

## INTRODUCTION

*Words strain  
Crack and sometimes break  
Under the burden under the tension.  
—T. S. Eliot*

Unfortunately, medical science has not yet provided any effective long-term treatment for Alzheimer's disease. In the absence of a much-hoped-for miracle drug, it is our responsibility to find ways to enhance the lives of those stricken with the illness. Current major therapeutic approaches consist of practical and emotional support and of strategies that help strengthen remaining capacities. Art therapy, a relatively new resource, sets out to do exactly these things, offering an additional means to bolster the humanity of the Alzheimer's patient. Art therapy proves to be a powerful medium because it bypasses the dominant verbal aspects of brain function. The work is based on the assumption that in spite of deterioration and advancing limitations, the dementia patient is nevertheless a person with an interior subjective world. The afflicted person, overwhelmed by an inability to articulate, can give voice to this inner world through the use of art materials. In providing that person with the symbolic language of art, an alternative channel for communication is opened. This is a vital gift when words have lost their meaning.

Art therapists working with dementia sufferers are just at the beginning of a struggle for acknowledgment and legitimacy as they introduce their skills into new territories. Hopefully, this book will bring art therapy into the care system, provide a channel through which therapists can increase their communication with patients, and bring new information and a measure of understanding to

caregivers and loved ones who are increasingly cut off from Alzheimer's sufferers because of the dementia.

Art therapists maintain a fundamental belief in creativity as a defining principle of human life and aim to facilitate meaningful creative experiences rather than to produce "good" paintings. We talk of the importance of the *process* as opposed to the *product*. To elicit a personal mark, to become a catalyst for these creative assertions in individuals damaged by dementia, and to mine these residues of vitality and emotionality, is the basic mission of the dedicated art therapist. They nurse no illusions that the therapy can result in lasting changes in the personality structure, that patients can benefit from new insights, or that they can promote new coping strategies to deal with objective difficulties. Instead what art therapists do pursue is that which still exists, which has not yet been contaminated, and through encouraging personal expression, support the patient at his own particular level of functioning.

Through the period during which I worked as an art therapist in a psychogeriatric center, I must have unknowingly been nursing the idea of writing about the experience sometime in the future. Gathering my patients' artwork with no conscious plans of what to do with it, and unable to discard even seemingly trivial scribbles or messy pages of murky paint, I haphazardly stored them away. It is difficult to throw away productions that seem to emanate from real creative desire even if the pages themselves looked primitive or stereotypical. This reluctance to dispose of artwork has been influenced by years of working with different populations and witnessing the way in which pictures or sculptures become imbued with magical powers for the creator. The way even the most seemingly insignificant artwork is treasured was brought home to me by the child who requested the sculpture of "my father," years after she had squashed a piece of clay, seemingly casually, between her fingers. Choosing from a box of unlabeled remains of clay work, she was quite specific about which lump of clay was "the father." Equally, a simple pencil drawing on a small page can evoke emotions long after its creation, proving that it represented internal experiences meaningful to the creator at the time of its making. Alzheimer's patients, deprived of their memory, cannot sustain their connection to their art, but I can, and I did, and I simply could not discard the pages of work. What a treasure this collection turned out to be when I did finally decide that I wanted to share my experience, the lessons I had learned from it, and what I could teach others about it.

I actually came to work with Alzheimer's patients in a quite fortuitous manner. As a teacher in a postgraduate art therapy program, I was in the process of investigating facilities that worked with a range of disorders, so that I could recommend these as work placements for my students after the completion of

their studies. Reluctantly, I admit, I visited the psychogeriatric center, fundamentally quite doubtful about the contribution that art, as therapy, could make to people suffering from what I knew to be an irreversible degenerative disease. For this visit, I had to overcome an unexamined resistance to face the depressing reality of the aging process exacerbated by dementia. The abrupt switch from skepticism to enthusiasm took me quite by surprise. Instead of the overwhelming picture of gloom and hopelessness that I anticipated as I walked with trepidation through the locked doors of the unit, I encountered a palpable atmosphere of gentleness and kindness. These qualities cannot be measured, neither are they considered valid therapeutic tools; certainly they are not mentioned much in psychological literature. However, the dedication of the staff members was heartwarming, directed as it was toward the confused and troubled people who, I knew, could find little place for themselves in the hurried world outside the facility. The staff, whether the kitchen workers, the coordinators of activities, social workers, psychologists, or medical team, all conveyed tolerance and forgiveness for the slowness, repetitions, and constant complaints of the patients. Therapists made themselves available to attend to often incoherent communications, sometimes with a hand placed gently on a patient's shoulder. They listened, answered, and consoled, and I witnessed grateful and smiling patients, who appeared to feel safe and protected. Soon after, quite unexpectedly, I became the art therapist at the center, and I remained in that position for the next eight years.

These years of work gave me an understanding of what it must be like to face the cruel losses of dementia. As I learned about the disruptions in functioning, the gradual damage to capacities, I was more able to react with compassion to the frustration, depression, and apathy that patients expressed. And slowly I began to see a more hopeful aspect. I saw that even human beings with very diminished capacities could live lives of contentment and satisfaction; that though many mechanisms are failing, there remain abilities and faculties through which to take pleasure in life. Art therapy, I became convinced, was a resource that could provide a means of expression of emotions, a tool to bolster self-image, and an alternative language of symbols, metaphors, images, color, line, and form through which patients could communicate.

The last decade has seen an onslaught of information, both in scientific publications and the popular press, about the "new epidemic," the "ravages of dementia," and the "erosion that sweeps over the brain," as well as anxiety-provoking warnings that we are "racing against time." Statistical figures show us the growing danger that each of us might face this "long goodbye." Theories abound, none yet conclusively proven, about the cause of the spread of plaques and tangles that attack the synapses of the brain, interfering with transmission

of messages from one neuron to the other. According to Madeleine Nash (2000) the disease has affected an estimated 20 million people around the world, and the number will triple by the year 2050 as the population ages (p. 52). And we continue to hope that we will not be among those who have to suffer this painfully drawn out, irreversible, and ultimately fatal condition that causes cognitive, emotional, and behavioral deterioration.

Elizabeth Cohen (2003), in her deeply touching memoir, *The House on Beartown Road*, warns:

People aren't prepared for what is coming. It will hit them as it has me. An army of the forgetful is about to march on the whole country. . . . If it hasn't happened to you, then it must seem so abstract. The words *aging population* just don't have the urgent ring of *tornado, hurricane, famine, or flood*. But it is the same thing. Disaster is about to strike, hard and fast, and when it does it will leave us reeling and vulnerable as a society. It will cripple our medical system; it will absorb all sorts of resources. It will exhaust the whole nation. (p. 192)

This might smack of exaggeration, a strongly emotional response from a daughter witnessing, firsthand, the agonizing, slow loss of her father as she once knew him. But Alzheimer's disease is indeed an epidemic and one that society is ill-equipped to deal with. It is making huge demands on the allocation of funds as people are living longer, and savings that once promised a life of security are often consumed by expensive long-term care. The modern Western world has lost much of its sense of community, so that old people have little chance of enjoying the support of an extended clan or the consolation that might come from continued social participation. The dispersal of families is, in many cases, further disrupting the support system, leaving many people who have a relative ailing with Alzheimer's essentially alone to deal with the hardships. Societal attitudes are permeated by ageism, a blight not dissimilar to racism, in which the old are attributed a group of negative characteristics that disregard the personal traits of the individual, relegating him to one pre-defined negative category. Our society has failed to develop any rituals or discourse through which to process the reality and finality of decay and death, so the inevitable darker facets of life are experienced as dangerous territory to be avoided. It is easier to turn our backs on suffering and illness about which we can do little, for which there is no cure, in which deterioration is unavoidable. Contact with those who are elderly, weak, and vulnerable, brings up fears of our own future frailty and dependence. When we live in a world of pressures, ambitions, egocentrism, pleasure seeking, and work demands, the sudden

reality of a parent, spouse, or sibling stricken with dementia is enormously challenging. And if to begin with we didn't care very much for this ailing family member, if this is the end stage of a long, negative relationship with residues of resentment and hurt, then the extra burden of the disease is a cause for more unpleasantness. If we did feel affection for them, if they have been loving, supporting, presences during our lives, the gradual change as they progress into a state of more dependency and helplessness, is shocking and sad, to say the least. And yet, we have to deal with the reality, if in the first case only out of obligation, or in the second, because of our love and commitment.

While I was honing my skills as an art therapist, learning how to initiate creativity with Alzheimer's patients, it was becoming clear that my elderly mother was herself in the process of cognitive decline due to the disease. I had to mine different abilities in order to deal with her illness on a more personal and emotional level. This firsthand experience added a different dimension to my growing familiarity with the process of the disease. In the years that followed her diagnosis, I tried to be a good-enough daughter to my ailing mother. It still hurts when I think of the times that I was harsh and unforgiving, when I could no longer bear the endless questions, when I slipped in to see her and left hastily after ten minutes, smarting from her pleading "so soon?" as she grabbed onto my arm. Many people are compelled to tell the story of this difficult relationship for their own healing purposes, seeking self-forgiveness or extracting personal meaning out of their encounter with Alzheimer's. Others, haunted by the years of physical and emotional distress, desire to use their painfully acquired knowledge to inform and console those who are in the midst of the one-way journey. Diana Friel McGowin, in *Living in the Labyrinth* (1993), wrote a rare account of her own struggle with the disease when she first became aware of her memory loss and bouts of disorientation. Linda Grant (1999), John Bayley (1999), Sue Miller (2003), Elizabeth Cohen (2003), and Eleanor Cooney (2003) all recount the havoc caused by the invasion of the illness on their beloved parents and spouses and the agonizing struggle to take care of them without allowing themselves to fall apart in the process. Other writers have woven these themes into their novels: Kate Jennings in *Moral Hazard* (2002), the Japanese author Sawako Ariyoshi in *The Twilight Years* (1972), and Michael Ignatieff in *Scar Tissue* (1994). The drive to record, to gather the pieces of one's experience and turn them into a coherent and consoling story is what gave birth to my own brief, personal contribution to the ever-growing library of accounts and memoirs. It was born out of a need for the proverbial closure after my mother's death, a way of joining the community of caretakers still reeling from the "enemy of forgetting" that, as Cohen says, "steals what a person truly owns; it takes the life he has lived, leaving him

stranded on the island of the present” (p. 5). The story of my mother’s illness quite naturally runs through my understanding and learning in the professional world, providing insights without the distancing and potential intellectual escape and barriers of the professional role. I wonder what sort of therapist I would have been had my mother not taught me all she did through those long years of her struggle with the illness. Ultimately, these quite different experiences, professional and personal, intellectual and emotional, are blended together in the book.

The story of Alzheimer’s disease is one of increasing loss that finally damns the patient to complete helplessness after the breakdown of mental and bodily functions. As the patient is diminished by the illness, his experience of the world is altered, as are his behavior and his emotional response to it. Increasingly isolated by the inability to manipulate and understand language, often overwhelmed in any verbal question-and-answer situation, the patient can give voice, without threat, to his inner life through the use of art materials.

One of the earliest signs of Alzheimer’s is a growing loss of short-term memory, a difficulty retaining and recalling recent information. However, there is more than one kind of memory, such as those of feelings, sensibilities, un verbalized moral codes, and intuitions. These are memories of a different kind, located and processed in the right hemisphere of the brain, where they remain intact for far longer than does memory in the verbal left brain. The onset of dementia, with its telltale signs of misplacing objects, difficulty in recalling names, uncomfortable inability to recall recent incidents, until the final, almost totally vegetative state is followed by a long process of deterioration. The official diagnosis is usually followed by a mostly static seven-year period during which the level of impairment is to a large extent maintained. During the subsequent years—fifteen or more—there is significant deterioration and severe cognitive decline. The initial seven-year period provides a window of opportunity, during which, though the patient may be confused and forgetful, he continues to have an accessible emotional world. Though their emotions may be less richly textured, patients continue to express desires, hurts, personal tastes, and views on life, as well as a capacity and interest in relating to those around them. Supportive therapies can sustain these existing abilities and protect the patient from the sort of neglect that would spiral him into much more profound dementia, compounded by isolation, loneliness, and depression.

### **MORAL DILEMMAS**

This book is directed in part to the audience of professional art therapists, because it outlines and details the craft of art therapy when applied to the

dementia population. It will also be of use to many of the other professional caregivers involved with Alzheimer's care, such as psychiatrists, psychologists, and occupational therapists, all of whom can benefit by discovering another way into the inner world of their patients. But I also hoped to imbue the book with moral and ethical questions that should be of concern to anyone involved with the aging process and the provisions made for the old, the frail, and the diminished. Because there is no way out of old age except through an untimely early death, each society has to articulate ways in which it copes with the last stage of life. The legendary Eskimo solution, in which those who do not function adequately are cast out from the community, strikes us with its heartless practicality. Fictions of the old being led away to a barren, cold place to die fill us with horror. Velma Wallis highlights this tragic dismissal of the aged in her book *Two Old Women: An Alaskan Legend of Betrayal, Courage, and Survival* (1993). In it, she retells the story of two elderly women abandoned by their tribe and the ensuing guilt and self-repugnance experienced by the tribe when they reunite with the women who survived because of their fierce determination. The tribe then has to face their moral failure and attempt to make reparations for their heartlessness. At the other extreme are the societies in which the aged continue to be respected, cared for, and loved by the younger members of the tribe. They are seen as sources of wisdom and even valued as essential bridges between life and death.

The attitude of the contemporary Western world lies somewhere between these two attitudes. Our sense of morality dictates that we take care of our aged, an ethical commitment instilled by the biblical commandment to "Honor thy father and thy mother," which must include taking responsibility for them in their final dependent and disabled condition. Yet, there are times when our solutions are reminiscent of the chilling notions of Eskimo society: millions of frail aged live on their own, often abandoned by family, and many are marginalized in protected facilities, removed from the rest of the community in an attenuated version of "being led away." Tom Kitwood in his book *Dementia Reconsidered* (1997) presents his case for better care for Alzheimer's patients. He rails against the "malignant social psychology" found in dementia care (p. 11) with the callous disregard for human dignity and integrity, and pleads for what he calls a culture of care. In this new culture he believes that we would not pathologize people who have dementia but focus instead on the uniqueness of each person with respect and compassion, acknowledging the essential social aspect of all existence, even a diminished one. In a similar manner, Oliver Sacks (1985) seeks the human, the personal, and the emotional in each patient stricken with bizarre symptoms and acute limitations. They too are beings with longings, desires, tastes, and loves, if only someone would see

through the confusion to the human kernel and discover the shape of a person still experiencing life but unable to articulate who he is. Sacks contemplates the “undiminished possibility of reintegration by art, by communion, by touching the human spirit . . . and this can be preserved in what seems at first a hopeless state of neurological devastation” (p. 37).

As we face the gradual reversal of roles in which our once active, dependable, and vibrant parents now turn to us for decision making, advice, and support, we become increasingly aware that we are next in line. We fear that what we neglect now will come back to haunt us when we are old and dependent, that what we prepare now, what we invest in, in terms of resources and commitment, will come back to us when it is our time to seek assistance. When our strength has waned and our capacity to initiate has diminished, we will wish for others to honor us with concern and devotion. Yet very few of us will be fortunate enough to continue to live within the young, active world we have occupied for so long. We will be separated from the community, having to make a new life essentially with other old people.

This uncomfortable realization was highlighted for me when my mother became more helpless and dependent and Tessa entered our lives as a live-in caretaker. Tessa had left her children with her extended family in the Philippines, sacrificing her relationship with them for many years, in order to increase her income and provide them with a better education. She took on a strange, complex place in my mother’s life as well as in mine, entering into a deeply committed partnership with me, a mix of sister and friend, when I felt so alone with my mother’s illness. She cared for my mother with devotion and love. It was she who smiled with me, sharing my pride when my mother managed to remember a song from the past, she who had tears in her eyes when my mother lay groaning in pain and could not explain what hurt. I felt both deep compassion for Tessa, who had made these familial sacrifices for economic reasons, as well as guilt that I, instead of her children, should benefit from her nurturing. Imagine my surprise when she confided apologetically one day that she felt sorry for me. She was concerned, she said, that no one would be there to look after me when I became old and helpless like my mother, whereas she would have her entire village around her to take care of her. What a twist! In spite of my privileged life, she pitied me. Tessa didn’t know of anyone in her community who had had Alzheimer’s, but then she admitted she wouldn’t have noticed if they had. No one has any intellectual expectation of the old, nor is there a demand on them to be enlightened about current events or to carry on a conversation. They sit on the balcony and talk with contemporaries, rock the babies, and watch the young people as they go about their business. They continue to live within the community of the

young, no longer taking an active part in the daily grind of life, but neither discarded nor neglected.

### **THE IMPORTANCE OF THE IMAGE**

When a disability limits the use of language, images become particularly significant both as a means to communicate emotional material and as a means to heal. Ancient shamans used the imagination as a powerful source of healing, and today it is widely accepted that the mind plays a major part in influencing healthy functioning. Jeanne Achterberg (1985) writes about the growing medical and psychological consensus regarding the negative power of the imagination on well-being; agreement that fear, anxiety, and depression increase the likelihood of ill health, and that there is a causal relationship between negative states of mind and the diminished resistance to disease. It seems reasonable to assume that the reverse is also true. There is a renewed “focus on the imagination as . . . a potent aspect of healing,” says Achterberg (1985, p. 4), the imagination having a pronounced effect on the body, yielding “power over life and death” (p. 3). Using the latest data from modern medicine, she shows that what has often been considered “worthless” medical intervention—suggestion, placebo drugs, and imagery—is responsible for major changes in biochemistry. For instance, mental rehearsal of an event, or an experience, can evoke major muscular changes, increase blood pressure, and cause changes in brain waves. Phyllis J. Jarvinen and Steven R. Gold (1979) found that it was possible to reduce levels of depression by encouraging severely depressed patients to attend to nondepressive daydreams. Thought, ideas, fantasies, and images seem to have a more concrete physical impact than any skeptic would believe.

The right hemisphere of the brain makes use of images and symbolic language to process material and remains intact far longer than the verbal left brain, once Alzheimer’s sets in. Through the image, the aphasic patient (one whose language ability is to varying degrees compromised) can be provided with experiences that favorably influence his well-being and self-image in spite of his being unable to verbalize such positive feelings. This supports the case for the benefit of the use of images in art activities, particularly for Alzheimer’s victims who are in the process of losing their verbal capacities.

### **THE IMPORTANCE OF THE ARTWORK**

Throughout this book, I have included examples of the artwork of my artist/patients in order to demonstrate the therapy in process and to display

the surprising beauty of the creative act where one might least expect it. Often, against all odds, and in spite of eyesight severely damaged by cataracts or glaucoma, hands that shake from Parkinson's, pains of arthritis, or general weakness, a small but wondrous work will be born. A sigh of satisfaction will emerge as patients gaze in surprise at their success. And though moments later they might already have forgotten that they are the creators of this work, the experience has been had. We take it on faith that the memory of that experience exists at some experiential level beyond the moment, yet it is not only faith that we rely on. We see the very gradual acquisition of minor skills and familiarity with the materials over a period of time, indicating that there is an accumulation of memories. As some patients gravitate independently toward the art room, one might ask them why they are there and receive a puzzled shrug of the shoulders. Yet, moments later, without direction from the therapist, a few will have returned to their usual seat, will pull a page toward themselves, choose a color, and begin smearing enthusiastically—something that would have been unexpected a few months earlier. This is a sort of remembering, though one most of them cannot articulate.

The central documentation of the therapy process must be the artwork itself and the stories it tells. Without these one cannot claim respect for the images or argue for their value as tools for therapy. Describing a picture and the details of its contents never has the impact of the actual artwork, or at least a photographic documentation of it. But on their own, the pictures also lack the power to convince. The combination of the artwork, the circumstances of its birth, some understanding of the world of the creator, and the context of its creation, all tell a greater story than a glance at an image on a page can reveal.

A story will illustrate this point. Very recently, I visited a psychogeriatric unit to observe the work of a member of the staff who is in charge of art activities. Shelly is not an art therapist but an inspiring art teacher who has a deeply optimistic belief in her patients' capacities. She has an enthusiastic and intuitive ability that facilitates exceptionally lively creative activity. Her room is a buzz of activity and color, and the dynamic Shelly responds to requests, advising, energizing, and encouraging. As I stood admiring some of the works, a handsome, robust man in his early seventies strolled into the room and greeted Shelly with a friendly, collegial smile. I recognized him immediately as a familiar flamboyant artist and popular raconteur. I presumed he was there to contribute his artistic assistance to the unit, stretched out my hand, received a warm handshake, and reminded him of our various mutual friends and past meetings. Though his answer was friendly and gallant, I quickly picked up a revealing flatness in his polite words that I recognized as confabulation, a way of using language to hide the confusion and lack of comprehension that people

with dementia experience. My heart sank when I realized that Paul was not a volunteer to the unit but a very confused dementia patient. Remembering various events at which the charming, often provocative, and entertaining artist had been the center of attention, and observing him now, still so physically youthful, was chilling. "I'd better go now. They're coming. You know. Them." he said to Shelly with a tense smile. On the table lay a beautifully drawn picture with richly shaded forms and well-articulated images, the pencil work of a skilled artist. "I did this yesterday," he said, "but I'm still working on it." It was a landscape, a hill covered with trees and leafy growth. On top of the hill stood a proud goat, formed with the casual graphic skill acquired by artists through years of experience. I was delighted to see such abilities still intact and chose to relate particularly to the wonderfully crafted goat. Paul looked exasperated, discarding my admiration, and pointed out a tiny, primitive figure at the bottom of the hill, embedded somewhat in an indentation. "It's him," he said. "He doesn't know where to go. Look. He's lost. His feet are in the water. He's the one," he insisted. What I heard was the urgent desire to share his concern for the lost man, to show something that was significant to him within the picture rather than to impress the viewer with his skills. I learned that he had actually drawn this picture months before and had resolutely refused to create any artwork since, instead staring daily at the lost man, asking, "Which way should he go?" Paul, it appeared, had a far greater hunger than showing off his abilities. What he needed was to express what he felt as he mourned his artistic losses. In a sense, and quite unconsciously, he was begging to turn the observer's gaze away from the past, from what he knew no longer exists. He needed one's gaze to focus on the poorly articulated, childishly drawn little man, threatened by the waters of the river. Paul was not my patient, and I was only a casual visitor, but I did respond to his plea by turning my attention to the lost man, thus acknowledging Paul's current feelings of diminishment.

This incident illustrates the complexity of the different meanings that a page of artwork can acquire, the importance of the context in which the work was done, and the different responses that it elicits, depending on the agenda of the facilitator. Artwork can have therapeutic value of very differing kinds for very different reasons. Sometimes the artist/patient might need confirmation of his skill and creative ability, to be encouraged and admired. Another may need to communicate, with no less urgency, his sense of failure, and disappointment. One patient will want to share his pride and pleasure; another, his despair and pain. In the former, the gaze of admiration will complete the creative act. In the latter, the gaze moves toward the patient's suffering and loneliness, and the gift is in the form of an encounter in which the "other" does not shift his eyes away from the suffering but, through compassion and acceptance,

provides a container for the emotions. Paul's world was fragmenting, and his truth was no longer the well-structured goat, but that of disorganization and disorientation. It is very tempting to admire, to be smitten by the creativity and talent of one's patients. For Paul, such admiration only increased his loneliness and sense of invisibility.

We see in this vignette a significant difference between the art teacher and the art therapist. Shelly's agenda was improving the skills and the artistic productions of the patient, thus providing hours of pleasure as well as confirmation for them regarding their capacities. The art therapist has a different agenda. While the beautifully crafted picture is always a pleasure, it is not the main issue; encounter is. The understanding of the patient's emotional process will profoundly influence one's understanding of it and one's response to it, and it is this that transforms the art activity into a form of therapy.

### **A PLACE FOR OPTIMISM**

Finally, my intention has been to introduce a thread of optimism into this book. The harsh diagnosis of Alzheimer's does not imply that all is lost. From the moment of diagnosis until profound deterioration sets in, that point at which meaningful communication is almost impossible, there is much opportunity to alleviate suffering and enrich lives that otherwise would be discarded as useless. Artistic skill is often surprisingly preserved, even after damage to the brain. Professional artists suffering from varying types of brain damage may still produce work of high quality, though the style and standard of the productions may have altered. Willem de Kooning, the great abstract expressionist painter of the twentieth century, continued to paint long after Alzheimer's had set in. Some of these paintings began to look "weary and thin," but many were still "deft" and "gorgeous," sparkling in the exhibition halls, in spite of the artist's increasing dislocation from the world (Plagens, 1997, p. 54) For amateur artists, though similar changes of style are seen, the artistic ability often persists in spite of impairment to certain cognitive skills. There are rare cases, such as in frontotemporal dementia, in which a period of exceptional creativity accompanies the onset of dementia, even as the patients begin to lose their ability to use language. Apparently, damage to one part of the brain may lead to enhanced functioning in another. Bruce L. Miller and Margaret Mary Clausen (1998) point out, "We never think about the strengths of patients. We only think of the weaknesses. Now I always ask if there is anything patients are doing very well, or better than before" (p. 3).

When one enters a geriatric unit for dementia patients, one will be witness to diverse scenes. An old man with a strong Parkinsonian tremor sits close to

the locked exit door, staring outside longingly, with dull and lonely eyes. A tiny woman stands at the main desk, barely able to see over the top of it, pleading with the secretary that she wants to go home, demanding that she phone her mother to come and get her. A robust-looking, slim man paces backward and forward, mumbling aggressively, while two women, pushing their walkers, argue nastily, gesticulating with bony fingers, stammering their indignation, each determined to get through the door before the other. But in this very same space, there are other scenes to be viewed. Three women sit involved in a conversation, maybe complaining about the food, or the staff, but making contact nevertheless. An old man has taken a frail woman by the arm and is leading her into a room for the “current affairs” group meeting. At the door of the art room, a woman consults with the art teacher about the appropriate place to hang her drawings. You can cast your eye this way or that. The choice is yours, and ultimately it will affect the way you feel about the contribution of such a facility and the value you place on the care of Alzheimer’s patients.

On one occasion, a long-time member of my art group informed me that she was bringing along a friend to join our sessions. I had little choice but to agree, since this practically aphasic woman already had her new friend by the hand; the man was a newcomer to the unit with whom she had instantly bonded and for whom she began to jealously guard a seat next to hers whenever she came to future meetings. This woman and man were both severely confused and dislocated, and yet they had formed a bond, and though I doubt they ever learned each other’s names, they had embarked on a new relationship. They had a life and were still capable of new loyalties and affection. These are the healthy, lively aspects of functioning that often evade the attention of caretakers whose attention is taken up with the illness and pathology.

While working on this book I was, inadvertently, assisted by simple but challenging questions that people repeatedly posed and that forced me to re-examine and articulate important issues. One that I heard often was, “Does it really help?” and similarly, “Is it really worth it?” But who is to tell us when a life is no longer worth living? It is only if one drops such judgments and sustains the belief that there is life to be had in spite of limitations that one can work with people who find themselves in such a diminished position. Ultimately we are all decaying and dying, and the question is what we do while we wait for that to happen. The medical world faces similar dilemmas as it seeks to improve its palliative care for the terminally ill. Physicians find it hard to provide care for patients they can’t cure, though easing the end of life is surely no less important to a good doctor. While we might wait optimistically for a cure, we have a chance to enhance people’s lives and say, “Yes, art therapy

helps!” and, “Yes, it is a worthwhile endeavor!” So though this book concerns the harrowing predicament of Alzheimer’s, it is ultimately a book about life, color, and creativity and of art therapy as a means of providing a forum for their flowering.