Is Art Therapy more than the Sum of its Parts:

Does Art Therapy Improve Life for Aged Care Residents

more than Art or Supportive Groups

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Declaration

I hereby declare that this submission is my own work and to the best of my knowledge it contains no materials previously published or written by another person, nor material which to a substantial extent has been accepted for the award of any other degree or diploma, except where due acknowledgement is made in the thesis. I also declare that the intellectual content of this thesis is the product of my own work, except to the extent that assistance from others in the project’s design and conception or in style, presentation and linguistic expression is acknowledged.

Signed: ____________________________

Dated: _______ 7th April 2015 _______
Acknowledgements

I would like to thank all the aged care facilities that opened their doors to me and freely offered me their premises in which to conduct my group research for this thesis. In particular I would like to thank Hunter Anglican Care who kindly let me facilitate groups at four of their facilities (CA Brown; Carey Bay Gardens; Greenmount Gardens; & Scenic Lodge). Thanks also to Uniting Care at Koombahla, The Belmont Whiddon Group, and the Edgeworth RFBI Hawkins Masonic Village. A special thanks to all the staff (centre managers, lifestyle and activities officers) that helped me to recruit participants, set up work spaces and to remind residents about session timings. In particular I would like to thank Jane Meldrum, Chrystine Banning, Louise Howell, Cheryl Mead, Lana Cooper, Michelle Henderson, Vanessa Puller, Irene Ross, Jeanette Williams, Jennifer Newburn, Jessica McLean and Tracy Burns. I would also like to express my gratitude and appreciation to all the participants of my study who shared with me their time, their memories, their wisdom and their humour.

I sincerely thank my supervisor, Dr Bruce Stevenson, whose support, knowledge and advice was invaluable. I would also like to thank my Mother, Matthilda Brown, for her encouragement and wisdom throughout the past few years; she has helped me immeasurably by being my sounding board and reading my drafts. A special thank you also to Dr Renata Bali who helped proof read my drafts and listen to me incessantly talk about my project. Finally I would like to thank my family; my husband Kevin McMahon and daughters, Briahna and Georgia who have provided me with love, encouragement and patience.
Abstract

Australia has an aging population, with increasing numbers of elderly people requiring assisted-living in residential facilities. Within these facilities there is a high prevalence of depression and anxiety, while quality of life is reduced. The present study aimed to determine the relative value of short-term group interventions to improve the lives of these residents. In particular Art Therapy (making art and using the creation to facilitate discussion and insights) was compared to therapies making up its individual components: Art-as-Therapy (making art with no subsequent discussion) and Support Therapy (non-directive group discussions lead by an empathetic facilitator). A total of 50 residents at seven long-term care facilities in the Newcastle area completed this study: 16 in Art Therapy groups, 16 in Art-as-Therapy groups, and 18 in Support Therapy groups. This study found that the 5 weekly group sessions significantly improved mental and physical quality of life and these improvements were maintained in the short-term. However, there was no significant difference between the interventions. Participation in Art Therapy sessions was found to also significantly reduce depression and anxiety for residents, with these improvements persisting in the short-term. Art-as-Therapy did not significantly reduce depression, but anxiety levels decreased throughout the intervention and follow-up period such that a significant reduction in anxiety was found at the end of the 5 week follow-up period. Neither depression nor anxiety were significantly reduced for Support Therapy participants, with a longer intervention period potentially required. Therefore, Art Therapy appears to provide the greatest benefits to long-term care facility residents by providing a better emotional outlet for participants and a greater resolution of issues that underlie feelings of depression and anxiety than either Art-as-Therapy or Support Therapy.
Is Art Therapy more than the Sum of its Parts: Does Art Therapy Improve Life for Aged Care Residents more than Art or Supportive Groups

Australia has an aging population in which the proportion of people aged over 65 is increasing, with the ratio of people aged over 85 almost doubling in the last twenty years (ABS, 2014). Consequently, the number of people requiring assisted-living in long-term care (LTC) facilities is increasing (Baldwin, Chenoweth & dela Rama, 2015). People living in these facilities often have high levels of depression (Polyakova et al., 2014), anxiety (Haugan & Drageset, 2014) and reduced quality of life (Scocco, Rapattoni & Fantoni, 2006). Therefore, interventions that address these issues are needed.

Improving Depression and Anxiety

Five therapies (supportive, reminiscent, cognitive behavioural, interpersonal and problem-solving therapy) are commonly used to assist depression and anxiety in the elderly (Wang & Blazer, 2014; Ayers, Sorrell, Thorp & Wetherell, 2007). The most common is supportive therapy (ST), which simply involves forming a therapeutic relationship through empathy and active listening (Areán et al., 2010). A number of studies have shown ST (usually conducted for 12 weeks) significantly improves anxiety (Nordhus & Pallesen, 2003; Wetherell, Gatz & Craske, 2003) and depression in older adults (Areán et al., 2010; Cuijpers et al., 2012). As this therapy does not require specialised training it is often utilised in LTC facilities and as a comparison intervention in psychotherapeutic trials (Wang & Blazer, 2014).

More recently, less traditional interventions (other than the five commonly used) have been trialled to relieve depression and anxiety in older adults, including Art Therapy (AT). This intervention “uses creative modalities, including visual art-making, drama and dance/movement within a therapeutic relationship to improve and inform physical, mental and emotional well-being” (ANZATA, 2012). Two distinct forms of this therapeutic intervention exist; Art-as-Therapy (AaT) and Art Therapy (AT).
Art-as-Therapy is the process of art-making without any directed verbal disclosure concerning current issues. Emotional and mental healing is promoted purely through the personal expression and fulfilment that comes from making art (Farokhi, 2011). In general, participating in AaT has been shown to reduce stress levels, negative mood, depression and anxiety (Curry & Kasser, 2005; Bell & Robins 2007; Henderson, Rosen & Mascaro 2007; Toyoshima, Fukui & Kuda, 2011). Doric-Henry (1997) specifically examined the impact of individual weekly pottery sessions (AaT) with residents in a single LTC facility. The 20 participants in the pottery classes showed significantly reduced depression and anxiety and improved self-esteem compared to 20 control participants who did nothing.

Art Therapy (as distinct from AaT) includes art-making but then examines the art produced in conjunction with an Art Therapist in relation to current issues. The artwork is viewed as the externalisation of internalised feelings and events, which when discussed with a therapist, enhances verbal disclosure and facilitates insights (Katz & Hershkowitz, 2010; Farokhi, 2011). A number of well-designed studies have shown AT significantly reduces depression and anxiety and improves quality of life in cancer sufferers, prison inmates, children and war veterans (Thyme et al., 2009; Gussak, 2009; Lyshak-Stelzer, Singer, St. John & Chemtob, 2007; Kopytin & Lebedev, 2013).

Studies specifically targeting the elderly have also found significant improvements in depression and anxiety following AT (Im and Lee, 2014; Choi & Jeon, 2013; Kim, 2013), including those with dementia (Rusted, Sheppard & Waller, 2006; Ri, Jeong & Jung, 2014). In a randomised control study, Kim (2013) found a statistically significant improvement in self-esteem and a significant reduction in depression, anxiety and negative affect for elderly participants in AT groups compared to active control groups (involving reading, playing board games or watching TV). Another research project compared an independent garden-walking group, a guided garden-walking group and an AT group conducted for 6 weeks.
This study found significant decreases in depression for all groups. However, while the exercise and connection to nature improved depression in this study, many residents of LTC facilities have mobility issues and therefore, would have extreme difficulty or be incapable of garden walking.

**Improving Quality of Life**

As well as depression and anxiety, more generally improving quality of life (QoL) for LTC residents is increasingly becoming a focus of research. QoL is a difficult concept to define as it involves a range of components (including physical, psychological and social) which can change depending upon societal and individual influences (Van Malderen, Mets & Gorus, 2013). Currently, only a small number of studies utilise evidence-based research to assess QoL improvements (Van Malderen et al., 2013). This is also the situation when examining AT and QoL and although the limited evidence suggests improvements, much of the research is qualitative or consists of case studies (Chancellor, Duncan & Chatterjee, 2014).

One study looking at AT using collages to stimulate memories and emotions with Korean women at risk of dementia (Choi & Jeon, 2013) found a significant improvement in QoL and a significant reduction in depression compared with the control (do nothing) group. A significant improvement in mental QoL with Japanese adults suffering from Alzheimer’s disease (Hattori, Hattori, Hokao, Mizushima & Mase, 2011) was found with AaT when compared to a learning group. A number of other studies qualitatively assessed measures that could contribute to QoL (such as sociability, physical competency, calmness, engagement, confidence, motivation, relaxation and well-being) and found AT and AaT participation resulted in positive improvements in these measures (Jones, Warren & McElroy, 2006; Rusted et al., 2006; Alders & Levine-Madori, 2010; Stephenson, 2013).
**Present Study**

This paper adds to the current body of research by examining the relative value of group AT, compared to group AaT or group ST, for LTC residents. On the basis of past findings, it is expected that each therapy will reduce anxiety and depression and increase quality of life immediately post-intervention. It is expected that the greatest improvement will be found for participants receiving AT due to this intervention combining the benefits of both the pleasure and relaxation afforded by AaT and the discussion involved in ST (with the discussion in AT being more targeted to examine issues that may be causing psychological distress). Previous research (Wetherell et al., 2003) has shown that elderly patients participating in ST discussion groups have maintained psychological improvements for up to six months post-intervention and the same is expected for participants in this research.

The reasons why AaT is beneficial are not fully understood, but one explanation is that it provides a positive outlet for energy and emotion as it involves doing something, stimulating the senses and resulting in relaxation, excitement and pleasure (Lusebrink, 2004; Smeijsters, Kil, Kurstjens, Welten & Willemars, 2011). Another explanation is that the focused concentration involved in art-making may interrupt habitual negative thoughts or reduce attention to anxiety-producing or stressful concerns. As Smeijsters et al. (2011) claim, AaT requires a person to surrender themselves “unthinkingly but actively to the present moment”. Recent studies into brain-wave activity during art-making have suggested that it may induce meditative-like states within participants (Kruk, Aravich, Deaver & DeBeus, 2014; Belkofer, Van Hecke & Konopka, 2014), although further work on this issue is required. All of the above accounts suggest that the impact of AaT would primarily be evident while art-making was ongoing and participants’ well-being measures would be expected to return to pre-intervention levels in the short-term post-intervention.
Similarly, the reasons why AT is beneficial are not fully understood. Art-making is thought to firstly engage the visual and tactile-haptic sensory systems involved with implicit memory, thus enabling greater memory retrieval, which when examined and verbally discussed, engages cognitive processes creating explicit memories (Lusebrink, 2004). This can enable disjointed feelings, emotions and memories to be better integrated (Sarid & Huss, 2010). AT can further enhance verbal counselling methods as the art-work provides a non-threatening medium in which feelings and emotions can be externalised and objectively discussed reducing the emotional intensity that can be associated with disclosure. In addition, the art creation can be more revealing, as the client usually does not censor their artistic expression unlike their verbal expression (either consciously or unconsciously). Therefore, the art acts as a non-judgemental catalyst for disclosure that can enable the reframing of events or thoughts, consequently reducing psychological distress not only in the present but also in the longer term. If these accounts are correct then the beneficial psychological effects of AT should extend beyond the intervention and produce greater psychological improvements than either AaT or ST in the short-term post-intervention.

Therefore, it is firstly hypothesised that all interventions (AT, AaT & ST) will reduce anxiety and depression and improve QoL immediately post-intervention. The second hypothesis is that participants in the AT condition will show the greatest post-intervention improvement due to this intervention combining the benefits of both ST and AaT, while also being more targeted in examining issues potentially causing psychological distress. Previous research with ST (Wetherell et al., 2003) have found improvements last up to six months post-intervention and therefore, the third hypothesis is that the ST participants in this study will maintain their psychological improvements in the short-term post-intervention. As AaT is thought to primarily provide only momentary pleasure and a distraction from distressing thoughts, the fourth hypothesis is that the AaT participants will not maintain their
improvements in the short-term but will return to pre-intervention levels. The final hypothesis is that AT participants will maintain their improvements better than the ST group in the short-term, as the greater disclosure and reframing afforded by the AT will enhance resolution of thoughts and actions underlying any psychological distress.

Method

Participants

A total of 73 participants, without a diagnosis of dementia or a psychiatric disorder, were recruited through Directors and/or Activity Officers at seven LTC facilities in the Newcastle region. Of these, 23 participants did not complete the project due to illness, hospitalization, death, moving to other facilities or because they declined to participate after the initial session(s). The final 50 participants consisted of 11 males, aged between 63 and 96 years ($M=81.7$, $SD=10.9$), and 39 females, aged from 62 to 97 years ($M=86.0$, $SD=6.6$). This study was conducted with approval from the University of New England's human ethics committee and participation was voluntary.

Materials

Depression Anxiety Stress Scale (DASS-21). Antony, Bieling, Cox, Enns and Swinson (1998) developed this 21-item self-report inventory (a shortened version of the DASS (Lovibond & Lovibond, 1995)) which consists of three 7-item self-report scales for depression, anxiety and stress. This scale requires participants to rate the extent to which each item has been experienced over the past week on a 4-point severity scale from 0 (did not apply to me at all) to 4 (applied to me very much, or most of the time), with higher scores denoting increased severity of depression, anxiety or stress. This scale has shown high reliability (Cronbach’s alpha of .89), high concurrent validity coefficients (.87 & .84) and strong test-retest reliability (.99) (Akin & Cetn, 2007). Reliability in the present study was
high for the total scale, as measured by Cronbach’s alpha ($\alpha=.95$), and good for the three subscales of depression, anxiety and stress ($\alpha=.89$, .79 & .89 respectively).

**Short Form Health Survey (SF-36) Version 2** (Maruish, 2011) was used to evaluate participants’ QoL. This 36-item self-report instrument assesses eight domains (physical functioning, social functioning, role limitations due to physical problems, role limitations due to emotional problems, pain, mental health, vitality, and general health) which are combined to provide two summary measures of physical and mental QoL. It is scored on a scale of 1-5, with all raw scores then converted to a scale of 0 (worst possible health) to 100 (best possible health) providing sum scores for each domain, with a score of 50 being the mean for the general population. Each of the individual domain scores are then weighted (both positively and negatively) and used to calculate the validated physical QoL and mental QoL scores. The subscales have shown high reliability (ranging from Cronbach’s alpha of .81 to .92) (Sanson-Fisher & Perkins, 1998) and good test-retest reliability at two weeks with coefficients ranging from 0.60 to 0.94 (Brazier et al., 1992; Li, Wang & Shen, 2003). Reliability, as measured by Cronbach’s alpha, in the present study was generally high for the subscales ($\alpha=.68$ to .89).

**Counsellor Rating Scale – Short Form (CRS-SF).** This 12-item inventory was developed by Corrigan and Schmidt (1983) to measure clients’ perceptions of their counsellor on three measures (expertness, attractiveness and trustworthiness). Participants are asked to rank the counsellor’s traits using adjectives (such as friendly, experienced and honest) ranging from 1 (not very) to 7 (very), with higher scores denoting more positive views. This scale was used to assess any researcher bias in facilitating the groups across the different interventions. Split-half reliability scores ranged from .85 to .91 (Corrigan & Schmidt, 1983), while high reliability has also been shown for three subscales using Cronbach’s alpha ($\alpha=.76$ to .87) (Epperson & Pecnik, 1985). Reliability in the present study was high for the total scale ($\alpha=.96$) and the three subscales ($\alpha=.87$ to .91).
Procedure

Participant groups (of 3-6 individuals) at each LTC facility were randomly assigned to either Support Therapy (ST), Art-as-Therapy (AaT) or Art Therapy (AT). If more than one group of participants were available at a single facility, then each group received a different intervention to minimise any facility bias in the results. At the start of the project all participants read the information sheet, gave written consent and completed the SF-36 and DASS-21 scales. Additional demographic and medical information were also collected to identify variables that may influence results; including gender, age, length of time they have resided in LTC and also if they had previously suffered from depression or anxiety (to distinguish between trait/state). The sessions were 1-2 hours long and ran weekly for a total of 5 weeks. At the end of the last session all participants completed the SF-36, the DASS-21 and the CRS-SF. The SF-36 and DASS-21 were again completed by participants at 5 weeks post-intervention to examine whether changes endured over the short-term. The participant information sheet and questionnaires are provided in Appendix A (except for SF-36v2 due to copyright restrictions).

**ST Intervention.** The sessions for these groups consisted of non-directive, unstructured, verbal discussions. It predominantly involved listening to the group members discussing their situation and problems being experienced. Occasional generic questions were asked to prompt discussion such as “How have you been during the last week?”, “Has anyone had a similar experience?” or “Would you like to explain that more?”

**AaT Intervention.** The sessions for these groups were intended to engage the participants’ creativity without specifically targeting issues being faced. The first week, designed to be non-confrontational and ease any fears associated with art-making, consisted simply of colouring in pre-drawn mandalas (circular formatted art work). During the second week participants used clay to create a sculpture, name plaque or a bowl of their choice. The
third session involved shaving cream paintings; using paint mixed with shaving cream into which light cardboard was pressed to create patterns. While these paintings dried, the clay pieces made during the previous session were painted. The fourth week used paper to make a 3-D sculpture (a paper dahlia or origami piece). The final session consisted of providing a blank circle to the participants and having them design and make their own mandalas utilising collage materials including stickers, feathers, paint, sequins, bits of paper, etc.

**AT Intervention.** The sessions for these groups were focused on the participants gaining insights about themselves, their feelings, and other relevant issues. A set art task was undertaken for the first part of the session, with the last part devoted to discussing the art works and verbalising emotions/feelings they triggered. The art works created each week used similar techniques and formats to the AaT group (see Table 1).

Table 1

*Summary of Art Tasks for AaT and AT Interventions*

<table>
<thead>
<tr>
<th>Week/Session</th>
<th>AaT Intervention</th>
<th>AT Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pre-drawn Mandalas</td>
<td>Pre-drawn Mandalas</td>
</tr>
<tr>
<td>2</td>
<td>Clay Sculpture</td>
<td>Clay Sculpture of Happy Moment</td>
</tr>
<tr>
<td>3</td>
<td>Shaving Cream Paintings</td>
<td>Shaving Cream Paintings plus Themselves</td>
</tr>
<tr>
<td>4</td>
<td>Decorative Paper Sculpture</td>
<td>Elimination Paper Sculpture which is Burnt</td>
</tr>
<tr>
<td>5</td>
<td>Create Own Mandala</td>
<td>Create Own Mandala</td>
</tr>
</tbody>
</table>

The first week consisted of colouring in pre-drawn mandalas with discussion of the art guided to elicit positive responses and touch on how the participants were feeling as displayed in the drawings. In the second week, participants were asked to remember a time in their life they felt strong and happy and then to sculpt that feeling/event out of clay. Subsequent discussion focused on the event, what about it made each participant feel strong and happy, and what engenders the same feelings. The third session used shaving cream painting, with
participants asked to describe the patterns produced. They were also asked to place themselves on the page, with discussion of their placement relating to how they feel they are “placed” in life. The fourth week involved the participants thinking about something they wanted to get rid of that would make their life better (for example pain; frustration; anger, etc) and then making a paper sculpture of this. The artworks were discussed and then burnt or destroyed with water (due to OH&S) to symbolise eliminating the “thing” from their life. In the last week, participants created their own mandala from collage materials with the discussion focusing on how individual elements were placed within the mandala and any feelings triggered.

**Statistical Analysis**

A power analysis (assuming a medium effect size, alpha level of .05 and target power of .80) using G*Power3 (Faul, Erdfelder, Lang & Buchner, 2007) indicated a minimum of 54 participants would be needed to conduct a repeated measures Analysis of Variance (ANOVA). However, time constraints, difficulty recruiting LTC facilities and the large drop-out rate resulted in only 50 participants completing the project. All analyses were run using SPSS statistical software version 18, with ANOVA and non-parametric tests (Freidman, Wilcoxon and Kruskal-Wallis) conducted.

**Results**

**General Participant Characteristics**

One-way ANOVA’s or Chi-Square Tests were conducted to assess the homogeneity of the intervention groups. Table 2 displays the means or frequencies of these variables and shows that the only significant difference between intervention groups was gender ($\chi^2=7.02$, $p=.030$), with the AaT intervention having relatively more males than the other interventions. Despite this, the groups did not significantly differ on any of the pre-intervention measures of depression, anxiety, physical QoL or mental QoL, with all $F^*$s <1.0 as shown in Table 3.
Table 2

*Homogeneity of General Characteristics of the Intervention Groups*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Category</th>
<th>ST (M±SD or n(%))</th>
<th>AaT (M±SD or n(%))</th>
<th>AT (M±SD or n(%))</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (Years)</td>
<td></td>
<td>88.1±4.1</td>
<td>82.9±7.6</td>
<td>84.1±10.2</td>
<td>.120</td>
</tr>
<tr>
<td>Time Lived in LTC (Years)</td>
<td></td>
<td>2.5±2.7</td>
<td>2.0±1.5</td>
<td>2.2±2.2</td>
<td>.843</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>15(83.3)</td>
<td>9(56.3)</td>
<td>15(93.8)</td>
<td>.030</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>3(16.7)</td>
<td>7(43.7)</td>
<td>1(6.2)</td>
<td></td>
</tr>
<tr>
<td>Prior Diagnosis of Depression or Anxiety</td>
<td>No</td>
<td>13(72.2)</td>
<td>8(50.0)</td>
<td>9(56.3)</td>
<td>.390</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>5(27.8)</td>
<td>8(50.0)</td>
<td>7(43.7)</td>
<td></td>
</tr>
</tbody>
</table>

Table 3

*Homogeneity of Intervention Groups on Psychological Measures (n=50)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>ST (n=18)</th>
<th>AaT (n=16)</th>
<th>AT (n=16)</th>
<th>F (2,47)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>5.83±5.91</td>
<td>5.25±5.75</td>
<td>6.44±6.32</td>
<td>0.16</td>
<td>.855</td>
</tr>
<tr>
<td>Anxiety</td>
<td>4.56±5.09</td>
<td>5.19±4.40</td>
<td>5.88±6.21</td>
<td>0.27</td>
<td>.768</td>
</tr>
<tr>
<td>Physical QoL</td>
<td>35.67±7.58</td>
<td>37.92±7.19</td>
<td>37.60±6.36</td>
<td>0.51</td>
<td>.604</td>
</tr>
<tr>
<td>Mental QoL</td>
<td>51.67±10.65</td>
<td>51.75±11.38</td>
<td>48.16±10.78</td>
<td>0.57</td>
<td>.568</td>
</tr>
</tbody>
</table>

**Depression and Anxiety**

Significant violations of parametric assumptions were found in the Depression and Anxiety scores. A number of transformations were performed, however none of these were effective. Therefore, non-parametric Friedman three-way ANOVA’s were conducted for each intervention to assess significant effects across the three survey periods for each psychometric measure. Where necessary Wilcoxon signed rank tests were subsequently performed. Table 4 provides a summary of these results.
Table 4
Summary of Friedman ANOVA and Wilcoxon Signed Rank Tests for Depression and Anxiety

<table>
<thead>
<tr>
<th></th>
<th>$\chi^2$ (df = 2)</th>
<th>T2-T1</th>
<th>Z</th>
<th>p</th>
<th>T3-T2</th>
<th>Z</th>
<th>p</th>
<th>T3-T1</th>
<th>Z</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Depression</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ST</td>
<td>1.94</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AaT</td>
<td>2.86</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AT</td>
<td>8.00*</td>
<td>-3.69</td>
<td>2.67</td>
<td>.008*</td>
<td>0.33</td>
<td>0.22</td>
<td>.823</td>
<td>-3.63</td>
<td>2.67</td>
<td>.008*</td>
</tr>
<tr>
<td><strong>Anxiety</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ST</td>
<td>2.67</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AaT</td>
<td>6.84*</td>
<td>-1.75</td>
<td>1.78</td>
<td>.074</td>
<td>-0.60</td>
<td>0.00</td>
<td>1.00</td>
<td>-1.81</td>
<td>2.55</td>
<td>0.11*</td>
</tr>
<tr>
<td>AT</td>
<td>6.13*</td>
<td>-2.44</td>
<td>2.12</td>
<td>.034*</td>
<td>-0.44</td>
<td>1.66</td>
<td>.096</td>
<td>-2.88</td>
<td>2.14</td>
<td>0.33*</td>
</tr>
</tbody>
</table>

* p<.05
Z has been corrected for ties
T1 = pre-intervention. T2 = post-intervention. T3 = 5 week follow-up
T3-T1 has been included to identify cumulative effects that are not sufficiently strong in either of the two study phases.

No significant changes in depression levels were found for ST ($\chi^2=1.94$, df=2, p=.380) or AaT ($\chi^2=2.86$, df=2, p=.239), but there was a significant difference for AT ($\chi^2=8.00$, df=2, p=.018). The Wilcoxon signed rank tests, using a Bonferroni adjusted $\alpha$ of 0.17, indicated the source of this effect was a large ($r=.67$) decrease in depression from pre-intervention (Mean Rank=2.50) to post-intervention (Mean Rank=1.75; p=.008), with no subsequent change to follow-up (Mean Rank=1.75; p=.823). Figure 1 shows the mean depression scores.

Therefore, a significant reduction in depression only occurred for participants in AT during the 5 week intervention period and this improvement persisted in the short term (5 weeks later).
A non-parametric Friedman three-way ANOVA was also performed on anxiety for each individual intervention to assess significant effects of Time (see Table 4). No significant changes in anxiety levels were found for ST ($\chi^2=2.67, df=2, p=.264$), but there was a significant difference for AaT ($\chi^2=6.84, df=2, p=.033$) and AT ($\chi^2=6.13, df=2, p=.047$). The Wilcoxon signed rank tests and a Bonferroni adjusted $\alpha$ of 0.017 for the AaT intervention indicated the source of this effect was a large ($r=.63$) decrease in anxiety from pre-intervention ($Mean Rank=2.47$) to follow-up ($Mean Rank=1.72; p=.011$). No significant change was found from pre to post-intervention ($Mean Rank=1.81; p=.074$) or post-intervention to follow-up ($p=1.00$). Figure 2 shows the mean anxiety scores. The Wilcoxon signed rank tests for the AT intervention indicated there was a large ($r=.53$) decrease in anxiety from pre-intervention ($Mean Rank=2.34$) to post-intervention ($Mean Rank=2.06; p=.034$), with no subsequent change to follow-up ($Mean Rank=1.56; p=.096$) (see Figure 2). No Bonferroni adjustment was used for AT as it would not have produced any significant

Figure 1. Mean depression scores in the three survey periods for each intervention group: ST ($n=18$); AaT ($n=16$); and AT ($n=16$).
results and consequently, the significance in the Freidman ANOVA would not have been identified. Therefore, a significant reduction in anxiety occurred for participants in AT during the 5 week intervention period, and this improvement persisted in the short term. The AaT intervention cumulatively reduced anxiety levels throughout the intervention and follow-up period, such that anxiety was significant reduced at the 5 week follow-up when compared to pre-intervention levels.

<table>
<thead>
<tr>
<th></th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
<th>5-Week Follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST Group</td>
<td>5.2</td>
<td>4.5</td>
<td>3.8</td>
</tr>
<tr>
<td>AaT Group</td>
<td>5.8</td>
<td>4.3</td>
<td>3.5</td>
</tr>
<tr>
<td>AT Group</td>
<td>6.0</td>
<td>5.0</td>
<td>4.2</td>
</tr>
</tbody>
</table>

*Figure 2.* Mean anxiety scores in the three survey periods for each intervention group: ST (n=18); AaT (n=16); and AT (n=16).

**Quality of Life**

An inspection of skewness, kurtosis, boxplots and Shapiro-Wilk statistics indicated that the assumption of normality was supported for physical QoL across the intervention groups and time periods, and mostly supported for mental QoL, except for a few outliers which were trimmed. Homogeneity of variance was also supported for physical QoL ($F_{max}=3.48$) and mental QoL ($F_{max}=2.36$), while Mauchly’s test was not significant for either measure indicating the assumption of sphericity was not violated.
To assess changes in physical QoL, repeated measures ANOVA was conducted to analyse the three interventions (ST, AaT & AT) across the three survey periods (pre-intervention, post-intervention & 5 week follow-up). Findings showed there was a significant change in physical QoL over Time, where $F(2,94)=6.75, p=.002, \eta^2=.12$. Using repeated orthogonal contrasts, the source of this effect was an increase from pre-intervention ($M=37.1, SD=1.0$) to post-intervention ($M=39.6, SD=1.1; p=.001$), with no subsequent change to follow-up ($M=39.9, SD=0.9; p=.765$). This effect was consistent across all interventions (interaction $F<1$), and there was no significant difference between Interventions ($F(2,47)=1.56, p=.221, \eta^2=.06$). Figure 3 displays means and standard deviations. Therefore, a significant improvement in physical QoL occurred during the 5 week intervention period, and this improvement persisted in the short term. There is no evidence to suggest this varied across the three interventions, nor that one intervention was better than another.

![Figure 3](image-url)

*Figure 3.* Mean physical QoL scores (and SD bars) in the three survey periods for each intervention: ST ($n=18$); AaT ($n=16$); and AT ($n=16$).
A repeated measures ANOVA was conducted to analyse the three interventions across the three survey periods for mental QoL, with a significant change found over Time, where $F(2,94)=8.06$, $p=.001$, $\eta^2=.14$. Using repeated orthogonal contrasts, the source of this effect was an increase from pre-intervention ($M=50.5$, $SD=1.6$) to post-intervention ($M=53.0$, $SD=1.5$; $p=.023$), with a trend towards a further increase to follow-up ($M=55.2$, $SD=1.3$; $p=.066$). This effect did not vary across the three interventions, as there was no evidence of an interaction ($F<1$), nor was there a main effect for Intervention ($F<1$). Figure 4 displays means and standard deviations. Therefore, a significant improvement in mental QoL occurred during the 5 week intervention period, and this improvement persisted and showed signs it might still be improving in the short term. There is no evidence to suggest that this varied across the three interventions, nor that one intervention was better than another.

![Figure 4](image-url)  
*Figure 4.* Mean Mental QoL scores (and SD bars) in the three survey periods for each intervention: ST ($n=18$); AaT ($n=16$); and AT ($n=16$).
Facilitator Rating

Significant violations of parametric assumptions were found in the CRS-SF subscales and a number of transformations were attempted to resolve these issues, however none were successful. Therefore, non-parametric Kruskal-Wallis ANOVA’s were performed to assess participants’ perception of the researcher’s facilitation of the groups. This showed there were no statistically significant differences between the intervention groups when the researcher was assessed for attractiveness ($\chi^2=1.762$, $p=.414$), expertness ($\chi^2=2.082$, $p=.353$) and trustworthiness ($\chi^2=0.603$, $p=.740$). Therefore, there is no evidence of experimental bias based on the interventions given.

Discussion

The initial hypothesis that all interventions would result in an improvement on all psychological measures was only partially supported by the results. Significant improvements in physical and mental QoL for residents of LTC facilities were found after 5 weeks of group involvement in either ST, AaT or AT. This is consistent with previous findings for AT (Choi & Jeon, 2013) and AaT (Hattori et al., 2011), while these findings are the first to provide empirical support for ST improving QoL. However, depression and anxiety were only significantly reduced for AT, with neither AaT nor ST showing a significant improvement in these measures during the intervention period.

While previous research found ST significant improved depression and anxiety (Nordhus & Pallesen, 2003; Wetherell et al., 2003; Areán et al., 2010; Cuijpers et al., 2012), the current research did not. A possible explanation may be that most of the previous studies conducted ST for 12 weeks and a longer time-frame may be necessary for ST to produce significant results. Rankanen (2014) also highlights that a discussion group can feel more threatening than an art-making group which provides greater structure to participants. During this research, where multiple groups were held at the one facility, some ST participants
expressed a desire to participate in art activities “like the other group” and this comparison may also have resulted in feelings of dissatisfaction that affected the outcomes of the research.

The AaT results of this study are also inconsistent with previous research that found this intervention significantly improved depression and anxiety (Curry & Kasser, 2005; Bell & Robins 2007; Doric-Henry (1997). The small number of participants in the present study may have resulted in insufficient statistical power: this intervention had a medium to large ($r=.27 & .45$) effect on reducing depression and anxiety post-intervention but the results not statistically significant.

The second hypothesis that the AT condition would show the greatest post-intervention improvement compared to ST or AaT is only partially supported by the results of this study. AT was the only intervention to significantly improve depression and anxiety, and therefore, it appears, that AT is more targeted towards examining issues potentially causing psychological distress than either AaT or ST. This is consistent with previous findings (Kim, 2013; Katz & Hershkowitz, 2010; Farokhi, 2011). However, AT showed no greater improvement for physical or mental QoL than the two comparison interventions. With limited empirical data for QoL in LTC residents, this result cannot be compared to prior research findings.

Partial support was also found for the third hypothesis that ST participants would maintain their psychological improvements in the short-term post-intervention (5 weeks later). Results showed that mental and physical QoL significantly improved during the intervention period and that this improvement was maintained for physical QoL in the short-term and showed a trend of improving further for mental QoL across all intervention groups. Despite an extensive search of the literature, no prior study could be found that empirically assessed ST with the elderly in regards to improving QoL in the short-term and therefore, these findings are unique. Wetherell et al (2003) found discussion groups with the elderly
(comparative to the present study’s ST groups) reduced anxiety post-treatment and maintained this improvement for up to six months. However, contrary to this finding the current research did not show any significant change in depression or anxiety scores immediately post-intervention or at the 5 week follow-up point. Again the difference in research findings may be due to the shorter length of the intervention in the present study (5 weeks compared to 12 weeks) and some participants displaying feelings of dissatisfaction within their group allocation.

It was anticipated that improvements for the psychological measures in AaT participants would not be maintained post-intervention; however, this hypothesis was not supported. The results showed that mental and physical QoL improved during the intervention period and that these improvements were maintained in the short-term for all interventions including AaT. In addition, anxiety scores for AaT participants did not show a significant improvement immediately post-intervention, but continued to improve such that anxiety was significantly reduced at the 5 week follow-up survey point when compared to pre-intervention levels. Depression was not significantly different for this intervention at any of the survey times (despite a medium to large effect). Therefore, contrary to the hypothesis, the improvements in the psychological measures experienced by the AaT participants were maintained or continued to improve in the short-term. These results suggest that AaT is contributing to well-being in other ways than merely providing momentary pleasure and a distraction from distressing thoughts, but is having a residue effect. Within this study most of the AaT participants kept some or all of the art they produced and either displayed it in their rooms or elsewhere (the shaving cream paintings were laminated and often used as dining room placemats). These art works consequently served as a visual reminder of the pleasurable experiences and also potentially engendered feelings of pride and accomplishment.
in the participants. This may account for the maintenance or improvements found in the psychological measures in the short-term for these participants.

The final hypothesis was that AT participants would maintain their improvements in the short-term better than the ST group, due to the greater disclosure and reframing afforded by the AT. Again this hypothesis was only partially supported, with physical and mental QoL improvements being maintained in the short-term, but not significantly different from the other interventions. However, the significant improvements in depression and anxiety levels in the AT group were maintained in the short-term, while the ST group showed no significant difference in these measures at any point in time. Therefore, it appears that AT provides a better emotional outlet for participants and a greater resolution of issues that underlie feelings of depression and anxiety for LTC facility residents compared to ST, but does not result in a greater improvement in QoL measures.

**Limitations and Future Research**

Recent reviews of the efficacy of AT (Maujean, Pepping, Kendall, 2014; Reynolds, Nabors, & Quinlan, 2000; Slayton, D’Archer & Kaplan, 2010) have determined that much of the published research: lacks standardised reporting; lacks an adequate control group that is actively doing something; uses anecdotal case material to determine outcomes rather than psychometric measures; and lacks detailed descriptions of the treatment interventions to enable results to be replicated. These limitations are particularly evident when the focus of research is on the elderly (Rusted et al., 2006; Cowl & Gaugler, 2014). The present study has attempted to address many of these limitations by comparing AT with two active control groups (AaT and ST), using psychometric measures to determine the outcomes and providing sufficient detail regarding the interventions to enable the results to be replicated. However, other limitations could not be overcome.
Firstly, the study had a small sample size and consequently the research may have not had sufficient power to adequately detect significant changes within or between some of the interventions being assessed. Full random assignment was also not conducted, with a group of participants at each facility randomly assigned an intervention rather than each participant being randomly assigned. Facility managers and activity officers also assisted in recruiting participants and dividing them into groups and this may have resulted in unintentional biases in group membership. The fact that participants were aware of different intervention groups being conducted may also have negatively influenced some results through dissatisfaction as previously discussed. The other primary limitation of this research was that the researcher facilitated all intervention groups; however the counsellor rating results showed no evidence of facilitator bias between any of the interventions.

Future research replicating this study, but having a larger number of participants would resolve any potential power concerns and assist in teasing out the significant differences both within and between the interventions being assessed. In addition, the present study was the first to empirically show a significant improvement in QoL with ST and replication of these results would be advantageous. An additional follow-up assessment of measures 6-months post-intervention would enable more robust assessment of any residual effects of each intervention. Undertaking the same intervention with all groups at a single facility may also overcome the potential for dissatisfaction through a desire to participate in an alternative intervention, but may introduce facility bias.

Conclusion

The findings of the current study have important implications for LTC facilities and their residents. Significant improvements in residents’ physical and mental QoL have been achieved with all relatively short-term, group-based interventions, with these improvements persisted for at least 5 weeks post-intervention. Group Art Therapy also significantly reduced
depression and anxiety in residents, while Art-as-Therapy showed a trend in reducing anxiety that continued post-intervention, such that it was significant reduced at the 5 week follow-up point. No significant decreases in depression or anxiety were found for Support Therapy participants. Therefore, Art Therapy seems to provide the greatest benefits to participants, followed by Art-as-Therapy, while Support Therapy may require a longer intervention period.
References


Thyme, K. E., Sundin, E. C., Wiberg, B., Öster, I., Åström, S., & Lindh, J. (2009). Individual brief art therapy can be helpful for women with breast cancer: a randomized controlled clinical study. *Palliative and Supportive Care, 7*(01), 87-95. doi:0.1017/S147895150900011X


Van Malderen, L., Mets, T., & Gorus, E. (2013). Interventions to enhance the quality of life of older people in residential long-term care: A systematic review. *Ageing research reviews, 12*(1), 141-150. doi: 10.1016/j.arr.2012.03.007

Appendix A

Improving Quality of Life for People in Aged Care Facilities

Participant Information Sheet

Before you decide whether or not you wish to participate in this research study, it is important that you understand why the information is being collected and what it will involve. Please read the following information carefully and don’t hesitate to contact me if you have any questions.

Invitation

I would like to invite you to participate in a study regarding the relative value of various therapies as a way to assist people living in an aged care facility, both mentally and emotionally.

This research aims to investigate how effective five weeks of small group intervention is at helping reduce stress and improve quality of life. I am an honours student in psychology at the University of New England (UNE) and am conducting this study for my honours thesis, with Dr Bruce Stevenson supervising this research.

Participants who cannot take part in the study are those with a cognitive or intellectual impairment, or a mental illness.

Time Requirements?

Participation in this study will take up to two-hours per week (most likely only 1-1½ hours) for five weeks. You will also be asked to do a questionnaire five weeks after the last session which should take no more than 20 minutes to complete.

What will you be asked to do?

You are invited to attend five weekly group sessions, which will consist of yourself and up to five other residents. Each session will run for up to two hours and will be facilitated by myself (Ms Khaalyd Brown). You will also be asked to provide some basic information about yourself (age, gender, current medical treatment, etc). At the beginning of the first session, the end of the last session and five weeks after the last session you will also be asked to complete a short questionnaire that asks you to rate your feelings over the past week.

What happens with your information?

Your participation will be entirely anonymous. Your name will not be recorded, except on a consent form. There will be no identifying details attached to the data collected, except for a participant number to allow the results of the three questionnaires to be linked to each other, but not linked to any person in particular. Information will be stored as a computer file on a...
password protected account which only myself can access and consent forms will be stored in a locked filing cabinet at the University and will be destroyed after the research is finished. No individual will be identified by name in any publication of the results.

What if you don’t want to participate or change your mind later?
Participation is entirely voluntary. If you decide to participate, that is great, but you are free to withdraw your consent from the project and discontinue at any time without having to give a reason and without consequence. If you withdraw from the study all information collected from you will be destroyed immediately.

Are there any risks?
It is possible during the intervention sessions that some personal or upsetting issues may arise but if this occurs these will be discussed within the session and hopefully resolved. If any concerns arise that are not resolved and you would like to talk through with a counsellor, you could contact Lifeline Telephone Counselling anytime (13 11 14); which is a free and confidential services Australia wide.

What is the research process?
It is anticipated that this research will be completed by the end of February 2014. The results may also be presented at conferences or written up in journals without any identifying information. If you participate and would like a copy of the research results these can be sent to you when the research is completed.

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No. HE14-137, Valid to 28 May 2015).

Further information
If you have any questions or concerns regarding the study, I can be contacted by email at kmaryott@myune.edu.au or by phone on 0424 180 999. My supervisor Dr Bruce Stevenson can also be contacted on 02 6773 2565 or bstevens@une.edu.au.

Who should you contact if you have complaints about the research?
Should you have any complaints concerning the manner in which this research is conducted, please contact the Research Ethics Officer at the following address:

Research Services
University of New England
Armidale, NSW 2351.
Telephone: (02) 6773 3449
Facsimile (02) 6773 3543
Email: ethics@une.edu.au

Thank you for your time and consideration
Improving Quality of Life for People in Aged Care Facilities

I ________________________________, have read the information contained in the Information for Participants sheet, and any questions I have asked have been answered to my satisfaction. Yes / No

I agree to participate in this research study, realising that I may withdraw from the study at any time. Yes / No

I agree that research data gathered in the study may be published, providing my name is not used. Yes / No

I agree that discussions undertaken during the sessions are private and will not repeat anything discussed by another participant outside of the sessions Yes / No

I would like to receive a copy of my results Yes / No

I am older than 18 years of age Yes / No

Participant Signature__________________________ Date______________

Researcher Signature__________________________ Date______________
Demographic/Medical/SUDS Questions

No names are being collected on these forms so a reference code needs to be given so that data collected at the beginning and end can be matched together. The reference code will consist of 8 numbers and letters.

The first two letters will be the first two letters of your mother’s maiden name. For example if her maiden name was Smith then the first two letters are SM. The next two are numbers and are the last two digits of the year you were born in, for example if you were born in 1924 the numbers would be 24. The next two are letters and are the last two letters of your first name. For example if your name is Mavis the next two letters would be IS. The final two digits are the day you were born, for example if you were born on the 9th the last two digits would be 09.

Example:

Mother’s Maiden Name: Smith
Date of Birth 09-05-1924
Your Name Mavis

The Reference Code would be: SM24IS09

Your Reference Code Is: __________________

Below are a number of demographic and medical questions that will assist with the research study. Please provide information where you can.

1) What is your age? __________________

2) What is your gender? Male / Female

3) How long have you been living at this facility? __________________

4) Do you have any major medical conditions? __________________

5) Have you ever been diagnosed with anxiety or depression? Yes / No

6) On a scale of 1 to 10 (where 1 is the best you can feel and 10 is the worst) how, in general have you felt over the past week? _______
**DASS**

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

*The rating scale is as follows:*

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I found it hard to wind down</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>I was aware of dryness of my mouth</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>I couldn’t seem to experience any positive feeling at all</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>I experienced breathing difficulty <em>(eg, excessively rapid breathing, breathlessness in the absence of physical exertion)</em></td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>I found it difficult to work up the initiative to do things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>I tended to over-react to situations</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>I experienced trembling <em>(eg, in the hands)</em></td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>I felt that I was using a lot of nervous energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>I was worried about situations in which I might panic and make a fool of myself</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>10</td>
<td>I felt that I had nothing to look forward to</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11</td>
<td>I found myself getting agitated</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>12</td>
<td>I found it difficult to relax</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>13</td>
<td>I felt down-hearted and blue</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>14</td>
<td>I was intolerant of anything that kept me from getting on with what I was doing</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>15</td>
<td>I felt I was close to panic</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>16</td>
<td>I was unable to become enthusiastic about anything</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>17</td>
<td>I felt I wasn’t worth much as a person</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>18</td>
<td>I felt that I was rather touchy</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>19</td>
<td>I was aware of the action of my heart in the absence of physical exertion <em>(eg, sense of heart rate increase, heart missing a beat)</em></td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>20</td>
<td>I felt scared without any good reason</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>21</td>
<td>I felt that life was meaningless</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
CRS – SF Questionnaire

On the following pages, each characteristic is followed by a seven-point scale that ranges from "not very" to "very". Please mark an "X" at the point on the scale that best represents how you viewed the therapist. For example:

FUNNY
not very ______:_____:_____:_____:_____:_____:_____:_____: very

WELL DRESSED
not very ______:_____:_____:_____:_____:_____:_____:_____: very

These ratings might show that the therapist did not joke around much, but was dressed well.

Though all of the following characteristics we ask you to rate are desirable, therapists may differ in their strengths. We are interested in knowing how you view these differences.

FRIENDLY
not very ______:_____:_____:_____:_____:_____:_____:_____: very

EXPERIENCED
not very ______:_____:_____:_____:_____:_____:_____:_____: very

HONEST
not very ______:_____:_____:_____:_____:_____:_____:_____: very

LIKABLE
not very ______:_____:_____:_____:_____:_____:_____:_____: very

EXPERT
not very ______:_____:_____:_____:_____:_____:_____:_____: very

RELIABLE
not very ______:_____:_____:_____:_____:_____:_____:_____: very
SOCIABLE

not very ______:_______:______:________:________:______ very

PREPARED

not very ______:_______:______:________:________:______ very

SINCERE

not very ______:_______:______:________:________:______ very

WARM

not very ______:_______:______:________:________:______ very

SKILLFUL

not very ______:_______:______:________:________:______ very

TRUSTWORTHY

not very ______:_______:______:________:________:______ very