8.28$ ), while the pretest mean score for Experimental Group II, GLSNT, was 21.50 ( $SD=5.84$ ). For the dependent variable, *POMS-B* (McNair et al., 2003), the pretest mean score for Experimental Group I, GAT, was 22.43 ( $SD=18.23$ ); while the pretest mean score for Experimental Group II, GLSNT was 5.58 ( $SD=8.55$ ). Table 4 presents the results of the Levene's test (for equality of variance) and *t*-Test (for equality of means) for independent samples by treatment group.

Table 4

*t*-Tests for Equality of Means between group (before treatment)

		Levene's Test for Equality of Variances		<i>t</i> -Test for Equality of Means						
		F	Sig.	<i>t</i>	<i>df</i>	Sig. (2- tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
SWLS Pre Score	Equal variances assumed	4.68	.047	-2.07	15	.056	-7.07	3.41	-14.34	.20
	Equal variances not assumed			-1.95	10.08	.080	-7.07	3.63	-15.16	1.02
POMS Pre Score	Equal variances assumed	9.18	.008	2.57	15	.021	16.85	6.55	2.90	30.82
	Equal variances not assumed			2.28	7.87	.053	16.85	7.40	-.27	33.97

For the dependent variable SWLS, the Levene's test found evidence that the pretest scores between the two groups came from populations with unequal variances ( $p=.047$ ). As a result, the preferred *t*-test was the one that allowed for variances to differ. The results of the *t*-test (for the dependent variable, SWLS) implied no significant differences were found between GAT and GLSNT ( $t=-1.95$ ,  $df=10.08$ ,  $p=0.080$ ); therefore, baseline equality was established for SWLS.

For the dependent variable, mood (POMS-B), results of the Levene's test also found pre-scores (between groups) came from populations with unequal variances ( $p=.008$ ). Therefore, the preferred *t*-test, again, was the one where equal variances were not assumed. Despite the large difference in pretest mean scores of the two groups, with respect to the POMS-B scale (22.43 and 5.58), the *t*-test reveals there is no significant difference once the differing variances of the two groups are taken into account; therefore, baseline equality was established for the POMS-B ( $t=2.28$ ,  $df=7.87$ ,  $p=.053$ ).

### *Research Questions and Hypotheses*

This experimental two-group pretest/posttest design examined the differential effects of two group therapies, Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT) on levels of life satisfaction and mood of older women residing in nursing homes. This study attempted to answer the following two research questions: (1) Will Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT) be equally effective in increasing levels of Life Satisfaction of older women, age 65+, living in nursing homes; and (2) Will Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT) be equally effective in decreasing mood disturbance levels in older women, age 65+, living in nursing homes? Two hypotheses corresponded with the two research questions and were tested using inferential statistical analyses. Decisions on the statistical significance of the findings were made using an alpha level of 0.05.

#### *Null Hypothesis # 1 (SWLS)*

First hypothesis stated there would be no significant differences in mean scores on Life Satisfaction between older women, age 65+, participating in Experimental Group I, Group Art Therapy (GAT) and older women, age 65+, participating in Experimental Group II, Group Life Stories Narrative Therapy (GLSNT). Descriptive statistics by treatment group were obtained from changes in posttest measures on the dependent variable, life satisfaction. Table 5 presents the posttest descriptive statistics for the dependent variable, life satisfaction, by treatment group.



Table 5

*Posttest Descriptive Statistics for Life Satisfaction by Treatment Group*

Treatment Group	Mean	Std. Deviation	N
Experimental Group I, GAT	18.86	4.22	7
Experimental Group II, GLSNT	28.90	4.12	10

The mean posttest scores on the dependent variable, Life Satisfaction, for Experimental Group I, GAT were 18.86 ( $SD=4.22$ ); and 28.90 ( $SD=4.12$ ) for Experimental Group II, GLSNT.

A Univariate Analysis of Covariance (ANCOVA) with group membership as the fixed independent variable was used to compare posttest scores. Pretest scores were included as covariates to control for the differences that were present between groups at the start of the study. Mean scores were compared (between groups) to determine which group had the highest increase in levels of Life Satisfaction, following 12 hours of treatment intervention over a four-week period. Table 6 presents the Univariate Analysis of Covariance (ANCOVA) for the Tests of Between-Subject Effects, for life satisfaction.

Table 6

*Univariate ANCOVA Tests of Between-Subjects Effects Dependent Variable: SWLS Post-score-Pre-score*

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared	Noncent. Parameter	Observed Power <sup>b</sup>
Corrected Model	415.91 <sup>a</sup>	2	207.96	11.23	.001	.62	22.47	.97
Intercept	1,069.44	1	1,069.44	57.78	.000	.81	57.78	1.00
SWLS pre	.61	1	.61	.03	.859	.00	.03	.05
Treatment Group	309.66	1	309.66	16.73	.001	.54	16.73	.97
Error	259.15	14	18.51					
Total	11,101.00	17						
Corrected Total	675.06	16						

*a. R Squared = .616 (Adjusted R Squared = .561)*

*b. Computed using alpha = .05*

After removing the effects of the covariate, the results of the Univariate Analysis of Covariance (ANCOVA) found significant differences between the two treatment groups ( $F=16.73$ ,  $df=1,16$ ,  $p=0.001$ ) for life satisfaction; with mean scores of  $M=18.86$  ( $SD=4.22$ ) for Experimental Group I, GAT and  $M=28.90$  ( $SD=4.12$ ) for Experimental Group II, GLSNT. The effect size, or Partial Eta Squared, was large at .54, and the Observed Power was .97.

While simply looking at SWLS group mean scores (from pre-to-post), it appeared both groups benefitted from the treatment; however, significant differences cannot be determined by descriptive results. Therefore, in order to discover how each intervention group performed from pre-to-post, or whether or not one/or both group(s) saw significant improvements in levels of life satisfaction, two (separate) Paired-Samples Tests were conducted on GAT and GLSNT. Table 7 presents the pre-and-post descriptive statistics, Paired Samples Test, on SWLS (Diener et al., 1985) for Experimental Group I, Group Art Therapy (GAT).

Table 7

*Descriptive Statistics Paired Samples Tests  
Experimental Group I, GAT SWLS Pre-and-Post Scores (Within)*

Group I, Group Art Therapy (GAT) SWLS		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Pre Score	14.43	7	8.28	3.13
	Post Score	18.86	7	4.22	1.60

The pretest/posttest mean scores on *SWLS* (Diener et al., 1985) for Experimental Group I, GAT were 14.43 ( $SD=8.28$ ) and 18.86 ( $SD=4.22$ ) respectively. Table 8 presents the results of the Paired Samples Test for Experimental Group I, GAT on the dependent measure, life satisfaction, as measured by the *SWLS* (Diener et al., 1985).

Table 8

*Paired Samples Test-Experimental Group I, GAT Life Satisfaction*

		Paired Differences					t	df	Sig. (2- tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference Lower Upper				
Pair 1	Group I, GAT SWLS Pre Score - Group I, GAT SWLS Post Score	-4.43	8.34	3.15	-12.15	3.29	-1.40	6	.210

The Paired Samples Test mean difference from pretest-to-posttest was -4.43. Although the posttest descriptive mean score on *SWLS* (Diener et al., 1985) for Experimental Group I GAT ( $M=18.86$ ,  $SD=4.22$ ) increased from the pretest mean score ( $M=14.43$ ,  $SD=8.28$ ), the difference was not significant ( $t=-1.40$ ,  $df=6$ ,  $p=0.210$ ).

Parametric tests, such as the Paired Samples Test, are based on means, which are more sensitive to outliers (extreme scores). Non-parametric tests, such as the Wilcoxon Signed Rank Test, make hypotheses about the median, which are not as sensitive to outliers. Due to the small sample size, the nonparametric, Wilcoxon Signed Ranks Test, was used to test Null Hypothesis #1, to see whether the median difference (between pretest and posttest) was zero. If the null were to be true, the mean-rank would be similar between pre and post scores. Table 9 presents the ranks for the Wilcoxon Signed Ranks Test for Experimental Group I, GAT, on life satisfaction, as measured by the *SWLS* (Diener et al., 1985).

Table 9

*Wilcoxon Signed Ranks – Experimental Group I, GAT Ranks – Life Satisfaction*

		N	Mean Rank	Sum of Ranks
Experimental Group I GAT	Negative Ranks	2 <sup>a</sup>	3.50	7.00
	Positive Ranks	5 <sup>b</sup>	4.20	21.00
SWLS Post Score- Experimental Group I GAT	Ties	0 <sup>c</sup>		
SWLS Pre Score	Total	7		

a. *Experimental Group I GAT SWLS Post Score < Experimental Group I GAT SWLS Pre Score*

b. *Experimental Group I GAT SWLS Post Score > Experimental Group I GAT SWLS Pre Score*

c. *Experimental Group I GAT SWLS Post Score = Experimental Group I GAT SWLS Pre Score*

Two posttest scores on *SWLS* (Diener et al., 1985) were less than pretest scores (negative differences), while the reverse was true for the remaining five; with posttest scores greater than pretest scores (positive differences). Table 10 presents the results of the Wilcoxon Signed Ranks Test for life satisfaction as measured by the *SWLS* (Diener et al., 1985).

Table 10

*Wilcoxon Signed Ranks Test Statistics – Group I, GAT – Life Satisfaction*

	Experimental Group I GAT SWLS Pre Score – Experimental Group I GAT SWLS Post Score
Z	-1.185 <sup>a</sup>
Asymp. Sig. (2-tailed)	.236
Exact Sig. (2-tailed)	.281
Exact Sig. (1-tailed)	.141
Point Probability	.023

a. Based on positive ranks.

The results of the Wilcoxon Signed Ranks Test Statistics (Exact Sig., 2-tailed) found no significant differences between pre and post scores; indicating no significant improvement can be determined for the art therapy intervention group ( $p=0.281$ ). Consequently, a lack of evidence exists (in both parametric and nonparametric tests) to conclude GAT treatment intervention had a significant effect on life satisfaction, for Experimental Group I.

Experimental Group II, GLSNT, pre-and-post scores were also examined utilizing Paired Samples Test. Table 11 presents the descriptive statistics for the Paired Samples Test, on the dependent variable, life satisfaction, for Experimental Group II, GLSNT.

Table 11

*Descriptive Statistics Paired Samples Tests  
Experimental Group II, GLSNT SWLS Pre-and-Post Scores (Within)*

Group II, GLSNT SWLS		Mean	N	Std. Deviation	Std. Error Mean
Pair 2	Pre Score	21.50	10	5.84	1.85
	Post Score	28.90	10	4.12	1.30

The pretest mean score for *SWLS* (Diener et al., 1985) for Experimental Group II, GLSNT, was 21.50 ( $SD=5.84$ ) and the posttest mean score was 28.90 ( $SD=4.12$ ). Table 12 presents the results of the Paired Samples Test for Experimental Group II, GLSNT, on the dependent measure, life satisfaction as measured by the *SWLS* (Diener et al., 1985).

Table 12

*Paired Samples Test-Experimental Group II, GLSNT Life Satisfaction*

Pair	Group	II	GLSNT	Paired Differences					t	df	Sig. (2-tailed)
				Mean	Std. Deviation	Std. Error	95% Confidence Interval of the Difference				
							Lower	Upper			
2	SWLS	Pre	Score -	-7.40	7.59	2.40	-12.83	-1.97	-3.08	9	.01
	Group	II	GLSNT								
			SWLS Post Score								

The posttest descriptive mean score for the *SWLS* (Diener et al., 1985) for Experimental Group II, GLSNT ( $M=28.90$ ,  $SD=4.12$ ), indicated an increase from the pretest mean score ( $M=21.50$ ,  $SD=5.84$ ), with a mean difference (from pretest-to-posttest) of -7.40. The results of the Paired Samples Test for Group II, found the existence of significant differences ( $t=-3.08$ ,  $df=9$ ,  $p=0.01$ ) implying GLSNT intervention led to improvements in levels of life satisfaction. Based on significant findings on differential group changes for Life Satisfaction, Null hypothesis #1 was rejected in favor of the alternative.

*Null Hypothesis #2 (POMS-B)*

Null hypothesis #2 stated there would be no significant differences in mean scores on Mood Disturbance (MD) between older women, age 65+, participating in Experimental Group I, Group Art Therapy (GAT) and older women, age 65+, participating in Experimental Group II, Group Life Stories Narrative Therapy (GLSNT). Descriptive statistics by treatment group were obtained from changes in posttest measures on the dependent variable, mood disturbance. Table 13 presents the posttest descriptive statistics for the dependent variable, mood disturbance, by treatment group.

Table 13

*Posttest Descriptive Statistics for Mood Disturbance by Treatment Group*

Treatment Group	Mean	Std. Deviation	N
Experimental Group I GAT	17.71	14.22	7
Experimental Group II GLSNT	-.30	8.63	10

The mean posttest scores on Mood Disturbance for Group I, GAT, were  $M=17.71$  ( $SD=14.22$ ) and  $M=-.30$  ( $SD=8.63$ ) for Group II, GLSNT.

A Univariate Analysis of Covariance (ANCOVA) with group membership as the fixed independent variable was used to compare posttest scores with pretest scores as covariates. Mean scores were compared to determine which group had the lowest levels (decreasing score) of Mood Disturbance, following 12 hours of treatment intervention over a four-week period. Table 14 presents the ANCOVA for the Tests of Between-Subject Effects for Mood Disturbance.

Table 14

*Univariate ANCOVA Tests of Between-Subjects Effects Dependent Variable: POMS-B Post-score*

Source	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared	Noncent. Parameter	Observed Power <sup>b</sup>
Corrected Model	1,628.52 <sup>a</sup>	2	814.26	7.164	.01	.51	14.33	.87
Intercept	122.31	1	122.31	1.08	.32	.07	1.08	.16
POMS pre	292.29	1	292.29	2.57	.13	.16	2.57	.32
Treatment Group	440.66	1	440.66	3.88	.07	.22	3.88	.45
Error	1,591.24	14	113.66					
Total	4,081.00	17						
Corrected Total	3,219.77	16						

*a. R Squared = .506 (Adjusted R Squared = .435)*

*b. Computed using alpha = .05*

After removing the effects of the covariate, the results of the ANCOVA found no significant differences between the two groups ( $F=3.88$ ,  $df=1,16$ ,  $p=0.07$ ) on Mood Disturbance levels, as measured by *POMS-B* (McNair et al., 2003). The effect size, or Partial Eta Squared, was small (0.22) and the Observed Power was .45.

The pretest/posttest (decreasing) mean scores on Mood Disturbance for experimental Group I, GAT, were 22.43 ( $SD=18.23$ ) and 17.71 ( $SD=14.22$ ) respectively. For Experimental Group II, GLSNT, the pretest/posttest mean scores were 5.58 ( $SD=8.55$ ) and -3.30 ( $SD=8.63$ ). Table 15 presents the pretest/posttest mean scores, by treatment group, on Mood Disturbance, as measured by the *POMS-B* (McNair et al., 2003).



Table 15

*Pre-and-Post Descriptive Statistics by Treatment Group Mood Disturbance*

	Treatment Group	N	Mean	Std. Deviation	Std. Error Mean
POMS Score	Pre Experimental Group I, GAT	7	22.43	18.23	6.89
	Experimental Group II, GLSNT	10	5.58	8.55	2.70
POMS Score	Post Experimental Group I, GAT	7	17.71	14.22	5.38
	Experimental Group II, GLSNT	10	-.30	8.63	2.73

While observing mean scores from pretest-to-posttest, it appears both Experimental Group I and Experimental Group II benefitted from their respective treatment interventions, with mean scores decreasing (as preferred); despite the existence of significant differences (found in ANCOVA).

In order to evaluate the performance of each group, from pretest-to-posttest on levels of mood disturbance, Paired-Samples Tests were conducted. Table 16 presents the descriptive statistics for the Paired Samples Test on the dependent variable, mood, for Group I, GAT, as measured by *POMS-B* (McNair et al., 2003).

Table 16

*Descriptive Statistics Paired Samples Tests  
Experimental Group I, GAT Mood Disturbance, Pre-and-Post Scores (Within)*

Group I, GAT POMS-B		Mean	N	SD	SEM
Pair 2	Pre Score	22.43	7	18.23	6.89
	Post Score	17.71	7	14.22	5.38

The pretest mean scores on the *POMS-B* (McNair et al., 2003) for Experimental Group I, GAT, were 22.43 ( $SD=18.23$ ), while the posttest mean scores were 17.71 ( $SD=14.22$ ). Table 17 presents the results of the Paired Samples Test for Experimental Group I, GAT, on the dependent variable, mood, as measured by *POMS-B* (McNair et al., 2003).

Table 17

*Paired Samples Test-Experimental Group I, GAT, Mood Disturbance*

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	Group I, GAT POMS-B Pre Score - Group I, GAT POMS-B Post Score	4.71	16.81	6.35	-10.83	20.26	.74	6	.50

Although mean scores decreased in the anticipated direction from pretest to posttest in Group I (GAT), and the mean difference was 4.71, differential changes on the dependent variable, mood disturbance, were not found to be significant ( $t=.74$ ,  $df=6$ ,  $p=.50$ ) on the Paired Samples Test.

Experimental Group II, GLSNT pretest-to-posttest scores were also examined utilizing Paired Samples Test. Table 18 presents the descriptive statistics for the Paired Samples Test on the dependent variable, mood, for Group II, GLSNT.

Table 18

*Descriptive Statistics Paired Samples Tests  
Experimental Group II, GLSNT, Mood Disturbance, Pre-and-Post Scores (Within)*

Group II, GLSNT		Mean	N	SD	SEM
Pair 2	Pre Score	5.58	10	8.55	2.70
	Post Score	-3.30	10	8.62	2.73

The pretest mean scores on the *POMS-B* (McNair et al., 2003) for Experimental Group II, GLSNT, were 5.58 ( $SD=8.55$ ), while the posttest mean scores were -0.30 ( $SD=8.62$ ). Table 19 presents the results of the Paired Samples Test for Experimental Group II, GLSNT, on the dependent measure, mood, as measured by the *POMS-B* (McNair et al., 2003).

Table 19

*Paired Samples Test-Experimental Group II, GLSNT Mood Disturbance*

				Paired Differences		95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)	
				Mean	SD	SEM	Lower	Upper			
Pair	Group	II	GLSNT								
2	POMS-B Pre Score -			6.00	11.00	3.50	-2.00	14.00	1.70	9	.124
	Group II GLSNT										
	POMS-B Post Score										

On Mood Disturbance, although the Paired Samples mean-difference for Group II, from pretest-to-posttest, was 6.00 ( $SD=11.00$ ), no significant differences were found ( $t=1.70$ ,  $df=9$ ,  $p=0.124$ ). Consequently, although mean scores from both groups (GAT and GLSNT) decreased in the preferred direction (indicating an improvement), the differences were not significant. Therefore, Hypothesis #2 was retained.

### *Summary*

Chapter IV presented the results of the differential effects of the two group treatment interventions on levels of life satisfaction and mood disturbance in older women age 65+, residing in two Metropolitan Detroit based skilled nursing home facilities. Chapter V presents an overview of the problem examined, relevant literature, methods and procedures, discussion of the results, and recommendations for future research.

## CHAPTER V

### SUMMARY AND DISCUSSION

#### *Introduction*

The purpose of this study was to examine the effects of group art therapy and group life stories narrative therapy on levels of life satisfaction and mood of older women living in two Metropolitan Detroit based skilled nursing home facilities. This chapter provides a summary of the statement of the problem, literature, methods and procedures. In addition, a summary and discussion of the results and recommendations for future research are also presented.

#### *Restatement of the Problem*

According to the United States Bureau of the Census, U. S. Pop Clock (March, 2011), the resident population of the United States is approximately 311 million. These numbers include the approximate 78 million baby boomers: those born between the years 1946 and 1964 (Frey, 2007). As of January 2011, the oldest members of the baby boom generation started celebrating their 65<sup>th</sup> birthday; in turn, subsequent members will continue to reach this milestone at the rate of 7,900 per day (United States Bureau of the Census, 2011). As a result of this new milestone, many more adults will be facing new challenges.

Among the many challenges facing our graying nation will be the health and well-being of our older population (Bush, 2009). Included, within issue of health and well-being, is an equally vital issue of mental health and well-being. According to the National Institute of Mental Health (2008), an estimated 20% of Americans, age 65+, have exhibited symptoms of depression or experienced some type of mental health issue. In nursing home facilities, however, over 25 % of Americans, age 65+, have experienced mental health issues.

In addition to the overall issues and challenges impacting our older population, gender-specific issues and challenges are also emerging. Correspondingly, as the age of our population steadily increases, so does the mortality rate of the male population; thus, a significant gender imbalance is created (Charnie, 2002). Consequently, as the ratio of females-to-males continues to increase, and as our population becomes predominantly more female, gender specific issues will also increase and become more prominent (Pirkl, 2009).

If the increase in the ratio of older females-to-males continues as projected, one of the natural consequences impacting the majority of older women will be the reality of living alone (Kaneda, 2006). Although the majority of older women prefer living independently, for as long as possible, the truth remains; many women will eventually be faced with the decision of either adjusting their lifestyle, or relocating all together. According to Rusted et al. (2006), assisting our nation's older female population to better cope with the vast challenges associated with aging, loss of independence, and relocation or moving to assisted or skilled nursing facilities, is critical. This is especially true when considering the rapid need, increase, and utilization of congregate facilities, by women (UN, 2009). According to Jones et al. (2009), out of 1.5 million adults living in nursing home facilities, throughout the United States today, 66% are women, age 65+. As a result, this study has focused on enhancing the quality of life and well-being of older women, age 65+, residing in skilled nursing home facilities.

#### *Literature Summary*

As the composition of our population shifts from young to old, the dynamics and concerns of our nation's social structure will explode causing a domino effect from areas of politics and economics to healthcare and quality of life (Charnie, 2002). Consequently, as the shape of the demographic landscape continues to expose a more mature facade, the definition of

what it means to be mature and grow older, in the United States, changes along with it (United States Bureau of the Census, 2003).

Our increasing older population not only impacts personal relationships within families, but it also impacts equity across generations and lifestyles (Administration on Aging [AoA], 2009b). According to the AoA (2009a), the percentage of older Americans age 65+ has tripled since the early 1900's, from 4.1% (3.1 million) of the U.S. population to 12.6% (37.9 million) (NIA-NIH, 2007). Additionally, approximately .21% or 90,000 Americans have reached the age of 100+ years (AoA, 2009a). However, along with the increasing numbers of our aging population comes another critical variable, the male-to-female ratio of our older population. "Women represent an increased proportion of the population, with each decade of age" according to Smith (2007, p. 277).

As our older population continues to increase in age, as well as in overall numbers, the occurrence and implications of various disabilities and chronic diseases will continue to increase, as well (HHS, 2009). Our increasing aging population not only includes increasing disabilities and chronic diseases but also includes the increasing number of older persons struggling with cognitive decline, dementia, and/or with Alzheimer's disease. As a result, the focus and impact of our aging population will continue to expand and intensify; not only in areas of healthcare, well-being, and mental health, but also in areas of economics, lifestyle, and environment (NIAIC, 2008).

The focus on health, lifestyle, and environment highlights one of the realities facing our older population; such as issues surrounding health, well-being, and environment are all interrelated. For example, a housing issue can create a health or well-being issue, and a health issue can create a housing issue (Lawler, 2001). With increasing age, decreasing mobility, health

complications and/or disability, the reality of independent living becomes more difficult to retain or worse, becomes no longer a possibility. As a result, other types of living arrangements and housing considerations must be reviewed and/or considered. The likelihood of alternative living arrangements becomes even more prevalent when financial issues and/or family support is limited (AoA, 2009b; Golant, 2003). In addition, because many current homes and communities are not designed for the needs of an aging society, many older adults become both physically and socially isolated. This not only increases the likelihood of older adults relocating to alternative living environments or facilities, but also increases the likelihood of depression and/or other psychological disorders (Scharlach, 2009).

The next 30-40 years will bring not only dramatic increases in the number of older persons in general, but also dramatic increases in the numbers of those considered most vulnerable, older women. High concentrations of older women living in nursing homes and other alternative living environments are expected to continue; thus increasing the demand for health care, special services, and support (NIAIC, 2008). Although many significant issues associated with our aging population require critical attention to both genders, the increasing ratio of older females-to-males requires separate, yet careful, considerations (U.S. Bureau of the Census, 2011; National Research Council, 2001). According to statistics from a 2004 National Nursing Home Survey (CDC, 2009), the lifetime risk of entering a nursing home is estimated to be 52% for women versus 30% for men. Today, the figures (approximately 65.7%) in the United States have women aged 65+ making up the majority of individuals living in skilled nursing facilities (CDC, 2009). As the feminization of our older population increases (United Nations, 1999), gender-specific issues will increase as well. As a result, the residential issues within nursing home facilities will be predominantly those of older women (Cook, 1998).

In a study focusing on the life satisfaction of older persons living in nursing homes, Subasi and Hayran (2004) reported environment or place-of-residence to be a statistically significant predictor of one's satisfaction with life. In the same study, the mean life satisfaction score of older active persons was shown to be significantly higher than those who were not active. However, in a separate qualitative study exploring the effects of activities and perception of life satisfaction of older adults living in long-term care facilities (in Massachusetts), McGuinn and Mosher-Ashley (2000) reported organized activities had less effect on perception of life satisfaction, than self-generated ones. In addition, McGuinn and Mosher-Ashley (2000) found gender to be a significant factor of one's participation in activities.

According to the AoA (2009b), variables of mood and life satisfaction are commonly seen as critical factors affecting a healthy aging society. The measurements of mood and life satisfaction in older adults can be closely tied to Erikson's stages or models of human life-span development, especially the eighth stage, ego integrity vs. despair (Erikson, 1982). Although, during each developmental stage, certain tasks or potential crisis are negotiated, the eighth stage offers older adults a chance to come to terms with their life. Ego integrity can be related to one's acceptance of life as it has been lived or one's willingness to accept responsibility for one's life. Despair often occurs when a person fails to successfully negotiate or resolve life tasks; thus, potentially resulting in increased feelings of pain, sorrow, or regret (Erikson, 1982). For many older adults living in nursing home facilities, these variables become heightened or more significant, subsequently impacting their mood and satisfaction with life.

As we age, natural, pathologic, and neurodegenerative disorders, such as dementia and Alzheimer's disease, can greatly impact our daily function, the way we communicate, and a basic quality of life (Lerner, 2007). Although addressing these changes and challenges can be



formidable, viable interventions exist to facilitate the aging process. Johnson and Sullivan-Marx (2006) regard the use of art and art therapy as an effective intervention when working with older persons; for it offers a unique and alternative means of communication, especially for those with language impairment (p. 310). For example, in order to externalize the process and thus, facilitate meaning, many art therapists utilize art, in a therapeutic context, as a visual means of communication (Arrington, 2001; Keeling & Bermudez, 2006; Riley, 2004). In 2001, Cohen conducted a longitudinal, multisite study measuring the impact of arts participation on the overall health and mental health of older adults (Cohen et al., 2006). Cohen, et al. (2006) found those participating in the arts group experienced increased mood levels, increased activity levels, decreased depression scores, and increased levels of independent functioning.

Narrative therapy is commonly viewed as an alternative approach to traditional or conventional counseling therapies (Besley, 2002; Gardner & Poole, 2009; Nylund & Nylund, 2003). Pioneers in the field of narrative therapy, such as White, Epston, Freedman, Nylund, Madigan, etc., believe humans live life according to their stories; as such, the narrative can “shift individual lives in preferred directions” (Nylund & Nylund, 2003, p. 393). Utilizing a biographical-narrative approach with Holocaust survivors, Rosenthal (2003) argued in favor of the narrative, especially as an intervention for its healing potential. Likewise, Kenyon (2003) supports the use of storytelling for the many ways it helps facilitate reminiscence and reflection. By externalizing the story, participants separate the issue from self; thereby opening a space to recreate or “re-author” their own lives (Nylund & Nylund, 2003, p. 389). In a 2004 study of 43 adults (age 65 to 93), examining the effects of life review on depression, Serrano et al. (2004) reported a significant improvement in depression scores, as measured by the *Center for Epidemiologic Studies-Depression Scale* [CES-D] (Radloff, 1977).

### *Review of Methods and Procedures*

This quasi-experimental pretest-posttest research study, conducted over a four-week period, included two 90-minute group counseling intervention sessions per week, for a total of twelve (12) hours. Two of four Metropolitan Detroit based Bortz skilled nursing facilities were randomly selected to serve as the settings for this study. Due to residential restrictions and limitations, random selection of participants to treatment was not possible. However, random assignment of treatment-to-group was made possible through the use of a coin toss. Group participants consisted of volunteer, female nursing home residents, age 65+ who were cognitively and physically able to participate in either group art therapy or group life stories narrative therapy intervention. Cognitive ability was determined by the use of the *Brief Interview for Mental Status, Minimum Data Set, 3.0, BIMS-MDS 3.0* (HHS, 2010), conducted by a member of the nursing staff prior to the study and utilizing a minimum assessment score of 8 (moderate impairment) out of a possible 15 (intact cognition).

The initial sample included 20 female volunteers; however, three were unable to complete the study. Seventeen older females, age 65+, living in two separate Metropolitan Detroit based nursing facilities for a minimum of three months, completed the study. The age of participants ranged from 65 to 92, with a mean age of 80. Eighty-two percent of group members were African American while 76% were widowed. Experimental Group I, GAT included seven participants and Experimental Group II GLSNT included ten participants.

The *Demographic Form* (Ryan, 2010) was used to describe personal characteristics of participants. The *Satisfaction with Life Satisfaction Scale (SWLS)*, Diener et al. 1985) and *Profile of Moods Scale-Brief (POMS-B)*, McNair et al., 2003) were used to measure the dependent variables, life satisfaction and mood

disturbance, respectively, pre-and-post treatment. All participants received a total cash compensation gift of \$20.00 (as a token of gratitude) and a personalized “Certificate of Appreciation” (see Appendix E).

*Restatement of the Research Questions and Associated Hypotheses*

A quasi-experimental, two-treatment group design was utilized to examine the pre and posttest data of two group therapy interventions, Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT), on the dependent variables, life satisfaction and mood, of older women living in two Metropolitan Detroit based skilled nursing home facilities. Two hypotheses were developed for this study and each was tested using inferential statistical analysis. All decisions on statistical significance were made using an alpha level of  $p < .05$ . This study strived to answer the following two research questions:

1. Will Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT) be equally effective in increasing levels of Life Satisfaction (LS) of older women, age 65+, living in two Metropolitan Detroit based skilled nursing home facilities?

$H_{01}$ : There will be no significant difference in mean scores on Life Satisfaction (LS) between older women, age 65+, participating in Experimental Group I, Group Art Therapy (GAT) and older women, age 65+, participating in Experimental Group II, Group Life Stories Narrative Therapy (GLSNT).

2. Will Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT) be equally effective in decreasing levels of Mood Disturbance (MD) of older women, age 65+, living in two Metropolitan Detroit based skilled nursing home facilities?

H<sub>02</sub>: There will be no significant difference in mean scores on Mood Disturbance (MD) between older women, age 65+, in Experimental Group I, Group Art Therapy (GAT) and older women, age 65+, in Experimental Group II, Group Life Stories Narrative Therapy (GLSNT).

### *Summary of Findings*

Cross-tabulations were used to describe the demographic data of participants prior to treatment intervention. Seventeen women completed the study with seven women in Group I, Group Art Therapy (GAT) and 10 women in Group II, Group Life Stories Narrative Therapy (GLSNT).

Random selection was not possible due to limitations and restrictions from the two nursing home facilities; however, random assignment of treatment to group was possible through the use of a coin toss. Results of the statistical analysis prior to treatment showed random assignment effective on both dependent variables. Prior to treatment, for the dependent variables (life satisfaction and mood disturbance) the Levene's test (extended to three decimals) found evidence the pre-scores came from populations with different variances; consequently, the *t*-test allowed for variances to differ. The results of the *t*-test implied no significant differences were found in pretest mean scores for both dependent variables; therefore, baseline equality was established.

The collected data analyzed from both pre and posttest instruments determined the differential effects of participation in GAT and GLSNT. Statistical analyses were conducted using *IBM-SPSS Statistical Program for Windows*, Version 19.0 (IBM Corporation, 2010) and all decisions on the results were made using an alpha level of .05.

The first hypothesis stated no significant differences would exist in mean scores on Life Satisfaction (LS) between older women, age 65+, participating in Experimental Group I, Group Art Therapy (GAT), and older women, age 65+, participating in Experimental Group II, Group Life Stories Narrative Therapy (GLSNT). Hypothesis #1 was tested using a Univariate Analysis of Covariance (ANCOVA) with group membership as the fixed independent variable and compared posttest scores with pretest scores as covariates. Mean scores were compared to determine which group had the highest increase in levels of Life Satisfaction, following 12 hours of treatment intervention over a four-week period. After removing the effects of the covariate, the results of the ANCOVA found significant differences occurred between the two treatment groups ( $F=16.73$ ,  $df=1,16$ ,  $p=0.001$ ).

In order to determine differences (i.e., significant improvements) within each treatment group, on life satisfaction, a Paired-Samples Test was first conducted on Group I, GAT. Although descriptive statistics by treatment group revealed the means increased in the anticipated direction from pre-to-post, the result of the Paired Samples Test for Group I, GAT on the dependent measure, life satisfaction, revealed differences were not significant ( $t=-1.40$ ,  $df=6$ ,  $p=0.210$ ). Due to the small sample size, the nonparametric Wilcoxon Signed Ranks Test was used to further examine significant differences. The results of the Wilcoxon Signed Ranks Test found no significant differences ( $p=0.28$ ); therefore, a lack of evidence exists (in both the parametric and nonparametric tests) to conclude Group Art Therapy treatment intervention had a significant effect on levels of life satisfaction.

The pre-and-post scores on the dependent variable, life satisfaction, for Experimental Group II, GLSNT, were also examined utilizing the Paired Samples Tests. The pretest/posttest descriptive mean difference of -7.40 revealed an increase in the preferred direction, while the

results of the Paired Samples Test confirmed the existence of significant differences ( $t=-3.08$ ,  $df=9$ ,  $p=0.01$ ). Therefore, Hypothesis #1 was rejected in favor of the alternative.

Hypothesis #2 stated there would be no significant differences in mean scores on Mood Disturbance (MD) between older women, age 65+, participating in Experimental Group I, Group Art Therapy (GAT) and older women, age 65+, participating in Experimental Group II, Group Life Stories Narrative Therapy (GLSNT). Although descriptive statistics by treatment group revealed mean scores decreased in the preferred direction (from pre-to-post) for both GAT and GLSNT, data analyses of ANCOVA ( $F=3.88$ ,  $df=1,16$ ,  $p=0.07$ ) and Paired Samples Tests for GAT ( $t=0.74$ ,  $df=6$ ,  $p=0.50$ ) and GLSNT ( $t=1.70$ ,  $df=9$ ,  $p=0.12$ ) revealed no significant differences existed between the art therapy group and the life stories narrative therapy group on levels of mood disturbance. Therefore, hypothesis #2 was retained.

#### *Discussion of Findings*

The differential outcome effects of two group therapy interventions, GAT and GLSNT, on levels of life satisfaction and mood disturbance of older women, age 65+, living in two Metropolitan Detroit based skilled nursing facilities were explored. Prior to treatment, it was anticipated GAT and GLSNT would be equally effective in increasing levels of life satisfaction and decreasing levels of mood disturbance.

On the dependent variable, life satisfaction, significant differences were not found in Group I, GAT; however, significant differences were found in Group II, GLSNT. Consequently, Group Art Therapy and Group Life Stories Narrative Therapy were not equally effective in increasing levels of life satisfaction. Therefore, Hypothesis #1 was rejected in favor of the alternative.

On the dependent variable, mood disturbance, no significant differences were found in either GAT or GLSNT. Consequently, Group Art Therapy and Group Life Stories Narrative Therapy were equally effective in reducing levels of mood disturbance. Therefore, Hypothesis #2 was retained.

Although significant differences were not found within the art therapy group, on the dependent variable life satisfaction, as well as between and within both group art therapy and life stories narrative therapy, on the dependent variable mood-disturbance, descriptive data analyses reveal mean scores moved in the preferred/anticipated direction, from pretest to posttest, over the four-week period. In addition to mean-score direction, verbal feedback and comments from participants were extremely positive in both art therapy and narrative therapy groups (i.e., participants expressed anticipation and enjoyment of the activities, interaction between group participants, and quality of the creative environment).

Feedback and comments from participants in the life stories narrative group revealed an appreciation for opportunities to tell their story, as well as opportunities to listen to other stories. On the other hand, participants in the art therapy group expressed an appreciation for opportunities to explore their creative side, while at the same time an appreciation to share life experiences.

In addition to the above, observed effects, both groups experienced the power of bonding. However, despite the positive qualitative outcomes associated with bonding and group cohesiveness, participants in Group I, Group Art Therapy, were faced with issues and feelings of grief, sadness, and disappointment (as two group members passed away and one group member became bed-ridden), as opposed to Group II. The impact of losing fellow group members was

highly visible in both affect and manner of the surviving participants. These critical life/death events may have greatly impacted the significant findings of the study.

#### *Limitations and Recommendations for Future Research*

There were several limitations to be considered while interpreting the results of this research study. The immediate limitation was sample size (N=17). Admittedly small, group size was limited by the ability and reality of working effectively within an older population. Although Yalom (2005) suggests the “ideal size of a therapy group is approximately seven or eight, with an acceptable range of five to ten” (p. 276), for research purposes, the numbers are small. Thus, placing severe limitations on study results such as the ability to generalize any outcome to other populations.

Another limitation to the study was the time frame (bi-weekly x four weeks). Although longer treatment duration is desirable, the reality of retaining intact groups (within an older nursing home population) is questionable. As indicated above, over a four-week period, Group I, GAT lost three participants; two participants passed away, while the third could not physically complete the study.

Future research in this area may benefit from larger sample sizes as well as from multiple locations and geographic areas. Also, in order to avoid any potential conflicts and/or complications, professional cooperation and guidelines should be strongly established between nursing home staff (i.e., activities department) and researchers, prior to the study.

Careful selection, screening, and use of appropriate testing material, especially when working with older populations, may provide for more significant outcomes. Although the POMS-B (McNair et al., 2003) was recommended and tested on older populations, in this study, the test design was not compatible with a majority of participants. The print was (relatively)



small, line spacing was close, and repetition of mood-states descriptors was exhausting and annoying to many. Consequently, participants voiced difficulty and frustration in completing the POMS-B (McNair et al., 2003).

### *Summary*

According to Rusted, Sheppard, and Waller (2006), it is critical society assist our older population, especially the most vulnerable: older women struggling and coping with the many challenges associated with aging. Many older women, especially those who have age-related circumstances (i.e., loss of spouse, financial difficulties, physical/mental limitations) often must relocate to unfamiliar environments. As a result of relocation, many older women experience mood disturbances and decreased satisfaction with life. Therefore, interventions designed to enhance life satisfaction and mood is essential.

One has to be careful while interpreting the results and generalizing the findings of this study to other populations and geographical locations. Considering the lack of significant findings for the dependent variable, mood disturbance, as well as a lack of significant differences within the art therapy group (on life satisfaction), interpretations and generalizations should be made with caution. As recommended, larger group sizes and multiple sites should be addressed in future research to determine the efficacy of group art therapy and/or group life stories narrative therapy with older women. Despite the lack of significant findings, further research in this area is warranted.

**APPENDIX A****CORRESPONDENCE**

Date: Fri, 30 Jul 2010 15:44:17 -0400  
To: edieneser@uiuc.edu  
Subject: SWLS permission: doctoral research

Dear Dr. Diener,

I am a doctoral candidate in the Behavioral and Theoretical Division, Department of Counselor Education at Wayne State University, Detroit, MI. As part of my dissertation research (comparing the effects of two group counseling therapies on life satisfaction and mood of older women in skilled nursing home facilities), I would like to use the Satisfaction With Life Scale.

Although I am aware the SWLS scale is in the public domain and therefore, no legal agreement is required; however, I wanted to provide information, if necessary and obtain a written document, if possible, acknowledging use this scale in my research, proposal, and completed dissertation. I will be happy to share the results of the study, if interested.

Thank you for your consideration.

Sincerely,

Bede R. Ryan, M. S., LPC

---

From: Micaela Chan <mychan2@cyrus.psych.uiuc.edu>  
Sent: Fri, Jul 30, 2010 4:17 pm  
Subject: Re: SWLS permission: doctoral research  
Dear Bede,

The scale is in the public domain (not copyrighted) and therefore you are free to use it without permission or charge by all professionals (researchers and practitioners) as long as you give credit to the authors of the scale: Ed Diener, Robert A. Emmons, Randy J. Larsen and Sharon Griffin as noted in the 1985 article in the Journal of Personality Assessment.

For more information, please visit Dr. Diener's website at [www.psych.uiuc.edu/~ediener](http://www.psych.uiuc.edu/~ediener)

Best,

Micaela Chan

Assistant to Ed Diener,  
Editorial Assistant  
Perspectives on Psychological Science  
University of Illinois at Urbana-Champaign  
Department of Psychology  
603 East Daniel Street  
Champaign, IL 61820

office:(217)333-4804  
 fax:(217)244-5876  
 mychan2@cyrus.psych.uiuc.edu  
 To: loriann.tulk <loriann.tulk@MHS.com>  
 Date: Fri, Jul 30, 2010 2:56 pm

Dear Loriann,

This message is in reference to our previous phone conversation regarding receipt of a formal letter permitting the use of the POMS-brief scale, for my research and dissertation.

I am a doctoral candidate in the Theoretical and Behavioral Foundations Division, Department of Counselor Education, at Wayne State University, Detroit, Michigan. As part of my dissertation research (*comparing the effects of group art therapy and group life stories-narrative therapy on levels of life-satisfaction and mood in older women residing in skilled nursing facilities*), I would like to use the POMS-Brief Scale.

The purpose of this letter is to obtain written permission to use the POMS-Brief instrument. I will be happy to share the results, if interested.

Thank you for your cooperation and support.

Sincerely,

Bede R. Ryan, M.S., LPC

---

From: loriann.tulk <loriann.tulk@MHS.com>

Subject: Permissions request

Date: Tue, Apr 13, 2010 12:14 pm

Hello,

I am emailing regarding your permissions application. You may include 6 items of the POMS or 20% of the test whichever is least in your dissertation.

Regards,

**Loriann Tulk**

Client Services Specialist-Public Safety

Tel: 1-800-268-6011 ext 232

1-800-456-3003 ext 232

416-492-2627 ext 232

Fax: 1-888-540-4484

416-492-3343

Email: [loriann.tulk@mhs.com](mailto:loriann.tulk@mhs.com)

Please visit our website at [www.mhs.com](http://www.mhs.com)

Canada

Multi Health Systems Inc  
 3770 Victoria Park Avenue  
 Toronto, Ontario  
 M2H 3M6

United States

Multi Health Systems Inc  
 P.O. Box 950  
 North Tonawanda, NY  
 14120-0950

**Sent:** Mon, August 2, 2010 4:09:43 PM  
**Subject:** Graduate/doctoral research permission

Ms. Judith Smythe  
Vice-President of Operations  
Bortz Health Care Facilities  
Detroit, Michigan

Re: Graduate Research Permission

Dear Ms. Smythe,

I am a Licensed Professional Counselor and doctoral candidate in the Theoretical and Behavioral Foundations Division of the Department of Counselor Education, at Wayne State University, Detroit, Michigan. In partial fulfillment for the degree of Doctor of Philosophy, I am required to conduct an experimental research study. As a result, I am interested in studying the effects of two group counseling therapies on levels of life-satisfaction and mood of older women residing in skilled nursing facilities.

The purpose of this letter is to obtain written permission to conduct my research and therapy sessions at two Bortz (Detroit area) facilities. I feel my area of interest fits well with the mission statement of your organization: "To enhance the well-being and quality of life of its residents."

I am available to meet with you and your staff to explain the study, more fully; as well as offer a pre-study information session to potential volunteer participants. In addition, although all *personal* research information will be kept confidential, I will be happy to share the *results of the study*, if interested.

Thank you for your time and consideration. I look forward to hearing from you soon.

Sincerely,  
Bede R. Ryan, M.S., LPC

---

**From:** jsmythebhcf@yahoo.com  
**Sent:** Wed, August 4, 2010 11:54 AM  
**Subject:** Re: Graduate/doctoral research permission

Bede,  
Thank you for picking Bortz facilities to do your research. We have four facilities in the Detroit area and any one is available to you. Please call me at 586-759-5966 to finalize the program.

Judy Smythe,  
Executive Vice President

## APPENDIX B

## HIC APPROVAL FORMS

WAYNE STATE  
UNIVERSITY

HUMAN INVESTIGATION COMMITTEE  
87 East Canfield, Second Floor  
Detroit, Michigan 48201  
Phone: (313) 577-1628  
FAX: (313) 993-7122  
<http://hic.wayne.edu>



## NOTICE OF EXPEDITED APPROVAL

**To:** Bede Ryan  
Theoretical & Behavior Foundations

**From:** Dr. Scott Millis N. Nahan / (23)

**Date:** December 09, 2010

**RE: HIC #:** 118910B3E  
**Protocol Title:** Effects of Two Group Counseling Interventions on Life Satisfaction and Mood of Older Females in Skilled Nursing Home Facilities

**Funding Source:**  
**Protocol #:** 1011009106

**Expiration Date:** December 08, 2011

**Risk Level / Category:** Research not involving greater than minimal risk

The above-referenced protocol and items listed below (if applicable) were **APPROVED** following *Expedited Review* Category ( #7 ) \* by the Chairperson/designee for the Wayne State University Institutional Review Board (B3) for the period of 12/09/2010 through 12/08/2011. This approval does not replace any departmental or other approvals that may be required.

- Flyer
- Consent Form (dated 11/16/10)

- Federal regulations require that all research be reviewed at least annually. You may receive a "Continuation Renewal Reminder" approximately two months prior to the expiration date; however, it is the Principal Investigator's responsibility to obtain review and continued approval **before** the expiration date. Data collected during a period of lapsed approval is unapproved research and can **never** be reported or published as research data.
- All changes or amendments to the above-referenced protocol require review and approval by the HIC **BEFORE** implementation.
- Adverse Reactions/Unexpected Events (AR/UE) must be submitted on the appropriate form within the timeframe specified in the HIC Policy (<http://www.hic.wayne.edu/nicpol.html>).

## NOTE:

1. Upon notification of an impending regulatory site visit, hold notification, and/or external audit the HIC office must be contacted immediately.
2. Forms should be downloaded from the HIC website at **each** use.

\*Based on the Expedited Review List, revised November 1998



**WAYNE STATE  
UNIVERSITY**

HUMAN INVESTIGATION COMMITTEE  
87 East Canfield, Second Floor  
Detroit, Michigan 48201  
Phone: (313) 577-1628  
FAX: (313) 993-7122  
<http://hic.wayne.edu>



### NOTICE OF EXPEDITED AMENDMENT APPROVAL

**To:** Bede Ryan  
Theoretical & Behavior Foundations

**From:** Dr. Scott Millis *S. Millis / (25)*  
Chairperson, Behavioral Institutional Review Board (B3)

**Date:** December 17, 2010

**RE:** HIC #: 118910B3E  
Protocol Title: Effects of Two Group Counseling Interventions on Life Satisfaction and Mood of Older Females in Skilled Nursing Home Facilities  
Funding Source:  
Protocol #: 1011009106

**Expiration Date:** December 08, 2011

**Risk Level / Category:** Research not involving greater than minimal risk

The above-referenced protocol amendment, as itemized below, was reviewed by the Chairperson/designee of the Wayne State University Institutional Review Board (B3) and is APPROVED effective immediately.

- Flyer - Modified to delete words "When: Month, Day, 2010."

## APPENDIX C

### INFORMED CONSENT FORM

EFFECTS OF TWO GROUP COUNSELING THERAPIES ON LIFE SATISFACTION AND MOOD OF OLDER FEMALES IN SKILLED NURSING HOME FACILITIES

#### Research Informed Consent

Title of Study: EFFECTS OF TWO GROUP COUNSELING THERAPIES ON LIFE SATISFACTION AND MOOD OF OLDER FEMALES IN SKILLED NURSING HOME FACILITIES

Principal Investigator [PI]: Bede Redpath Ryan, Doctoral Candidate  
College of Education  
Department of Theoretical and Behavioral Foundations  
248-875-4008

#### Purpose

You are being asked to volunteer as a participant in a research study, examining the effects of two group counseling therapy interventions on life satisfaction and mood of older females living in skilled nursing facilities. As a 65<sup>+</sup> year old female resident of Bortz Skilled Nursing Care Facilities (Redford Geriatric Facility and Cranbrook Nursing Facility), who is cognitively and physically able, you are entitled to participate in this study. The total combined estimated number of participants to be enrolled, between the two proposed sites, is approximately 16-20. **Please read this form and ask any questions you may have before agreeing to be in the study.**

The purpose of this study is to help enhance the quality of life (i.e., life-satisfaction and mood) of older women (age 65+) living in two Detroit, Michigan based skilled nursing care facilities. The interventions are designed to facilitate socialization, communication, and coping skills of group participants through the use of Group Art Therapy or Group Life Stories Narrative Therapy.

#### Study Procedures

If you agree to take part in this research study:

- You will meet with the researcher at a preliminary, ninety-minute informational session, the first day, of the first week, of the study. The researcher will provide an overview of the methods and procedures of the study. In addition, information on group art therapy and group life stories narrative therapy, as well as information all research documents will be provided. You will also be informed of the guidelines, purpose, and expectations of the study. Included will be issues of confidentiality, potential overall benefits, as well as risks, of participating in a research study. You will have an opportunity to ask questions concerning the study.
- Volunteers who agree to participate in the research study will be asked to read and sign the informed consent document. Assistance will be provided at your request. You will receive a copy of the signed informed consent document.
- You will be asked to choose a personal four-digit identifying number, such as four digits of a phone number, to be used throughout the duration of the study, for data identification purposes. You will be instructed to remember and record this number on all pre-and post-test



EFFECTS OF TWO GROUP COUNSELING THERAPIES ON LIFE SATISFACTION AND MOOD OF OLDER FEMALES IN SKILLED NURSING HOME FACILITIES

instruments. There will be no master list of names associated with the four-digit coded numbers. The four-digit code will provide anonymity and help maintain confidentiality.

- Following completion of the informed consent document, you will complete the *Demographic Questionnaire*, *Satisfaction of Life Scale [SWLS]* and *Profile of Mood States-Brief form [POMS-B]* to provide base levels of life satisfaction and mood.
- Following completion of all paperwork, group members will be informed of the day and time of next group counseling therapy intervention session, as well as the type of group counseling therapy intervention to be received. Each group counseling therapy intervention session will meet for ninety minutes, two-times/per week, for a total of four weeks. Therefore, including the first preliminary informational group session, your total group participation/time commitment will be: two (ninety-minute) sessions per week – over a four-week period – equaling a total of eight sessions, or 12 hours, of group counseling therapy.
- At the conclusion of the final group counseling therapy intervention session, on the final day, you will complete the post-test questionnaires, to provide the post-treatment data. Having completed the study, you will receive a personalized ‘Certificate of Appreciation’ and a total cash gift of \$20.00.

### Benefits

Although there may be no direct benefits to individual female participants, information garnered from this study may ultimately benefit other older women living in skilled nursing care facilities, either now or in the future. You may benefit indirectly by being provided the opportunity to learn coping skills, communication skills, increased opportunities for social connections, enhanced emotional expression, as well as offered opportunities to increase autonomy, choice, and some elements of control. Consequently, benefits such as enhanced levels of life satisfaction and mood may result from participation.

### Risks

By taking part in this study, you may experience:

- *Psychological/Emotional risks:* Research participants may be placed at risk of feelings of sadness, anxiety, negative emotions, or embarrassment, due to the nature of inquiry. If needed, referral for professional counseling services will be made available to participants. Every attempt will be made to ensure participant's psychological health by providing a secure, confidential and therapeutic group environment. Group counseling therapy intervention sessions will be held in an area away from the general nursing home population to maintain confidentiality and anonymity. You will be cautioned to maintain professional and confidential behavior.
- *Social/Economic risks:* Research participants may be placed at risk of embarrassment, anxiety, negative emotions, or sadness due to the nature of inquiry. Every attempt will also be



EFFECTS OF TWO GROUP COUNSELING THERAPIES ON LIFE SATISFACTION AND MOOD OF OLDER FEMALES IN SKILLED NURSING HOME FACILITIES

made to minimize participants' social risk, by maintaining a professional and confidential environment during the group counseling therapy intervention sessions. Every attempt will be made to preserve participants' beliefs, values, and social relationships. Appropriate resources and referrals for additional support will be made available to any participant, if requested or deemed necessary. There are no known reported incidents of economic harm to participants in similar studies.

- *Legal risks:* Information must be released, to the appropriate authorities, if at any time during the study there is concern regarding elder abuse, and/or illegal criminal activities.

There may also be risks involved from taking part in this study that are not known to the researcher at this time.

#### **Alternatives**

The only alternative offered to this study is your choice not to participate.

#### **Study Costs**

Participation in this study will be of no cost to you.

#### **Compensation**

For taking part in this research study, you will receive a cash gift of \$20.00 at the conclusion, and final session, of the group counseling therapy study.

#### **Research Related Injuries**

In the event this research related activity results in an injury, treatment will be made available including first aid, emergency treatment, and follow-up care, as needed. Care for such will be billed in the ordinary manner to you or your insurance company. No reimbursement, compensation, or free medical care is offered by Wayne State University. At any time during the study, if you think that you have suffered a research related injury, please contact the PI (Principal Investigator) at 248-875-4008.

#### **Confidentiality**

All information collected about you during the course of this study will be kept confidential to the extent permitted by law. A coded, four-digit number, selected by you, will identify you, in the research records. Information that identifies you, personally, will not be released without your written consent. However, the study sponsor, the Human Investigation Committee (HIC) at Wayne State University, or federal agencies with appropriate regulatory oversight [e.g., Food and Drug Administration (FDA), Office for Human Research Protections (OHRP), Office of Civil Rights (OCR), etc.], may review your records.

EFFECTS OF TWO GROUP COUNSELING THERAPIES ON LIFE SATISFACTION AND MOOD OF OLDER FEMALES IN SKILLED NURSING HOME FACILITIES

When the results of this research are published or discussed in conferences, no information will be included that would reveal your identity.

**Voluntary Participation/Withdrawal**

Taking part in this study is voluntary. You have the right to choose not to take part in this study. If you decide to take part in the study you can later change your mind and withdraw from the study. You are free to only answer questions that you want to answer. You are free to withdraw from participation in this study at any time. Your decisions will not change any present or future relationship with Wayne State University or its affiliates, or other services you are entitled to receive.

The PI may stop your participation in this study without your consent. The PI will make the decision and let you know if it is not possible for you to continue. The decision that is made is to protect your health and safety, or because you did not follow the instructions to take part in the study.

**Questions**

If you have any questions about this study, now or in the future, please contact Bede Redpath Ryan, M.S., L.P.C. at (248) 875-4008 or Dr. Arnold B. Coven at (313) 577-1655. If you have questions or concerns about your rights as a research participant, the Chair of the Human Investigation Committee can be contacted at (313) 577-1628. If you are unable to contact the research staff, or if you want to talk to someone other than the research staff, you may also call (313) 577-1628 to ask questions or voice concerns or complaints.

**Consent to Participate in a Research Study**

To voluntarily agree to take part in this study, you must sign on the line below. If you choose to take part in this study you may withdraw at any time. You are not giving up any of your legal rights by signing this form. Your signature below indicates that you have read, or had read to you, this entire consent form, including the risks and benefits, and have had all of your questions answered. You will be given a copy of this consent form.

\_\_\_\_\_  
Signature of participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of participant

\_\_\_\_\_  
Time

\_\_\_\_\_  
Signature of witness\*\*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed of witness\*\*

\_\_\_\_\_  
Time

Submission/Revision Date: 11/16/2010  
Protocol Version #: 1

Page 4 of 5

\_\_\_\_\_  
Participant's Initials  
HIC Date: 01/09



EFFECTS OF TWO GROUP COUNSELING THERAPIES ON LIFE SATISFACTION AND MOOD OF  
OLDER FEMALES IN SKILLED NURSING HOME FACILITIES

\_\_\_\_\_  
Signature of person obtaining consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of person obtaining consent

\_\_\_\_\_  
Time

**APPROVAL PERIOD**  
DEC 09 '10      DEC 08 '11  
HUMAN INVESTIGATION COMMITTEE

**APPENDIX D****CRITERION INSTRUMENTS***Demographic Questionnaire*

Participant Identification Number \_\_\_\_\_

Please provide the following demographic information by checking the appropriate box for each category. This information will be used confidentially in a written report. Thank you for your cooperation.

Date of birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ (Years)

Marital Status:  Single  Married/Living together  Divorced/Separated  
 Widowed  Other: please specify: \_\_\_\_\_

Ethnicity:  Caucasian  African American  Hispanic/Latino  
 Native American  Asian American  Arabic  
 Other: please specify: \_\_\_\_\_

What is the highest educational degree you have completed?

- Less than high school diploma  High School/GED  Some College Credits  
 Associate Degree  Bachelor Degree  Master Degree  
 Doctorate Degree

Health Status:  Good  Average  PoorMobility Status:  Good (Independent)

- Average (Some Assistance)  
 Poor (Total Assistance)

Current level of participation in extracurricular activities:

- Participates in majority of announced activities  
 Participated in 5 – 10 activities during current year  
 Participated in 1 – 4 activities during the current year  
 Did not participate in any activities during the current year

*Satisfaction with Life Scale (SWLS)*

Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by circling the appropriate number preceding that item. Please be open and honest in your response. The 7-point scale is as follows:

- 1 = Strongly disagree
- 2 = Disagree
- 3 = Slightly disagree
- 4 = Neither agree nor disagree
- 5 = Slightly agree
- 6 = Agree
- 7 = Strongly Agree

Statement:	Scale
1. In most ways my life is close to my ideal.	1 2 3 4 5 6 7
2. The conditions of my life are excellent.	1 2 3 4 5 6 7
3. I am satisfied with my life.	1 2 3 4 5 6 7
4. So far I have gotten the important things I want in life.	1 2 3 4 5 6 7
5. If I could live my life over, I would change almost nothing.	1 2 3 4 5 6 7

The *SWLS* (Diener, Emmons, Larsen, & Griffin, 1985) is in the public domain.

Permission is not needed to use it.

*Group Counseling Session Summary (GCSS)*

Counselor: \_\_\_\_\_

Date: \_\_\_\_\_ Session #: \_\_\_\_\_ Time: \_\_\_\_\_

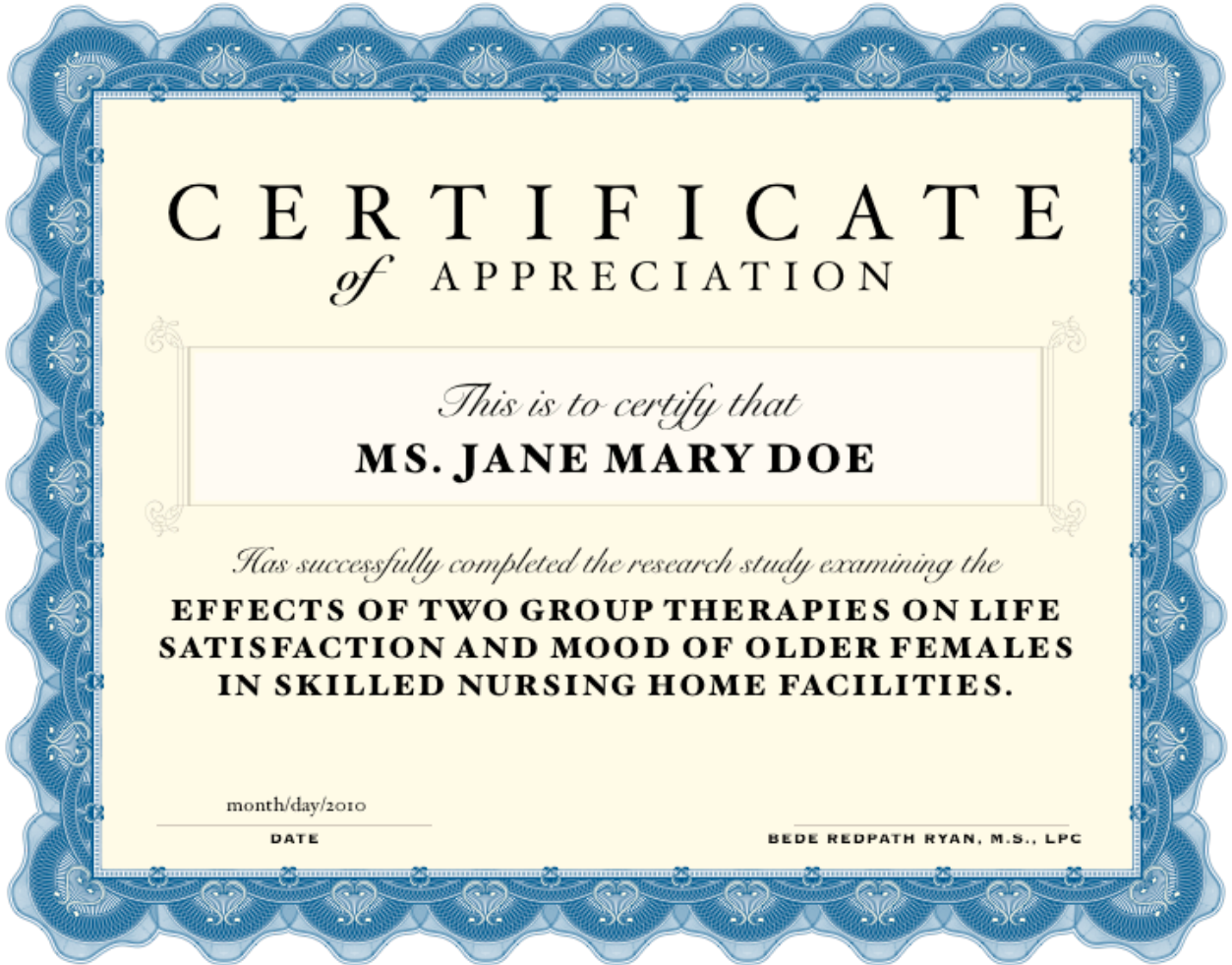
 Group Art Therapy     Group Life Stories Narrative Therapy
Members attending: \_\_\_\_\_  
\_\_\_\_\_

Note in your own words, your reactions and interpretations relating to:

- I. Group themes developed:
  
- II. Group member roles (initiators, stoppers, silent members, scapegoats, etc) and what group members were doing:
  
- III. Significant patterns (i.e. seating arrangements, nonverbal data, etc):
  
- IV. Interventions (i.e., who, what occurred before, during and after; effective ones and/or ineffective ones; identify as appropriate or inappropriate; and why):
  
- V. How group sessions began and ended:
  
- VI. Goals and plans for ensuing sessions (short and long-term goals, homework, etc.).

## APPENDIX E

## OTHER RELEVANT MATERIAL

*Certificate of Appreciation*

## Recruiting Flyer

### Recruiting Flyer



Join a **RESEARCH STUDY** examining  
**LIFE SATISFACTION & MOOD** of **OLDER WOMEN**  
living in skilled health care facilities.

**Location:** Bortz Health Care Facility:  
Redford Geriatric Facility and Cranbrook Nursing Facility

**Incentive:** Volunteer participants will be awarded a personalized 'Certificate of Appreciation' and a cash gift of \$20.00 on the final day of the research study session.

**Who can participate:** **Mobile women, age 65 years and above, residing in Bortz-owned Cranbrook Nursing or Redford Geriatric Health Care Facility, for at least 3 months.**

**Volunteers must be willing to participate in:**

- **2 (90-minute) group sessions/per week**
  - Conducted over a **4-week period**
  - For a **total of 8 group sessions (12 intervention hours).**

Data gathered from female volunteer participants will be anonymously used in the following dissertation:

*The Effects of Two Group Counseling Interventions  
On Life Satisfaction and Mood of older Females in Skilled Nursing Home Facilities*

**Further information, please contact:** **Bede R. Ryan, M.S., L.P.C.**

Doctoral Candidate  
Wayne State University  
Counselor Education Program

**APPROVAL PERIOD**

DEC 17 '10

DEC 08 '11

HUMAN INVESTIGATION COMMITTEE



## REFERENCES

- Administration on Aging (AoA). (2009a). *Aging statistics*. Retrieved from Administration on Aging website:  
[http://www.aoa.gov/AoARoot/Aging\\_Statistics/future\\_growth/aging21/health.aspx](http://www.aoa.gov/AoARoot/Aging_Statistics/future_growth/aging21/health.aspx)
- Administration on Aging (AoA). (2009b). *Challenges of global aging*. Retrieved from Administration on Aging website:  
[http://www.aoa.gov/AoARoot/AoAPrograms/Special\\_Projects/Global\\_Aging/index.aspx](http://www.aoa.gov/AoARoot/AoAPrograms/Special_Projects/Global_Aging/index.aspx)
- Alfonso, V. C., Allison, D. B., Rader, D. E., & Gorman, B. S. (1996). The extended satisfaction with life scale: Development and psychometric properties. *Social Indicators Research*, 38(3), 275-301. Retrieved from <http://www.jstor.org/stable/27522934>
- American Art Therapy Association. (2010). Retrieved from American Art Therapy Association website: <http://www.americanarttherapyassociation.org/aata-aboutarttherapy.html>
- American Association of Retired Persons (AARP). (2007). Housing considerations: Health, travel, baby boomers, elections, financial planning, family, games, volunteer, retirement, discounts, seniors. Retrieved from AARP.org website: <http://AARP.org>
- Amundson, J. K. (2001). Why narrative therapy need not fear science and “other” things. *Journal of Family Therapy*, 23(2), 175-188. doi: 10.1111/1467-6427.00177
- Argyle, E., & Bolton, G. (2005). Art in the community for potentially vulnerable mental health groups. *Health Education*, 105(5), 340-354. doi: 10.1108/09654280510617178
- Arrington, D. B. (2001). *Home is where the art is: An art therapy approach to family therapy*. Springfield, IL: Charles C. Thomas Publishers.
- Ayers, C. R., Sorrell, J. T., Thorp, S. R., & Wetherell, J. L. (2007). Evidence-based psychological treatments for late-life anxiety. *Psychology and Aging*, 22(1), 8-17. doi:

10.1037/0882-7974.22.1.8

- Barnes, R. R. (2005). The non-regulation of independent living. In *Retirement Homes, Retirement Communities, Assisted Living, & Senior Housing Options*. Retrieved from <http://www.retirementhomes.com/library/legal-and-insurance/legal-services/the-non%11regulation-of-independent-living-2005111089.html>
- Bell, C., & Robbins, S. (2007). Effect of art production on negative mood: A randomized controlled trial. *Journal of the American Art Therapy Association (0742-1656)*, 24(2), 71-75.
- Besley, A. C. T. (2002). Foucault and the turn to narrative therapy. *British Journal of Guidance & Counselling*, 30(2), 125-143. doi: 10.1080/03069880220128010
- Birren, J. E., & Cochran, K. N. (2001). *Telling the stories of life through guided autobiography groups*. Baltimore, MD: The Johns Hopkins University Press.
- Birren, J. E., & Deutchman, D. E. (1991). *Guiding autobiography groups for older adults: Exploring the fabric of life*. Baltimore, MD: The Johns Hopkins University Press.
- Bongaarts, J. (2006). How long will we live? *Population and Development Review*. 32(4) 605-628. Retrieved from <http://www.popcouncil.org/pdfs/wp/215.pdf>
- Bonnie, R. J., & Wallace, R. B., (Eds.). (2003). *Elder mistreatment: Abuse, neglect and exploitation in an aging America*. Washington, DC: National Academies Press.
- Brookmeyer, R., Gray, S., & Kawas, C. (1998). Projections of Alzheimer's disease in the United States and the public health impact of delaying disease onset. *American Journal of Public Health*, 88 (9), 1337-1342. doi: 10.2105/AJPH.88.9.1337
- Brown, N. (1996). *Expressive processes in group counseling: Theory and practice*. Westport, CT: Praeger Publishers.

Buetell, N. (2006). *Life satisfaction, a Sloan work and family encyclopedia entry*. Retrieved from the Sloan Work and Family Research Network website:

[http://wfnetwork.bc.edu/encyclopedia\\_entry.php?id=3283&area=academics](http://wfnetwork.bc.edu/encyclopedia_entry.php?id=3283&area=academics)

Bush, S. S. (2009). *Geriatric mental health ethics: A casebook*. NY: Springer Publishing Company.

Caldwell, R. (2005). At the confluence of memory and meaning – life review with older adults and families: Using narrative therapy and the expressive arts to re-member and re-author stories of resilience. *The Family Journal*, 13(2), 172-175.

doi:10.1177/1066480704273338

Carroll, N. (2003). Art and mood: Preliminary notes and conjectures. *The Monist*, 86(4), 521-555. Retrieved from <http://www.questia.com/googleScholar.qst?docId=5006472784>

Centers for Disease Control and Prevention. (2008). *The state of mental health and aging in America. Issue Brief #1: What do the data tell us?* Retrieved from:

[http://www.cdc.gov/aging/pdf/mental\\_health.pdf](http://www.cdc.gov/aging/pdf/mental_health.pdf)

Centers for Disease Control and Prevention. (2009). National nursing home survey: 2004 Overview. Data from the national health care surveys. *Vital and Health Statistics*, 13(167). Retrieved from [http://www.cdc.gov/nchs/data/series/sr\\_13/sr13\\_167.pdf](http://www.cdc.gov/nchs/data/series/sr_13/sr13_167.pdf)

Chapman, L., Morabito, D., Ladakakos, C., Schreier, H., & Knudson, M. M. (2001). The effectiveness of art therapy interventions in reducing post traumatic stress disorder (PTSD) symptoms in pediatric trauma patients. *Art Therapy: Journal of the American Art Therapy Association (0742-1656)*, 18(2), 100-104. Retrieved from <http://arttherapy.metapress.com.proxy.lib.wayne.edu/content/j857831n894177g3/fulltext.pdf>

- Charnie, J. (Ed.). (2002). World Population Ageing: 1950-2050. *Welcome to the UN: It's your world*. Retrieved from <http://www.un.org/esa/population/publications/worldageing19502050/index.htm>
- Cohen, G, Perlstein, S., Chapline, J., Kelly, J., Firth, K., & Simmens, S. (2006). The impact of professionally conducted cultural programs on the physical health, mental health, and social functioning of older adults. *The Gerontologist* 46(6), 726-734. Retrieved from <http://gerontologist.oxfordjournals.org.proxy.lib.wayne.edu/content/46/6/726.full.pdf+html>
- Collie, K., Bottorff, J. L., & Long, B. C. (2006). A narrative view of art therapy and art making by women with breast cancer. *The Journal of Health Psychology* 11(5), 761-775. doi: 10.1177/1359105306066632
- Cook, E. (1998). Effects of reminiscence on life satisfaction of elderly female nursing home residents. *Health Care for Women International*, 19(2), 109-118. Retrieved from [http://pdfserve.informaworld.com.proxy.lib.wayne.edu/868167\\_731197542\\_713852223.pdf](http://pdfserve.informaworld.com.proxy.lib.wayne.edu/868167_731197542_713852223.pdf)
- Corey, G. (2005). *Theory and practice of counseling and psychotherapy* (7<sup>th</sup> ed.). Belmont, CA: Brooks/Cole-Thomson Learning.
- Corey, G. (2008). *Theory and practice of group counseling* (7<sup>th</sup> ed.). Belmont, CA: Brooks/Cole-Thomson Learning.
- Cuijpers, P., van Straten, A., & Andersson, G. (2008). Psychotherapy for depression in adults: A meta-analysis of comparative outcome studies. *Journal of Consulting and Clinical Psychology* 76(6), 909-922. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2408566/pdf/1471-244X-8-36.pdf>

- Cutchin, M. (2003). The process of mediated aging-in-place. *Social Sciences and Medicine*, 57, 1077-1099. Retrieved from doi:10.1016/S0277-9536(02)00486-0
- Darley, S., & Heath, W. (2008). *The expressive arts activity book: A resource for Professionals*. London: Jessica Kingsley Publishers.
- Davis-Basting, A. (2006). Arts in dementia care: This is not the end ... it's the end of this chapter. *Generations*, 30(1), 16-20. doi: 1070989121
- Davis-Jones, E., & Beck-Little, R. (2002). The use of reminiscence therapy for the treatment of depression in rural-dwelling older adults. *Issues in Mental Health Nursing*, 23, 279-290. doi:10.1080/016128402753543018
- DePetrillo, L., & Winner, E. (2005). Does art improve mood? A test of a key assumption underlying art therapy. *Journal of the American Art Therapy Association*, 22(4), 205-212. Retrieved from <http://arttherapy.metapress.com.proxy.lib.wayne.edu/content/rk1j4j2746058213/fulltext.pdf>
- Didion, J. (1979). *The white album*. NY: Simon and Schuster.
- Diener, E. (2009). Subjective well-being. In E. Diener (ed.), *The science of well-being: The collected works of Ed Diener* (Social Indicators Research Series 1, 37, 11-58). Springer Science + Business Media. doi: 10.1007/978-90-481-2350-6\_2
- Diener, E., Emmons, R., Larsen, R., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment*, 49(1), 71-75. Retrieved from Business Source Complete database.
- Diener, E., Oishi, S., & Lucas, R. E. (2003). Personality, culture, and subjective well-being: Emotional and cognitive evaluations of life. *Annual Review of Psychology*, 54, 403-25.

doi: 10.1146/annurev.psych.54.101601.145056

- Duffy, M. (1999). *Handbook of counseling and psychotherapy with older adults*. New York: Wiley.
- Eberstadt, N. (2002). Population sense and nonsense. *American Enterprise Institute for Public Policy Research*. Retrieved from <http://www.aei.org/issue/14294>
- Ellington, D. B. (1997). *Group counseling session summary (GCSS)*. Unpublished instrument. Wayne State University, Detroit, MI.
- Erikson, E. H. (1982). The life cycle completed: Extended version with new chapters on the ninth stage of development (Rev. ed). New York: W. W. Norton, & Company.
- Evans, G. W., Kantrowitz, E., & Eshelman, P. (2002). Housing quality and psychological well-being among the elderly population. *Journal of Gerontology: Psychological Sciences* 57B(4), 381-383. doi: 10.1093/geronb/57.4.P381
- Floyd, F., Haynes, S., & Doll, E. (1992). Assessing retirement satisfaction and perceptions of retirement experiences. *Psychology and Aging*, 7, 609-621. doi: 10.1037/0882-7974.7.4.609
- Fox, K., Stathi, A., McKenna, J., & Davis, M. (2007). Physical activity and mental well-being in older people participating in the Better Ageing Project. *European Journal of Applied Physiology*, 100, 591-602.
- Frey, B. S., & Stutzer, A. (2002). What can economists learn from happiness research? *Journal of Economic Literature*, XL, 402-435. doi: 10.1257/002205102320161320
- Frey, W. H. (2007). Mapping the growth of older America: Seniors and boomers in the early 21<sup>st</sup> century. *The Brookings Institution: Metropolitan Policy Program*. Retrieved from [http://www.frey-demographer.org/reports/R-2007-1\\_MappingGrowthOlderAm.pdf](http://www.frey-demographer.org/reports/R-2007-1_MappingGrowthOlderAm.pdf)

- Frisch, M. B. (2006). *Quality of life therapy: Applying a life satisfaction approach to positive psychology and cognitive therapy*. Hoboken, NJ: John Wiley, & Sons, Inc.
- Gabriel, Z., & Bowling, A. (2004). Quality of life from the perspectives of older people. *Aging, & Society, 24*, 675-691. doi:10.1017/S0144686X03001582
- Gallagher-Thompson, D., & Coon, D. W. (2007). Evidence-based psychological treatments for distress in family caregivers of older adults. *Psychology and Aging, 22*(1), 37-51. doi: 10.1037/0882-7974.22.1.37
- Gardner, P., & Poole, J. (2009). One story at a time: Narrative therapy, older adults, and addictions. *Journal of Applied Gerontology, 28*(5), 600-620. doi: 10.1177/0733464808330822
- Gatz, M., & Fiske, A. (2003). Aging women and depression. *Professional Psychology: Research and Practice, 34*(1), 3-9. doi: 10.1037/0735-7028.34.1.3
- Gitlin, L. N. (2003). Conducting research on home environments: Lessons learned and new directions. *The Gerontologist, 43*(5), 628-637. doi: 10.1093/geront/43.5.628
- Golant, S. M. (2003). Conceptualizing time and behavior in environmental gerontology: A pair of old issues deserving new thought. *The Gerontologist, 43*(5), 638-648. doi: 10.1093/geront/43.5.638
- Graham Pole, J. (2000). *Illness and the art of creative self-expression*. Oakland, CA: Harbinger Press.
- Gross, B. (2006). Group concerns. *Annals of the American Psychotherapy Association, 9*, 1-5. Retrieved from <http://www.questia.com/reader/printPaginator/73>
- Gueldner, S., Loeb, S., Morris, D., Penrod, J., Bramlett, M., Johnston, L., & Sholtzhauer, P. (2001). A comparison of life satisfaction and mood in nursing home residents and

- community-dwelling elders. *Archives of Psychiatric Nursing*, 15(5), 232-240.
- Hadley, R. G., & Mitchell, L. K. (1995). *Counseling research and program evaluation*. Pacific Grove, CA: Brooks/Cole.
- Haight, B. K. (1992). Long-term effects of a structured life review process. *Journal of Gerontology*, 47(5), 312-315. Retrieved from Research Library doi: 5305450
- Haight, B. K., & Haight, B.S. (2007). *The handbook of structured life review*. Baltimore, MD: Health Professions Press, Inc.
- Handy, S. L., Boarnet, M. G., Ewing, R., & Killingsworth, R. E. (2002). How the built environment affects physical activity: Views from urban planning. *American Journal of Preventive Medicine*, 23(2S). Retrieved from <https://woc.uc.pt/fcdef/course/MLDLELDL/2008-2009/AJ%20PREV%20MED%202002-built%20env1.pdf>
- He, W., Sengupta, M., Velkoff, V.A., & DeBarros, K.A. (U.S. Census Bureau), (2005). *65+ in the United States: 2005. Current population reports, P23-209*. Washington, DC: U.S. Government Printing office. Retrieved from <http://www.census.gov/prod/2006pubs/p23-209.pdf>
- Hidalgo, M., & Hernandez, B. (2001). Place attachment: Conceptual and empirical questions. *Journal of Environmental Psychology*, 21, 273-281. Retrieved from doi:10.1006/jevp.2001.0221
- Hill, M., (2003, May 15). Re: Healing grief through art: Art therapy bereavement group workshops (Online information site). Retrieved from <http://arttherapy.wordpress.com/2003/05/page/2/>
- Holst, G., Edberg, A.K., & Hallberg, I. R. (1999). Nurses' narrations and reflections about caring



- for patients with severe dementia as revealed in systematic clinical supervision sessions. *Journal of Aging Studies*, 13 (1). 89-107. Retrieved from doi:10.1016/S0890-4065(99)80008-5
- Houser, A. (2007). *AARP public policy*. AARP Public Policy Institute analysis of 2004 NNHS. Retrieved from [http://www.aarp.org/research/ppi/ltc/nurs-homes/articles/fs10r\\_homes.html](http://www.aarp.org/research/ppi/ltc/nurs-homes/articles/fs10r_homes.html)
- Houser, A., Fox-Grage, W., & Gibson, M. (2006). *Across the states: profiles of long-term care and independent living*. AARP Public Policy Institute (6th ed.). Retrieved from [http://www.aarp.org/research/ppi/ltc/Other/articles/across\\_the\\_states\\_2006\\_\\_profiles\\_of\\_long-term\\_care\\_and\\_independent\\_living.html](http://www.aarp.org/research/ppi/ltc/Other/articles/across_the_states_2006__profiles_of_long-term_care_and_independent_living.html)
- Hyer, L., Sohnle, S., Mehan, D., & Ragan, A. (2002). Use of positive core memories in LTC: a review. *Clinical Gerontologist*, 25 (1), 51-90. Retrieved from [http://dx.doi.org/10.1300/J018v25n01\\_04](http://dx.doi.org/10.1300/J018v25n01_04)
- IBM Corporation (2010). *IBM-SPSS Statistical Program for Windows* [Version 19.0] (computer software). Somers, NY: IBM Corporation.
- Johnson, C., & Sullivan-Marx, E. (2006). Art therapy: Using the creative process for healing and hope among African American older adults. *Geriatric Nursing*, 27(5), 309-316. Retrieved from doi: 10.1016/j.gerinurse.2006.08.010
- Johnson, M. (2003). Our guest editor. *Generations: Journal of the American Society on Aging*, 27(3), 4-5. Retrieved from Research Library doi: 515544231
- Jones, A., Dwyer, L., Bercovitz, A., & Strahan, G. (2009). The national nursing home survey: 2004 overview. *National Center for Health Statistics: Vital Health Stat 13*(167). Retrieved from Centers of Disease Control and Prevention National Center for Health

Statistics website: [http://www.cdc.gov/nchs/data/series/sr\\_13/sr13\\_167.pdf](http://www.cdc.gov/nchs/data/series/sr_13/sr13_167.pdf)

Kahneman, D., Diener, E., & Schwarz, N. (1999). *Well-being: The foundations of hedonic psychology*. New York, NY: Sage.

Kane, R. A. (2003). Definition, measurement, and correlates of quality of life in nursing homes: Toward a reasonable practice, research, and policy agenda. *The Gerontologist*, 43(2), 28-36. doi:10.1093/geront/43.suppl\_2.28

Kaneda, T. (2006). A critical window for policymaking on population aging in developing countries. *Population Reference Bureau*, Retrieved from <http://www.prb.org/Articles/2006/ACriticalWindowforPolicymakingonPopulationAginginDevelopingCountries.aspx>

Kaplan, F. (2000). *Art, science, and art therapy: Repainting the picture*. London: Jessica Kingsley Publishers.

Keeling, M., & Bermudez, M. (2006). Externalizing problems through art and writing: experiences of process and helpfulness. *Journal of Marital and Family Therapy*, 32 (4), 405-419. doi: 10.1111/j.1752-0606.2006.tb01617.x

Kenyon, G. M. (2003). Telling and listening to stories: Creating a wisdom environment for older people. *Generations: Journal of the American Society on Aging*, 27(3), 30-33. Retrieved from <http://search.proquest.com/docview/212188119?accountid=14925>

Kenyon, G., & Randall, W. (2001). Narrative gerontology: An overview. In G. Kenyon, P. Clark, & B. de Vries (Eds.), *Narrative gerontology: Theory, research, and practice* (pp. 3-18). New York, NY: Springer Publishing Co.

Kenyon, G., Clark, P., & de Vries, B. (2001). *Narrative gerontology: Theory, research, and practice*. New York, NY: Springer Publishing Co.

- Keyes, C. L., Shmotkin, D., & Ryff, C. D. (2002). Optimizing well-being: The empirical encounter of two traditions. *Journal of Personality and Social Psychology*, 82(6), 1007-1022. doi: 10.1037//0022-3514.82.6.1007
- Kinney, J. M., & Rentz (2005). Observed well-being among individuals with dementia: Memories in the making, an art program, versus other structured activity. *American Journal of Alzheimer's Disease and Other Dementias*, 20, 220-227. doi: 10.1177/1522217505020000406
- Knight, B. G. (2004). *Psychotherapy with older adults* (3<sup>rd</sup> ed.). Thousand Oaks, CA: Sage Publications.
- Kropf, N. P., & Tandy, C. (1998). Narrative therapy with older clients: The use of a “meaning-making” approach. *Clinical Gerontologist*, 18(4), 3-16. doi:10.1300/J018v18n04\_02
- Krout, J. A., & Wethington, E. (Eds.). (2003). *Residential choices and experiences of older adults: Pathways to life quality*. New York, NY: Springer Company, Inc.
- Kunkel, S. R., & Appelbaum, R. A. (1992). Estimating the prevalence of long-term disability for an aging society. *Journal of Gerontology*, 47(5), S253. Retrieved from Research Library doi: 5305466
- Lai, C. K., Chi, I., & Kayser-Jones, J. (2004). A randomized controlled trial of a specific reminiscence approach to promote the well-being of nursing home residents with dementia. *International Psychogeriatrics*, 16(1), 33-49. doi: 10.1017/S1041610204000055
- Lambert, M. J. (1992). Implications of outcome research for psychotherapy integration. In J. C. Norcross, & M. R. Goldstein (Eds.), *Handbook of psychotherapy integration* (pp. 94-129). New York: BasicBooks.

- Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin, & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 143-189). New York: Wiley.
- Landgarten, H. (1981). *Clinical art therapy: A comprehensive guide*. New York, NY: Brunner/Mazel Publishers.
- Lawler, K. (2001). Aging in Place: Coordinating housing and health care provisions for America's growing elderly population. Fellowship Program for Emerging Leaders in Community and Economic Development: Joint Center for Housing Studies of Harvard University. Retrieved from [http://www.jchs.harvard.edu/publications/seniors/lawler\\_w01-13.pdf](http://www.jchs.harvard.edu/publications/seniors/lawler_w01-13.pdf)
- Leith, K. H. (2006). "Home is where the heart is ... or is it?" A phenomenological exploration of the meaning of home for older women in congregate housing. *Journal of Aging Studies*, 20, 317-333. doi: 10.1016/j.jaging.2005.12.002
- Lerner, A. (2007). Keynote: The brain as a source of creativity (brochure). In The Art Therapy Studio: Art, & Health Symposium, Cleveland. Retrieved from [http://www.arttherapistudio.org/files/A\\_H\\_brochure\\_07.pdf](http://www.arttherapistudio.org/files/A_H_brochure_07.pdf)
- Levick, M. (2001). Art therapy. In R. J. Corsini (Ed.). *Handbook of innovative therapy* (pp. 25-37). New York: John Wiley, & Sons, Inc.
- Lichtenberg, P. A. (1994). *A guide to psychological practice in geriatric long-term care*. New York: Hawthorn Press.
- Lichtenberg, P. A., Kimbarow, M. L., Wall, J. R., Roth, R. E., & MacNeill, S. E. (1998). *Depression in geriatric medical and nursing home patients: A treatment manual*. Detroit, MI: Wayne State University Press.

- Linley, P., Maltby, J. Wood, A., Osborne, G., & Hurling, R. (2009). Measuring happiness: The higher order factor structure of subjective and psychological well-being measures. *Personality and Individual Differences, 47*(8), 878-884. doi: 10.1016/j.paid.2009.07.010
- Malchiodi, C. A. (2007). *The art therapy sourcebook*. New York: McGraw Hill.
- Malchiodi, C. A. (Ed.). (1999). *Medical art therapy with adults*. London: Jessica Kingsley Publishers, Ltd.
- Malchiodi, C. A. (Ed.). (2003). *Handbook of art therapy*. New York: Guilford Press.
- Manton, K.G., Stallard, E., & Liu, K. (1993). Forecasts of active life expectancy: Policy and fiscal implications. *The Journal of Gerontology, 48*(Special Issue), 11-26. doi: 10.1093/geronj/48.Special\_Issue.11
- Marshall, M., & Hutchinson, S. (2001). A critique of research on the use of activities with persons with Alzheimer's disease: a systematic literature review. *Journal of Advanced Nursing, 35*(4), 488-496. doi: 10.1046/j.1365-2648.2001.01887.x
- Mastel-Smith, B., Binder, B., Malecha, A., Hersch, G., Symes, L., & McFarlane, J. (2006). Testing therapeutic life review offered by home care workers to decrease depression among home-dwelling older women. *Issues in Mental Health Nursing, 27*, 1037-1049. doi:10.1080/01612840600943689
- Matzo, M., & Sherman, D. (Eds.). (2004). *Gerontological palliative care nursing: Across illness trajectories* (Illustrated ed.). St. Louis, MO: Mosby, Inc.
- McCurry, S. M., Logsdon, R. G., Teri, L., & Vitiello, M. V. (2007). Evidence-based psychological treatments for older adults. *Psychology and Aging, 22* (1), 18-27. doi: 10.1037/0882-7974.22.1.18
- McDougall, G. (1995). Existential psychotherapy with older adults. *Journal of the American*

- Psychiatric Nurses Association*, 1(1), 16-21. doi: 10.1177/107839039500100105
- McGuinn, K. K., & Mosher-Ashley, P. M. (2001). Participation in recreational activities and its effect on perception of life satisfaction in residential settings. *Activities, Adaptation, & Aging*, 25(1), 77-86. doi: 10.1300/J016v25n01\_06
- McNair, D. M., Lorr, M., & Droppleman, L. F. (1971). *The profile of mood states*. San Diego, CA: Educational and Industrial Testing Service.
- McNair, D. M., Lorr, M., & Droppleman, L. F. (1981). *Manual for the profile of mood states*. San Diego, CA: Educational and Industrial Testing Service.
- McNair, D. M., Lorr, M., Heuchert P., & Droppleman, L. F. (2003). *The profile of mood states-brief form*. Toronto, CN: Multi-Health Systems, Inc.
- McNeilly, G. (2005). *Group analytic art therapy*. London: Jessica Kingsley Publishers.
- McNiff, S. (2007). Empathy with the shadow: Engaging and transforming difficulties through art. *Journal of Humanistic Psychology*, 47, 392-399. doi: 10.1177/0022167807302181
- Menninger Clinic (2010). *Menninger's long history began with a small idea*. Retrieved from <http://www.menningerclinic.com/about/early-history.htm>
- Milligan, M. J. (1998). Interactional past and potential: The social construction of place attachment. *Symbolic Interaction*, 21(1), 1-33. doi: 10.1525/si.1998.21.1.1
- Molinari, V. (2003). Group therapy in long term care sites. *Clinical Gerontologist*, 25(1), 13-24. doi: 10.1300/J018v25n01\_02
- Monti, D., Peterson, C., Shakin-Kunkel, E. Hauck, W., Pequignot, E., Rhodes, L., & Brainard, G. (2006). A randomized, controlled trial of mindfulness-based art therapy (MBAT) for women with cancer. *Psycho-oncology*, 15, 363-373. doi: 10.1002/pon.988
- Mood. (2003). In *Collins English Dictionary-Complete and Unabridged*.

Mood. (2010). In *Merriam-Webster Online Dictionary*. Retrieved from <http://www.merriam-webster.com/dictionary/mood>

Mood. (n.d.). In *The American Heritage Stedman's Medical Dictionary*. Retrieved from Dictionary.com website: <http://dictionary.reference.com/browse/Mood>

Moon, B. L. (1995). *Narrative art therapy* (2<sup>nd</sup> ed.). Springfield, IL: Charles C. Thomas.

Moon, B. L. (2003). *Essentials of art therapy education and practice* (2<sup>nd</sup> ed.). Springfield, IL: Charles C. Thomas.

Moos, I., & Bjorn, A. (2006). Use of the life story in institutional care of people with dementia: a review of intervention studies. *Ageing, & Society*, 26, 431-454.

doi:10.1017/S0144686X06004806

Nainis, N., Paice, J. A., Ratner, J., Wirth, J. H., Lai, J., & Shott, S. (2006). Relieving symptoms in cancer: Innovative use of art therapy. *Journal of Pain and Symptom Management*, 31(2), 162-169. doi: 10.1016/j.jpainsymman.2005.07.006

National Institute of Mental Health, NIH Senior Health. (2008). *Depression: About Depression*.

Retrieved from <http://nihseniorhealth.gov/depression/aboutdepression/01.html>

National Institute on Aging Information Center. (2008) Retrieved from

<http://www.nia.nih.gov/Alzheimers/Publications/adfact.htm>

National Institute on Aging, National Institutes of Health. (2007). *Why population aging matters: A global perspective*. Retrieved from NIA/NIH website:

[http://www.nia.nih.gov/NR/ronlyres/9E91407E-CFE8-4903-9875-](http://www.nia.nih.gov/NR/ronlyres/9E91407E-CFE8-4903-9875-D5AA75BD1D50/0/WPAM.pdf)

[D5AA75BD1D50/0/WPAM.pdf](http://www.nia.nih.gov/NR/ronlyres/9E91407E-CFE8-4903-9875-D5AA75BD1D50/0/WPAM.pdf)

[http://www.nia.nih.gov/NR/ronlyres/9E91407E-CFE8-4903-9875-](http://www.nia.nih.gov/NR/ronlyres/9E91407E-CFE8-4903-9875-D5AA75BD1D50/0/WPAM.pdf)

National Mental Health Association. (2003). *Depression and older Americans*. Retrieved from

<http://secured.nmha.org/ccd/support/factsheet.older.cfm>

- National Research Council. (2001). *Preparing for an aging world: The case for cross-national research*, Panel on a Research Agenda and New Data for an Aging World, Committee on Population and Committee on National Statistics, Division of Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.
- Neighborhood Reinvestment Corp dba NeighborWorks America. (2010). *About aging in place*. Retrieved from Neighborhood Reinvestment Corp. website:  
<http://www.nw.org/Network/comstrat/agingInPlace/default.asp>
- Noice, H., Noice, T., & Staines, G. (2004). A short-term intervention to enhance cognitive and affective functioning in older adults. *Journal of Aging and Health, 16*(4), 562-585.  
doi:10.1177/0898264304265819
- Nordhus, I. H., & Pallesen, S. (2003). Psychological treatment of late-life anxiety: An empirical review. *Journal of Consulting and Clinical Psychology, 71*, 643-651. doi:10.1037/0022-006X.71.4.643
- Nylund, D., & Nylund, D. A. (2003). Narrative therapy as a counter-hegemonic practice. *Sage Publications, 5*(4), 386-394. doi: 10.1177/1097184X03251086
- Oswald, F., & Wahl, H.W. (2004). Housing and health in later life. *Reviews on Environmental Health, 19*(3-4). Retrieved from [http://www.psychologie.uni-heidelberg.de/ae/apa/pdf/literatur/fo\\_housinghealth.pdf](http://www.psychologie.uni-heidelberg.de/ae/apa/pdf/literatur/fo_housinghealth.pdf)
- Parmelee, P.A. (1998). Theory and research on housing for the elderly: The legacy of Kurt Lewin. In P. Windley, & R. Scheidt (Eds.), *Environment and aging theory: A focus on housing* (pp. 161-185). New York: Greenwood Press.
- Payne, K., & Marcus, D. (2008). The efficacy of group psychotherapy for older adult clients: A meta-analysis. *Group Dynamics: Theory, Research, and Practice, 12*(4), 268-278. doi:



10.1037/a0013519

- Pinquart, M., & Sorensen, S. (2001). Gender differences in self-concept and psychological well-being in old age: A meta-analysis. *The Journals of Gerontology. Series A, Biological Sciences and Medical Sciences*, 56(4), 195-213. doi: 10.1093/geronb/56.4.P195
- Pirkl, J. (2009). *Transgenerational design matters: The demographics of aging*. Retrieved from Transgenerational Design Matters website  
<http://www.transgenerational.org/aging/demographics.htm#SexRatio>
- Poggi, R. G., & Berland, D. I. (1985). The therapists' reactions to the elderly. *The Gerontologist*, 25(5), 508-513. doi: 10.1093/geront/25.5.508
- Ponzetti, J. (2003). Growing old in rural communities: A visual methodology for studying place attachment. *Journal of Rural Community Psychology*, E6 (1). Retrieved from  
[http://www.marshall.edu/jrcp/E6one\\_Ponzetti.htm](http://www.marshall.edu/jrcp/E6one_Ponzetti.htm)
- Prochaska, J., & Norcross, J. (2007). *Systems of psychotherapy: A transtheoretical analysis* (6<sup>th</sup> ed.). Belmont, CA: Thomson Brooks/Cole.
- Pynoos, J., Caraviello, R., & Cicero, C. (2009). Life long housing: The anchor in aging-friendly communities. *Generations: Journal of the American Society on Aging*, 33(2), 26-32. doi: 1901881801
- Quality of Life. (n.d.). *Dictionary.com Unabridged*. Retrieved from Dictionary.com website:  
[http://dictionary.reference.com/browse/Quality of Life](http://dictionary.reference.com/browse/Quality%20of%20Life)
- Qualls, S. H., Segal, D. L., Norman, S., Niederehe, G., & Gallagher-Thompson, D. (2002). Psychologists in practice with older adults: Current patterns, sources of training, and need for continuing education. *Professional Psychology: Research and Practice*, 33(2), 435-442. doi: 10.1037//0735-7028.33.5.435

- Radloff, L.S. (1977). *The CES-D scale: A self report depression scale for research in the general population*. *Applied Psychological Measurement*, 1, 385-401.
- Rejeski, W.J., & Mihalko, S. L. (2001). Physical activity and quality of life in older adults. *Journals of Gerontology: Series A*, 56A (Special Issue II), 23-35. Retrieved from Research Library doi: 90276144
- Rennie, D. L. (1994). Storytelling in psychotherapy: The client's subjective experience. *Psychotherapy: Theory, Research, Practice, Training*, 31(2), 234-243. Retrieved from doi:10.1037/h0090224
- Riley, S. (2004). The creative mind. *Journal of the American Art Therapy Association*, 21(4), 184-190. Retrieved from <http://eric.ed.gov/PDFS/EJ682602.pdf>
- Rosenthal, G. (2003). The healing effects of storytelling: On the conditions of curative storytelling in the context of research and counseling. *Qualitative Inquiry*, 9(6), 915-933. doi: 10.1177/1077800403254888
- Roush, C. V., & Cox, J. E. (2000). The meaning of home: How it shapes the practice of home and hospice care. *Home Healthcare Nurse (0884-741X)*, 18(6), 388-394. Retrieved from [http://ovidsp.tx.ovid.com.proxy.lib.wayne.edu/OvidSP\\_UI03.01.00\\_H8.101](http://ovidsp.tx.ovid.com.proxy.lib.wayne.edu/OvidSP_UI03.01.00_H8.101)
- Rubin, J. A. (1999). *Art therapy: An introduction*. Philadelphia, PA: Brunner/Mazel.
- Rubinstein, R. L., & Parmelee, P. A. (1992). Attachment to place and the representation of the life course by the elderly. In I. Altman, & S. M. Low (Eds.). *Place attachment* (pp. 139–163). New York: Plenum Press.
- Rubinstein, R., & de Medeiros, K. (2005). Home, self, and identity. In G.D. Rowles, & H. Chaudhury (Eds.), *Home and identity in late life* (pp. 47-62). New York, NY: Springer Publishing Company, Inc.

- Rusted, J., Sheppard, L., & Waller, D. (2006). A multi-centre randomized control group trial on the use of art therapy for older people with dementia. *Group Analysis*, 39(4), 517-536. doi: 10.1177/0533316406071447
- Ryan, B. R. (2010). *Demographic questionnaire*. Wayne State University. Unpublished instrument.
- Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, 57(6), 1069-1081. doi:10.1037/0022-3514.57.6.1069
- Saunders, E. J., & Saunders, J. A. (2000). Evaluating the effectiveness of art therapy through a quantitative, outcomes-focused study. *The Arts in Psychotherapy*, 27(2), 99-106.
- Scharlach, A. E. (2009). Creating aging-friendly communities. *Generations: Journal of the American Society on Aging*, 33(2), 5-11. doi: 1901881771
- Schwarz, B., & Brent, R. (Eds.). (1999). *Aging, autonomy, and architecture: Advances in assisted living*. Baltimore, MD: The Johns Hopkins University Press.
- Seligman, M. E. (2002). *Authentic happiness. Using the new positive psychology to realize your potential for deep fulfillment*. London: Nicholas Brealey Publishing.
- Senior Housing. (2008). In *Types of housing and care – Assisted living facilities, nursing homes and independent living*. Retrieved from <http://www.seniorhousingnet.com/care-types/index.aspx>
- Serrano, J. P., Latorre, J. M., Gatz, M., & Montanes, J. (2004). Life review therapy using autobiographical retrieval practice for older adults with depressive symptomatology. *Psychology and Aging*, 19(2), 272-277. doi:10.1037/0882-7974.19.2.272
- Sharp, J. G., & Bugental, J. T. (2001). Existential-humanistic psychotherapy. In R. J. Corsini

- (Ed.), *Handbook of innovative therapies*. (2<sup>nd</sup>. Ed., pp. 206-217). New York: Wiley.
- Shenk, D., Kuwahara, K., & Zablotsky, D. (2004). Older women's attachment to their home and possessions. *Journal of Aging Studies, 18*(2), 157-169. doi:10.1016/j.jaging.2004.01.006
- Shrestha, L. (2006). The changing demographic profile of the United States. *Congress Research Service (CRS), Report for Congress*. Retrieved from <http://www.fas.org/sgp/crs/misc/RL32701.pdf>
- Singer, J. (2004). Narrative identity and meaning making across the adult lifespan: An introduction. *Journal of Personality, 72*(3), 437-459. doi: 10.1111/j.0022-3506.2004.00268.x
- Smith, H. M. (2007). Psychological service needs of older women. *American Psychological Association, 4*(4), 277-286. Retrieved from doi: 10.1037/1541-1559.4.4.277
- Sousa, L., & Lyubomirsky, S. (2001). Life satisfaction. In J. Worell (Ed.), *Encyclopedia of women and gender: Sex similarities and differences and the impact of society on gender*. (Vol. 2, pp. 667-676). San Diego, CA: Academic Press.
- Spielberger, C. D. (1983). *STAI: Manual for the State-Trait Anxiety Inventory*. Palo Alto, CA: Counseling Psychologists.
- Spillman, B. C., Liu, K., & McGilliard, C. (2002). Trends in residential long-term care: Use of nursing homes and assisted living and characteristics of facilities and residents. In *Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, no. HHS-100-97-0010*. Retrieved from <http://aspe.hhs.gov/daltcp/reports/2002/rltct.pdf>
- Stephenson, R. C. (2006). Promoting self-expression through art therapy. *Generations: Journal of the American Society on Aging, 30* (1), 24-26. Retrieved from

<http://search.proquest.com/docview/217547775?accountid=14925>

Subasi, F., & Hayran, O. (2004). Evaluation of life satisfaction index of the elderly people living in nursing homes. *Archives of Gerontology and Geriatrics*, 41, 23-29.

doi:10.1016/j.archger.2004.10.005

Sykes, R. (1994). Older women and housing: Prospects for the 1990's. In R. Gilroy and R. Woods, (Eds.) *Housing women* (pp. 75-100). New York, NY: Routledge.

Thomas, W. H., & Blanchard, J. M. (2009). Moving beyond place: Aging in Community.

*Generations: Journal of the American Society on Aging*, 33 (2), 12-17. doi: 1901881781

United Nations. (2009). *World population ageing*. Retrieved from United Nations website:

[http://www.un.org/esa/population/publications/WPA2009/WPA2009\\_WorkingPaper.pdf](http://www.un.org/esa/population/publications/WPA2009/WPA2009_WorkingPaper.pdf)

United Nations; Department of Public Information. (1999). *International year of older persons:*

*Demographics of older persons*. Retrieved from

<http://www.un.org/NewLinks/older/99/older.htm>

United States Bureau of the Census. (2003). *The older population in the United States: March*

*2002. Population characteristics*. Retrieved from

<http://www.census.gov/prod/2003pubs/p20-546.pdf>

United States Bureau of the Census. (2011). *U.S. Popclock projection*. Retrieved from

<http://www.census.gov/main/www/popclock.html>

United States Department of Health and Human Services (HHS), Centers for Medicare and

Medicaid Services. Nursing Home Quality Initiatives, MDS 3.0 for Nursing Homes and

Swing Bed Providers. (2010). *Brief Interview for Mental Status (BIMS)-Nursing Home*

*Comprehensive Assessment, Minimum Data Set (MDS-3.0)*. Retrieved from

[http://www.cms.gov/NursingHomeQualityInits/25\\_NHQIMDS30.asp#TopOfPage](http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp#TopOfPage)

- United States Department of Health and Human Services (HHS), Health Resources and Services Administration, Maternal and Child Health Bureau. (2009). *Women's health USA 2009*. Retrieved from <http://mchb.hrsa.gov/whusa09/more/introduction.html>
- van der Velden, I., & Koops, M. (2005). Structure in word and image: Combining narrative therapy and art therapy in groups of survivors of war. *Intervention: International Journal of Mental Health, Psychosocial Work, & Counseling in Areas of Armed Conflict*, 3(1), 57-64. doi: 10.1177/0733464808330822
- van Deurzen, E. (2002). *Existential counseling and psychotherapy in practice*. London: Sage Publications Ltd.
- van Deurzen, E. (2007). Existential therapy. In W. Dryden (Ed.), *Dryden's handbook of individual therapy* (5<sup>th</sup> ed.), (pp. 195-226). London: SAGE Publications Ltd.
- Veenhoven, R. (1991). Is happiness relative. *Social Indicators Research*, 24(1), 1-34. doi: 10.1007/BF00292648
- Veenhoven, R. (2000). Freedom and happiness: A comparative study in forty-four nations in the early 1990s. In E. Diener, & E. M. Suh (Eds.), *Culture and subjective well-being*. (pp. 257-318). Cambridge, MA: MIT Press.
- Ventegodt, S., Clausen, B., Langhorn, M., Kromann, M., Andersen, N. J., & Merrick, J. (2004). Quality of life as medicine III. A qualitative analysis of the effect of a five-day intervention with existential holistic group therapy or a quality of life course as a modern rite of passage. *The Scientific World Journal*, 4, 124-133. doi: 10.1100/tsw.2004.10
- Wahl, H. W. (2003). Research on living arrangements in old age for what? In K. W. Schaie, H. W. Wahl, H. Mollenkopf, & F. Oswald (Eds.), *Aging independently: Living arrangements and mobility* (pp. 3-5). New York: Springer Publishing Company, Inc.

- Wahl, H. W., & Weisman, G. D. (2003). Environmental gerontology at the beginning of the new millennium: Reflections on its historical, empirical, and theoretical development. *The Gerontologist*, 43(5), 616-627. doi: 10.1093/geront/43.5.616
- Waidmann, T. A., & Liu, K. (2000). Disability trends among elderly persons and implications for the future. *Journal of Gerontology: Social Sciences*, 55(5), 298-307.  
doi:10.1093/geronb/55.5.S298
- Waller, D., & Dalley, T. (1992). Art therapy: a theoretical perspective. In D. Waller, & A. Gilroy (Eds.), *Art therapy: A handbook*. (pp. 3-24). Philadelphia: Open University Press.
- Watt, L. M., & Cappeliez, P. (2000). Integrative and instrumental reminiscence therapies for depression in older adults: intervention strategies and treatment effectiveness. *Aging & Mental Health*, 4(2), 166-177. doi:10.1080/13607860050008691
- Weisberg, N., & Wilder, R. (2001). *Expressive arts with elders: A resource*. London: Jessica Kingsley.
- Westerhof, G. J., Bohlmeijer, E., & Valenkamp, M. W. (2004). In search of meaning: A reminiscence program for older persons. *Educational Gerontology*, 30, 751-766. doi: 10.1080/03601270490498016
- Wikstrom, B. M. (2002). Social interaction associated with visual art discussion: A controlled intervention study. *Aging and Mental Health*, 6(1), 82-87. Retrieved from <http://www.informaworld.com.proxy.lib.wayne.edu/smpp/content~db=all~content=a713650096>
- Wister, A. V. (2005). The built environment, health, and longevity. *Journal of Housing for the Elderly*, 19(2), 49-70. Retrieved from [http://dx.doi.org/10.1300/J081v19n02\\_04](http://dx.doi.org/10.1300/J081v19n02_04)
- Wu, Z. (1991). The lived experience of being a foreigner. *Phenomenology and Pedagogy*, 9,

267-275. <http://www.phenomenologyonline.com/articles/wu.html>

Wynne, R. J., & Groves, D. L. (1995). Life span approach to understanding coping styles of the elderly. *Education, 115*(3), 448-449. Retrieved from [http://find.galegroup.com.proxy.lib.wayne.edu/gtx/start.do?prodId=ITOF&userGroupName=lom\\_waynesu](http://find.galegroup.com.proxy.lib.wayne.edu/gtx/start.do?prodId=ITOF&userGroupName=lom_waynesu)

Yalom, I., & Leszczm, M. (2005). *The theory and practice of group psychotherapy* (5<sup>th</sup> ed.). New York, NY: BasicBooks.



**ABSTRACT****EFFECTS OF TWO GROUP APPROACHES ON LIFE SATISFACTION AND MOOD OF OLDER FEMALES IN NURSING HOMES**

by

**BEDE REDPATH RYAN****May 2011****Advisor:** Dr. Arnold Coven**Major:** Counseling**Degree:** Doctor of Philosophy

The principle aim of this study was to evaluate whether two group therapy interventions would increase levels of life satisfaction and mood of older women, age 65+, living in two Metropolitan Detroit based skilled nursing home facilities. This quasi-experimental, two-treatment group design examined the pretest-posttest data of two group counseling therapy interventions, Group Art Therapy (GAT) and Group Life Stories Narrative Therapy (GLSNT). Seventeen participants completed the bi-weekly, 90-minute sessions, over a four-week period. A Univariate ANCOVA with group membership as the fixed independent variable was used to compare life satisfaction post scores with pre scores as covariates. Mean scores were compared to determine which group had the highest increase in life satisfaction following the group interventions. A statistically significant difference was found for life satisfaction between the two intervention groups. A Paired Samples Test was further conducted to determine which treatment intervention found significant differences. Due to small sample size, the Wilcoxon Signed Ranks Test was performed. No significant differences were found for GAT on life satisfaction. However, results of the Paired Samples Test on life satisfaction found significant differences for GLSNT. A Univariate ANCOVA with group membership as fixed independent

variable was also used to compare mood disturbance post scores with pre scores as covariates. Mean scores were compared to determine which group had the highest decrease in mood disturbance following the group interventions. No significant differences were found in either Group Art Therapy or Group Life Stories Narrative therapy for mood disturbance. Recommendations for future research were offered.

## AUTOBIOGRAPHICAL STATEMENT

### BEDE REDPATH RYAN

#### PROFESSIONAL EDUCATION AND LICENSE:

##### WAYNE STATE UNIVERSITY – DETROIT, MICHIGAN

- PH.D. – DOCTOR OF PHILOSOPHY – 2011
  - *COUNSELING*
  - *ART THERAPY COGNATE*

##### LONG ISLAND UNIVERSITY, C.W. POST – WEST POINT, NEW YORK

- M.S. – MASTER OF SCIENCE – 1990
  - *COUNSELING*

##### UNIVERSITY OF NORTH CAROLINA – CHAPEL HILL, NORTH CAROLINA

- B.F.A. – BACHELOR OF FINE ARTS – 1981
  - *STUDIO ART*

##### BOARD OF COUNSELING – STATE OF MICHIGAN

- LPC – LICENSED PROFESSIONAL COUNSELOR – (2006 – present)

#### PROFESSIONAL EXPERIENCE:

##### WAYNE STATE UNIVERSITY, DETROIT, MICHIGAN

- STUDENT ASSISTANT (JANUARY 2008 – MAY 2010)
  - *GROUP COUNSELING – COUNSELING & ART THERAPY*
  - *INTRODUCTION TO COUNSELING*
- GRADUATE STUDENT SUPERVISOR (JANUARY 2005 – MAY 2010)
  - *SUPERVISION – COUNSELING*
  - *TECHNIQUES – COUNSELING*

##### OAKLAND COUNTY COURTS, PONTIAC, MICHIGAN

- GROUP CO-FACILITATOR – INTERNSHIP (SPRING 2007 – FALL 2007)
  - *ANGER REDUCTION (STAR PROGRAM)*
  - *EFFECTIVE PARENTING (ADEPT PROGRAM)*

##### CORPS OF ENGINEERS, FRANKFURT, GERMANY

- ARTIST (1982 – 1984)
  - *GRAPHIC DESIGN*

##### UNITED STATES ARMY – CIVILIAN, FRANKFURT, GERMANY

- COMMUNITY LIFE PROGRAM (1981-1982)
  - *COMMUNITY COUNSELOR*
  - *FAMILY LIAISON*