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Article original

Art therapy for elderly women diagnosed with Alzheimers: A positive person-centred approach increases ease in the care process

L'art-thérapie pour des femmes âgées atteintes de la maladie d'Alzheimer : l'approche centrée sur la personne facilite le processus de soins

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Résumé

Les personnes diagnostiquées avec des maladies neurodégénératives d'Alzheimer peuvent utiliser une activité de soutien non pharmacologique dans les soins de santé pour augmenter leur estime de soi et diminuer ainsi leur anxiété. En France, l'art-thérapie moderne a été développée à cet effet comme une intervention de stimulation sensorielle amenant des

sensations agréables et de plaisir. Cette thérapie demande de la part de ces patients une relation de confiance avec le thérapeute afin de mieux s'engager dans l'activité. Cette étude de cas est une tentative pour examiner l'importance de la confiance interpersonnelle intégrée dans la relation thérapeutique. Basé sur l'approche centrée sur la personne développée par Carl Rogers, le présent article vise à explorer comment le comportement empathique du thérapeute peut aider le patient à développer sa confiance en soi à partir de sa propre confiance en ce thérapeute afin de mieux s'engager dans l'activité. Une grille d'observation a été établie en utilisant un modèle de l'estime de soi basé sur l'amour de soi, la confiance en soi, l'affirmation de soi et la confiance en l'autre. Les observations ont montré que cette dernière représentait environ 40 % de la variabilité du modèle. Ainsi, une approche empathique peut considérablement aider le patient à développer sa confiance en soi. Cette confiance en le thérapeute, considérée comme essentielle dans le contexte de cette étude, réactive la confiance en soi du patient ce qui provoque son engagement physique dans la pratique, engagement considéré comme une clé de l'activité art-thérapeutique.

Mots-clés : Art thérapie ; Confiance ; Estime de soi ; Maladie d'Alzheimer ; Psychothérapie ; Relation interpersonnelle

Abstract

This descriptive study aimed to increase knowledge of the influence of trust that Alzheimer's patients place in the practitioner in art therapy through the care process. Persons diagnosed with Alzheimer's neurodegenerative diseases may use a non-pharmacological supportive activity in healthcare to increase self-esteem and decrease anxiety. French modern art therapy has been developed for this purpose as a sensory stimulation intervention giving an increase in feeling pleasurable sensations. This therapy requires from such patients a trust-based relationship with the therapist in order to better commit to the activity. This case study is an attempt to examine the importance of interpersonal trust built into the therapeutic relationship. Based on the person-centred approach developed by Carl Rogers, the aim of this paper is to explore how the empathic-based therapist's behaviour can help the patient to develop self-confidence from trust he placed in this therapist in order to better commit to the activity. An observational grid established from a model using love of self, self-confidence, assertiveness and trust. Field observations showed that trust represented about 40% of the variability in the

self-esteem model. An empathic-based approach can considerably help the patient to develop trust. Thus, built trust between severe-stage Alzheimer's patients and the art therapist is regarded as essential in the context of this study. Trust reactivates self-confidence, which provokes a physical engagement in the art making, engagement regarded as key for art-therapeutic activity because the art making ultimately will lead to a decrease in anxiety. This is particularly noticeable at the beginning of the process at least during the first sessions (five in average in this study for elderly women diagnosed with Alzheimers) when the built interpersonal trust strengthens the therapeutic relationship. For the art therapists working with Alzheimer's disease people, this study recommends first increasing the empathic approach of practitioners to help the patient to develop trust. It also suggests better efficiency in the healthcare process when using a person-centred approach such as that established by Carl Rogers. The Rogers approach, as well as his dynamics of change theory, can apply to severe-stage neurodegenerative disease people and help the reactivation of patients' self-confidence. Such an approach is recommended at the beginning of the care process, and then must be released when the patients express assertiveness. Empathy as well as absence of judgment facilitate aesthetic expression and creativity.

Key-words: Alzheimer's disease; Art therapy; Interpersonal relationship; Self esteem; Psychotherapy; Trust

1. Background and Objectives

Art via art-therapeutic processes can give to people an empowering healing process that makes meaning making easier and positive arts interventions promote psychological well-being [15]. Art and aesthetics, by stimulating creativity and embodiment, also re-educate people and facilitate social connections [8, 21, 30, 51]. Neurodegenerative diseases provoke stress and distress, and a multisensory stimulation such as art therapy has a significant effect on the resulting anxiety and quality of life [21, 32, 52]. In France, increasing numbers of suffering persons have used a non-pharmacological supportive aesthetic-based activity in healthcare called modern art therapy, which refers to beauty. It has been defined by its founder Richard Forestier as “*the exploitation of the artistic potential of an individual in a*

humane and therapeutic goal” [24]. This therapy, aesthetics oriented, emphasizes the physical engagement in the art making to steer patients through her/his self-realization to ultimately recover her/his self-esteem [24, 45]. As such, people diagnosed with neurodegenerative diseases such as Alzheimers can improve their self-esteem and well-being by using creative activities, which produce pleasure and reduce anxiety [8, 28, 30, 39, 60]. This is likely because neurodegenerative diseases have a lower adverse impact on the human affect than cognitive faculties and such affected people remain sensitive to subjective art-based creative experiences [4, 14, 21, 30, 33, 61]. To date, self-esteem-oriented art-therapy has shown an increase in global self-worth [10, 11, 13, 26, 39].

The therapist’s attitudes and behaviours as well as the relationship, are regarded as key in cognitive behavioural therapies [41, 43]. The art therapy’s effectiveness can be mainly therapist-based with regard to the used approach [9], and the therapist’s variability in the alliance can be seen to be more important than the patient’s variability for improved patient outcomes [17]. Also, in psychotherapy, the accounted variance of the therapist was seen to be eight times more than the variance of the patient in treatment [41]. Overall, quantified common factors, which include the patient-therapist relationship, account for 30% of the variance in patient outcomes [42]. Personal attributes of the therapist, such as confidence and trust within the therapeutic frame, are regarded as essential to the therapeutic success [1] and a built and reliable physician-patient working alliance requires affective dimensions such as trust [31, 35]. This is because the therapeutic bond comes first through building mutual trust [4, 7]. An authentic partnership approach including trust is more and more required in dementia care [20, 54] and it can be expected that trusting the therapist will allow a decrease in anxiety and distress, the patient acquiring a certain emotional availability.

The quality of the relationship can be a central element in the care when the session occurs in a non-judgmental atmosphere [13, 27]. Non-judgmental absorption in what is being observed by the therapist requires empathy that enhances the therapeutic alliance [1, 25, 31] and empathy can be regarded as key for cognitive-behavioural therapies [18, 22]. Regularly, studies have demonstrated that patient-perceived empathy has increased patient trust [2, 16, 18, 31, 44]. An empathic behaviour is part of the person-centred approach established by Carl Rogers in 1961 [58]. A goal of such approach is to assist patients in becoming more autonomous and confident and the purpose of the therapist is to create a growth-promoting atmosphere to solve problems by being an empathic and attuned therapist [9, 50]. In this context, this case study aimed to address the influence of the developed interpersonal trust during modern art therapeutic-based sessions for elderly women affected by Alzheimers. Is

trust a lever acting at the beginning of the relationship and therefore can manage the therapeutic process? Modern art-therapy primarily focuses on the care effect of art on self-esteem, aesthetics-wise. How a positive and empathic (Roger's) approach can facilitate this process and can reinforce interpersonal trust for elderlies?

2. Patients & Method

2.1. Patients inclusion criteria and ethical approval

A partnership was established with a University Hospital in Burgundy, France, which manages a nursing home unit specifically dedicated to severe-stage Alzheimer's patients. This long-term geriatric area can receive 39 residents divided into three 13-bedded secured care units. The sexual gender was the first factor of inclusion (a sole man). The geometric mean of the age of the women was 86 years, with a variation from 69 to 98 years. The average duration of institutionalization was found to be 23 months, with a variation ranging from 1 to 70. The measured Mini Mental State Examination tests (MMSE's, [23]) quoted by the physicians of the units ranged from 1 to 15. Nine women were excluded because of temporary absence from the units, hospitalization (deteriorated health status) or not being able to attend a session (e.g. continuous ambulation). From the twenty-nine listed women left, twelve participants were randomly assigned. The draw identified five residents for the first unit, three residents for the second one and four for the last one. Ethical approval prior to the implementation of the study was obtained from the carers, mainly the families. The signed forms were stored in the files of the patients and were available on request. All the data were anonymised after recording.

2.2. Research model

“Patient's trust in a practitioner” was defined as a new component and added into the tripartite model that Bernhard & Millot established to define self-esteem [5]. This model used in modern art-therapy has been defined as the sum of three components, namely, love of self, self-confidence and assertiveness. The new model can be expressed as follows: [self-esteem] = [love of self] + [trust + self-confidence] + [assertiveness].

The model was stated as such: 1) The therapist establishes a confidence-based relationship by developing the patient's trust, which is initiated and reinforced with the help of an empathic person-centred approach; 2) Trust connects the patient with the therapist and then with her/himself. This mirrored confidence reactivates his/her self-confidence; 3) Self-confidence makes the patient want to commit to the activity.

2.3.Settings, protocol and therapeutic strategy

The duration of the study was set for four months. Weekly sessions were planned. One-to-one contact was preferred due to the high levels of anxiety [64]. The first session was regarded as an opening session and resulted in a discussion. It was also an attempt to complete the anamnesis often partially described in the medical file. The therapeutic strategy was first mimesis oriented during the starting sessions in order to connect any aesthetic intention. After asking the patient "What would you me to draw for your pleasure, what could I draw that could make you happy?", the art-therapist started to draw or paint and engaged the discussion in the same time to build interpersonal trust. A special focus was put on the emotional enhancement of memory by using souvenirs linked to family members or great personal details of their past life. The patients were also verbally and progressively led to develop their visual creativity by soliciting their imagination with the help of personal details of their lives and the use of preferred colours as preferences, because colours were observed as stable, despite the disease [51, 65] and were preferably seen to contribute to the sensual aspects of art-making amongst older women [56].

2.4.Methods of analysis

An observational grid was adequately established to fit with the model. Nine behavioural items were identified per component (36 items per person and per session independently quantified using a 5-point Likert scale; see appendixes 1 and 2). The scores were quoted by the therapist from his field observations just after the session. Note that when an item was not observed during the session, it was not rated (previous calculations showed that an added default score set at "3" to complete the matrix can significantly reduce the experimental variability). Such raw quoted data were used for the variability study and data were averaged per component and per session to calculate and monitor the self-esteem progression (Fig. 1).

2.5. Statistical Analysis

All statistics were calculated with a 95% confidence level in probability (Minitab PC 16 version). A p-value above 0.05 was regarded as not significant. No shift over time of the data was observed (time series analysis). The random distribution of the residuals was also checked for each calculation (homoscedasticity). The behavioural mode was coded as a dichotomous variable, active when the patient actively participated versus contemplative when the patient remained to observe the therapist acting. A Shapiro-Wilk test showed a normal distribution for the quoted items during the sessions for the 12 people when the item was quoted (n = 3289). Consequently, parametric statistics were used with no transformation. Multivariate General Linear Model ANOVA and correlation/regression tools were used. A minimum limit of 0.15 was established for the Pearson coefficient to consider the variables and 0.25 to quantify its response (R^2 regression value). The 36-item grid had a satisfactory degree of internal consistency. Cronbach's α was found to be 0.65, considering the four components of self-esteem (n = 646) and 0.70 without assertiveness (n = 579, assertiveness having the lowest number of calculated correlations).

3. Results

Between four and eight sessions (five on average) were required for a patient to become active. The bodily commitment was remarkable and observable via a positive gap of some quoted items. The clinical variability of the main field variables on self-esteem was studied via ANOVA (n = 3289, see Table 1).

Clinical variables	Expressed variability	F-value	p-value
Contemplative vs active mode	23%	996	< 0.001
Number of sessions	22%	91	< 0.001
Within person variability	15%	54	< 0.001
Age of the person	15%	58	< 0.001
Duration of institutionalization	15%	59	< 0.001
MMSE of the person	11%	50	< 0.001
Living unit	5%	81	< 0.001
Morning vs afternoon session	< 2%	10	< 0.001

Table 1 - Expressed variability of the influence of the main clinical variables

Overall, the expressed variability is slightly above 100% due to a residual collinearity. The two most influential identified factors were the mode and the number of sessions. As previously described, action is key (F-value of 996). The living unit factor had a noticeable impact, as it was the third pertinent factor (F-value of 81). This influence was confirmed by the staff because a patient is preferably placed following her/his dependency. Patient-related variables were seen to have a similar influence. Morning versus afternoon session had no influence. MMSE was found to slightly correlate with self-esteem ($r = 0.25$, $p < 0.001$) and, which is consistent, more significantly with the age of the person ($r = 0.51$, $p < 0.001$). The experimental variability of the physical activity (making), which occurred when switching from the contemplative to the active mode was expressed with regard to the components of self-esteem via ANOVA. The idea was to bond self-esteem and the action, which is the core of the care in art therapy. The results are summed up in Table 2 (n = 578 out of 963 dues to incomplete data).

Components of self-esteem	Calculated variability	F-value	p-value
Love of self	17%	111	< 0.001
Trust	37%	330	< 0.001
Self-confidence	21%	156	< 0.001
Assertiveness	21%	153	< 0.001

Table 2 - Influence of the components of self-esteem on the making.

96% of variability was explained by the model. Trust was expressed as the most influential component on the intention to act (F-value of 330). The first part of the research model was verified: patient trust is first required and is facilitated by a person-centred approach set up by the therapist. With the help of rounded values of the calculated variability in table 2, self-esteem was represented by the following equation:

$$[\text{self-esteem}] = 0.2[\text{love of self}] + 0.4[\text{trust}] + 0.2[\text{self-confidence}] + 0.2[\text{assertiveness}]$$

By the help of this equation, self-esteem was calculated from the Likert scale data and an overall tendency of self-esteem was depicted for the whole population (see Figure 1). A coefficient of 0.96 was determined, meaning a robust first-order regression. The equation ($y = 0.2x + 2$) showed that the initial self-esteem mean value doubled at the end of the four-month follow-up. The coefficient of proportionality of 0.20 expressed an overall gain of one point every five sessions. According to this model, correlations were calculated between the components of self-esteem (time analysis). Overall, correlations increased with time (see Table 3). The first significant correlation that manifested from Session 3 was love of self

versus trust ($r = 0.18$, $p = 0.012$), followed by trust versus self-confidence from Session 4 ($r = 0.16$, $p = 0.006$). Again, trust was regarded as the first lever, acting whatever the mode was. The correlations progressively reinforced over the course of the sessions, following the order of the model. The correlations involving trust and self-confidence were found to be significantly stronger in the active mode (e.g., see the cases from Session 6). This verified parts 2 and 3 of the research model: trust reactivated self-confidence, which manages the physical engagement. From Session 8, the correlation between self-confidence and assertiveness became positive for active people only ($r = 0.27$, $p < 0.001$). Overall, there were no observed positive correlations related to assertiveness when there was no action, since assertiveness requires self-assessed productions.

Number of sessions	n	Pearson coefficients (and p-values) obtained between		
		Love of self and trust	Trust and self-confidence	Self-confidence and assertiveness
Whole population (12 patients)				
3	324	0.18 (0.012)	0.02 (0.72)	0.01 (0.78)
4	432	0.27 (<0.001)	0.16 (0.006)	-0.01 (0.91)
5	540	0.30 (<0.001)	0.21 (<0.001)	-0.01 (0.87)
6	648	0.37 (<0.001)	0.30 (<0.001)	0.06 (0.23)
8	810	0.40 (<0.001)	0.36 (<0.001)	0.11 (0.060)
11	963	0.44 (<0.001)	0.45 (<0.001)	0.20 (<0.001)
Population in contemplative mode (4 patients)				
6	216	0.36 (< 0.001)	0.16 (0.05)	- 0.24 (0.004)
8	279	0.34 (< 0.001)	0.16 (0.03)	- 0.25 (0.001)
Population in active mode (8 patients)				
6	432	0.36 (< 0.001)	0.32 (< 0.001)	0.18 (0.01)
8	540	0.40 (< 0.001)	0.40 (< 0.001)	0.27 (< 0.001)
Population in active mode (11 patients)				
11	918	0.44 (< 0.001)	0.46 (< 0.001)	0.21 (< 0.001)

Table 3 – Calculated correlations illustrating the connections over time between the self-esteem components

Linear regressions were also calculated to correlate the components of self-esteem and trust, which was regarded as the marker of the person-centred approach. The calculations only used data collected during the active mode, and MMSE and the number of sessions were also added as the only influent continuous field variables (see equations, $n = 675, 744$ and 697 respectively). Interestingly, when trust was considered in a calculation, the three other components became non-relevant and were excluded.

$$\text{Love of self} = 2.1 + 0.18 \text{ Trust} + 0.09 [\text{number of sessions}] + 0.02 \text{ MMSE}$$

$$\text{Self-confidence} = 2.1 + 0.15 \text{ Trust} + 0.07 [\text{number of sessions}] + 0.03 \text{ MMSE}$$

$$\text{Assertiveness} = 2.7 - 0.14 \text{ Trust} + 0.12 [\text{number of sessions}] + 0.04 \text{ MMSE}$$

Interestingly, the factor quantifying trust was found negative for assertiveness. The number of sessions required for a patient to reach satisfactory values mirroring the field results for each component was calculated (the value was set up at 4, which can be seen as a satisfactory level of self-esteem) either with a person-centred approach (using the maximum value for a patient's trust, i.e., 5) or without (no established patient's trust, i.e., 0). Table 4 summarizes the results obtained within the encountered MMSE value range (from 1 to 15).

Number of sessions required to obtain (from equations 2 to 4)	Non-person-centred approach (trust factor = 0)		Person-centred approach (trust factor = 5)	
	MMSE = 1	MMSE = 15	MMSE = 1	MMSE = 15
Love of self = 4	21	17	11	7
Self-confidence = 4	26	21	16	10
Assertiveness = 4	11	6	16	11

Table 4 - Influence of a person-centred approach on the number of sessions for given values of the components of self-esteem

A helpful person-centred approach significantly reduces the number of sessions for a targeted level of self-esteem. On the other hand, such an approach adversely impacts assertiveness during the course of the sessions. The MMSE impact is similar whatever the approach is (average gap of five sessions).

4. Discussion

4.1. Empathy, absence of judgment and congruence

The present results reinforced previous outcomes regarding the impact of trust in the therapeutic relationship, which can be facilitated by a patient-centred approach. Such

approach was effective for people with dementia [12, 38, 46, 67]. Rogers' dynamics of change theory can be applied for people with neurodegenerative diseases having support with art-therapeutic activities. The tripartite model presented in this study could be compared with what Rogers called "the dynamics of change" ([58] pp 63-64):

1) In the present study, patient trust was first initiated and reinforced in an empathic person-centred approach (part 1 of the present research model). For Rogers, as the patient found someone else listening acceptantly to his feelings, he little by little became able to listen to himself and more acceptant of himself. The concept of trust focuses more on trusting the potential within the individual even before it manifests in his/her outward behaviour [57, 59].

2) The felt trust connected the person with him/herself, and this mirrored confidence reactivated his/her self-confidence (part 2 of the model). Rogers declared that as the patient found the therapist showing a consistent and unconditional positive regard for him and his feelings, slowly he moved towards taking the same attitude towards himself and was therefore ready to move forward in "the process of becoming".

3) Self-confidence made the patient active (part 3 of the model). Rogers concluded that as the patient finally listened more accurately to the feelings within, he also moved toward greater congruence. He found it possible to move out from behind the façades he had used. He found that he was at last free to change and to grow.

Rogers recommended an "unconditional positive regard" through his facilitative attitudes, meaning a kind of congruent and non-judgmental attitude. When a therapist via her/his congruent attitude takes the initiative to signal his/her desire to be trusted, a significantly higher level of trust can be observed in the relationship to respond [63]. There were opportunities during this survey for the therapist to signal his desire to take care of the patient during the contemplative stage. Similarly, the absence of even the slightest trace of judgment lets the patient's trust and his/her trust in the process develop. Immigrant students performing art therapy-based activities had a similar feeling. They remarked that when they earned respect from their peers, they were more likely to obtain self-esteem; they suggested that self-esteem firmly depends on the way peers see you [11]. The empathic behaviour of the therapist can be regarded as a mirror that reflects the patient's trust and transforms it into self-confidence: "*The therapist directs the looking; without the therapist, you might stick with what you were already thinking and a lot more can come out with the therapist's direction*" [13, Patricia's narratives p 136]. However, the centred approach adversely impacts assertiveness in long-term relationships and the present model may be assessed more accurately in the early stages of therapy, when patients' trust in their therapist develops [53].

In the present case, the therapist must pay attention to their behaviour at least from Session 6, especially for the patients having the highest MMSE values (see Table 4).

4.2. Five sessions to commit

Building trust occurs only when the patient realizes that the therapist is on her/his side (no need for supervision) and she/he can accept what interesting experience can come out of it [55]. The patient at this time can usually accept what the therapist suggests, even if the suggestion is not necessarily appealing at first. Thus, with the therapeutic bond elaboration coming first in trust/safety conditions, the patient can take her/his eyes off the therapist and think about her/his well-being [4]. Thus, the period of contemplation can be regarded as a “builder of trust”. A productive collaboration is not necessarily a natural or spontaneous process. It requires a series of efforts for both patient and therapist, meaning several sessions [4]. In average, five sessions were required here to build an identifiable trust-based relationship. This number follows certain reproducibility. Some authors have described the first critical alliance phase as being the initial development of trust, which usually takes place within the first five sessions [34]. Also, in a non-directive teaching experience, Rogers set unstructured courses without informing the class about it, just answering questions and waiting for student initiatives ([58] pp 299-304). By the fifth session, students spoke to one another and the self-conscious group became an interacting group. It took the class four sessions to realize that they were wrong and that they were very likely to develop mutual trust and self-confidence. Similarly, Rogers reported the case study of Mrs. Oak in a storyline regarding the experiencing of the potential self. From an early part of the fifth interview, verbal material emerged that described her awareness of experience, which was previously discussed ([58] p 77).

4.3. Risk versus trust

Mutual trust implies a mutually perceived promotive interdependence, i.e., a cooperative expectation from the one who trusts and a cooperative intention from the trusted one [47]. Such, an open and non-judgmental collaboration, which enhances mutual trust, can involve the patient and the therapist encountering one another through taking risks [4]. Berdondini referred to the notion of bond established by Bordin as part of the therapeutic alliance in

which, the patient-centred therapy tends to mute the responsibilities of the therapist and highlight those of the patient [7]. In any case, the patient takes some risks of sharing her/his experience and in developing a collaborative experience. Risk is crucial to the operation of trust. To trust is to let another think about and take action to protect and advance something that the “truster” cares about [3]. Deutsch also defined the translation of the expectations of the trusting person into behaviour under risk [19]. The development of trust aims to reduce uncertainty and consequently the feeling of risk. Luhmann precisely defined in German the word “vertrauen” for trust to mirror English, which dissociates the notion of confidence [48]. He also translated self-confidence as “insured confidence” and trust as “decided confidence” [49]. Decided confidence presupposes a risky situation that one thinks to avoid by deciding to rely on others (developed trust, part 1 of the proposed model), whereas insured confidence corresponds to the feeling of assurance in a situation where one would not imagine that the events are otherwise as expected (developed self-confidence, part 2 of the model). Certainly, in an affective context of trust, severe neurodegenerative disease patients are able to decide to take risks. This behaviour was verbally expressed by several patients at the Dijon University Hospital as an actual fear: “*What do you make me do?*” They continued to do such tasks anyway.

4.4.From trust to self-confidence

Carl Rogers's philosophy is based on a trust in an inherent impulse toward growth in every individual [59]. Proposed theories of trust concern the question of whether trust is a belief, an expectation, an attitude or an emotion; theoreticians have proposed cognitive, will-based or affective accounts of trust [3, 36, 37, 62]. Baier proposed a will-based account of trust involving the competences and the goodwill of the trustee [3]. However, like Jones, the present results reinforce affective accounts of trust, depicting it as a behaviour and emotion. It is likely that people diagnosed with severe-stage neurodegenerative diseases preferably rely on trust and self-confidence via their affect and later via their connotation in order to switch to the active mode. Self-confidence involves an affective attitude in addition to one's competence [37]. For Jones there is a parallel between trust and self-confidence. She distinguishes “be self-confident” and “trust yourself” because of an important difference between the two: willingness. With self-confidence, people are only worried about their capacities rather than their will. On the other hand, will is part of trust and one needs to trust

oneself - for instance, when one is worried about the possibility of self-sabotage [37]. During the opening session, some patients already expressed their willingness to actively collaborate, meaning they were in the “trust yourself” concept but not yet in the “be self-confident” one. This way to encompass trust can be seen as an optimistic attitude to oneself. In the standard case, the confident expectation that the one trusted will respond directly and favourably to the thought that the “truster” is counting on them is itself grounded in the attitude of optimism. Trust is optimism about the goodwill and competence of another, the way optimism leads people to anticipate a favourable outcome. This attitude of optimism makes the difference between trust and reliance [37]. Overall, women of the University Hospital of Dijon diagnosed with neurodegenerative diseases made an optimistic choice in according trust.

4.5. Aesthetics and affect

Shared visual aesthetic experience within the art therapy relationship makes the patients become able to express and communicate aesthetic pleasure resulting from the activity [8]. By making artistic choices that fitted with the environment of the patients, the therapist also expected to reactivate their imaginary world. The present observed behaviour showed that it was sometimes not possible to dissociate the artistic aspects from the relational ones confirming the previous Byers’s hypothesis that aesthetics can bring a point of resonance into the therapeutic relationship [8]. Motivated by the established interpersonal trust, most of the patients verbally expressed their will to share their feelings of sympathy with the therapist and what they aesthetically felt. Interestingly, when in 1873 the German philosopher Robert Vischer introduced the term of empathy (“Einfühlung”), it was to express the “aesthetic sympathy” he felt when he was presented with art [66]. Aesthetics is not only technical knowledge. Such intimacy is seen in the helping relationship, when the art therapist and the patient are engaged in a creative activity such as art therapy. Intimacy in a therapeutic context depends primarily on trust and may involve empathy and sympathy [40]. This intimacy is seen to make the link with the increase of positive feelings when a pleasant situation is shared, because the sharing amplifies the intensity of the experience [6]. Modern art therapy encourages this sharing for educational purposes (assertiveness) and results have suggested that more and less trained therapists can be equally liked and trusted [34]. The present study also focused the patient and therapist experiential collaboration on emotion-focused therapy, which offered a mutual involvement of equals and required the patient’s agreement and

commitment, and her coaching and even teaching [4]. Felt and expressed positive emotions engage in active imagination and healing [15, 59]. For patients affected by neurodegenerative disease, affect-based trust is preponderant. This is likely why the determined impact of the centred-person approach was found to be significantly higher than the MMSE impact (see Table 4).

4.6.Limits of the study

The main limitations of this observational case study are : 1) the limited size of the observed group (12 patients with 15% of non-quoted items, which led to 563 blanks out of 3852 data); 2) the absence of control groups either without any neurodegenerative disease (MMSE of 37) or encountering a non-empathic approach; and 3) the quotations conducted by the therapist himself in charge of the sessions. This methodological bias was characterized by the observed normal distribution of the data that confirms there was a sole field factor influencing the observations. Additional field determinants would have led to a skewed distribution (exponential influence). It can be supposed that this unidimensional model is due to the way the therapist quoted the observations. This is likely why there was some consistency with studies in which the therapist's trust was regarded as unidimensional from the patients' perspectives and a unidimensional conceptual model was found more representative and confirmed by the fact that global items were preferred and account for the largest category [29]. Anyway, a further generalisation of the 36-item grid could be done via the establishment of its inter-rater reliability (Kappa coefficient of concordance), obtained, for instance, from two trained observers rating the same individuals [39]. This would quantify the bias due to the subjective part of the therapist's quotation.

5. Conclusions

Severe-stage Alzheimer's patients require specific interpersonal styles when they face a practitioner in art therapy. A trust-based relationship established by the therapist can be a gateway to reactivate their self-confidence and accelerate a physical engagement essential to the art-therapeutic activity. Illustrated by the model proposed in the present study, trust can be an initial lever acting at the beginning of the relationship, and therefore manages the therapeutic process, which ultimately will lead to a decrease in anxiety. Carl Rogers' person-

centred approach appeared to be suitable for this purpose. Empathy was regarded as essential to reinforce the patient's trust establishment in the therapeutic relationship. The Rogers approach, as well as his dynamics of change theory, can apply to severe-stage neurodegenerative disease people and the reactivation of patients' self-confidence. Such an approach is recommended at the beginning of the care process, and then must be released when the patients express assertiveness.

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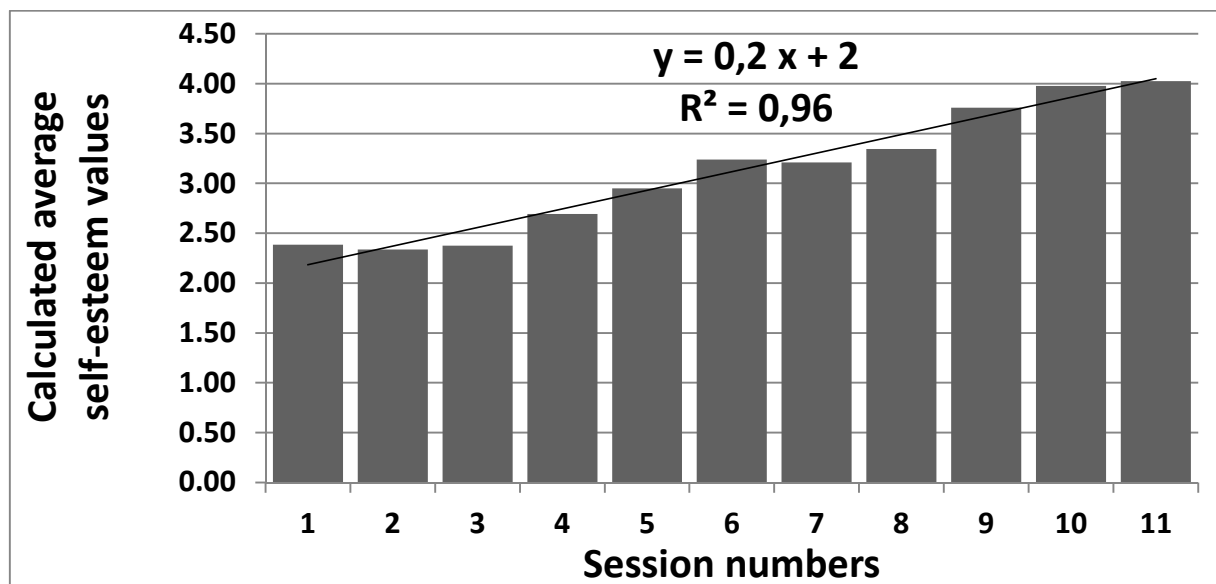


Figure 1 - Overall tendency of the self-esteem progression for the whole population

Appendix 1: the observational items used to evaluate the components of self-esteem.

Love of self

Complaints/activity	<input type="checkbox"/> none	<input type="checkbox"/> rare (1)	<input type="checkbox"/> sometimes (2-4)	<input type="checkbox"/> often (>5)	<input type="checkbox"/> permanent
Involvement in the activity	<input type="checkbox"/> voluntary	<input type="checkbox"/> active	<input type="checkbox"/> contemplative	<input type="checkbox"/> reluctant	<input type="checkbox"/> refusal
Duration of the activity	<input type="checkbox"/> 100% time	<input type="checkbox"/> > 50% time	<input type="checkbox"/> 50% time	<input type="checkbox"/> < 50% time	<input type="checkbox"/> 0% time
Attention by the gestures	<input type="checkbox"/> to slow down!	<input type="checkbox"/> continuous	<input type="checkbox"/> adapted	<input type="checkbox"/> discontinuous	<input type="checkbox"/> distraction
Thyme (mood)	<input type="checkbox"/> excellent	<input type="checkbox"/> good	<input type="checkbox"/> equal	<input type="checkbox"/> bad	<input type="checkbox"/> anxiety
Involvement in the relationship	<input type="checkbox"/> privileged	<input type="checkbox"/> voluntary	<input type="checkbox"/> in the expression	<input type="checkbox"/> listening	<input type="checkbox"/> absent
Aesthetic intention (Art I/II)	<input type="checkbox"/> 100% Art I	<input type="checkbox"/> 75% Art I	<input type="checkbox"/> 50/50 Art I & II	<input type="checkbox"/> 75% Art II	<input type="checkbox"/> 100% Art II
Care brought to the production	<input type="checkbox"/> meticulous	<input type="checkbox"/> neat	<input type="checkbox"/> correct	<input type="checkbox"/> neglected	<input type="checkbox"/> dirty
Pride related to the production	<input type="checkbox"/> admiration	<input type="checkbox"/> expressed	<input type="checkbox"/> modesty	<input type="checkbox"/> indifference	<input type="checkbox"/> spite

Trust

Somatic complaints	<input type="checkbox"/> none	<input type="checkbox"/> rare (1)	<input type="checkbox"/> sometimes (2-4)	<input type="checkbox"/> often (>5)	<input type="checkbox"/> permanent
Doubts of his/her abilities	<input type="checkbox"/> none	<input type="checkbox"/> rare (1)	<input type="checkbox"/> sometimes (2-4)	<input type="checkbox"/> often (>5)	<input type="checkbox"/> permanent
Devalues his/her production	<input type="checkbox"/> none	<input type="checkbox"/> rare (1)	<input type="checkbox"/> sometimes (2-4)	<input type="checkbox"/> often (>5)	<input type="checkbox"/> permanent
Evokes past failures	<input type="checkbox"/> none	<input type="checkbox"/> rare (1)	<input type="checkbox"/> sometimes (2-4)	<input type="checkbox"/> often (>5)	<input type="checkbox"/> permanent
Searches validation	<input type="checkbox"/> none	<input type="checkbox"/> rare (1)	<input type="checkbox"/> sometimes (2-4)	<input type="checkbox"/> often (>5)	<input type="checkbox"/> permanent
Therapist speech/credit	<input type="checkbox"/> approbation	<input type="checkbox"/> confirmation	<input type="checkbox"/> pay attention	<input type="checkbox"/> indifferent	<input type="checkbox"/> denigrate
Expresses feelings/emotions	<input type="checkbox"/> each time	<input type="checkbox"/> often	<input type="checkbox"/> on solicitations	<input type="checkbox"/> difficult	<input type="checkbox"/> never
Shows curiosity	<input type="checkbox"/> permanent	<input type="checkbox"/> regularly	<input type="checkbox"/> on solicitations	<input type="checkbox"/> ones	<input type="checkbox"/> never
Verbalizes self-confidence	<input type="checkbox"/> I know how to do	<input type="checkbox"/> I will see	<input type="checkbox"/> it is difficult but	<input type="checkbox"/> I try	<input type="checkbox"/> I don't know

Self-confidence

Verbal anxiety/activity	<input type="checkbox"/> none	<input type="checkbox"/> decreases	<input type="checkbox"/> constant	<input type="checkbox"/> increases	<input type="checkbox"/> fear
Gestural anxiety/activity	<input type="checkbox"/> none	<input type="checkbox"/> decreases	<input type="checkbox"/> constant	<input type="checkbox"/> increases	<input type="checkbox"/> fear
Attention related to the action	<input type="checkbox"/> permanent	<input type="checkbox"/> sustained	<input type="checkbox"/> relaxed	<input type="checkbox"/> weak	<input type="checkbox"/> without
Follow the instructions/rules	<input type="checkbox"/> total	<input type="checkbox"/> often (>5)	<input type="checkbox"/> a few (2-4)	<input type="checkbox"/> rare (1)	<input type="checkbox"/> none
Takes technical initiatives	<input type="checkbox"/> total	<input type="checkbox"/> often (>5)	<input type="checkbox"/> a few (2-4)	<input type="checkbox"/> rare (1)	<input type="checkbox"/> none
Use of tenses in speech	<input type="checkbox"/> 0% past	<input type="checkbox"/> 25% past	<input type="checkbox"/> 50% past	<input type="checkbox"/> 75% past	<input type="checkbox"/> 100% past

Body attitude	<input type="checkbox"/> involved	<input type="checkbox"/> calm	<input type="checkbox"/> hesitant	<input type="checkbox"/> agitated	<input type="checkbox"/> very disturbed
Accomplishment (production)	<input type="checkbox"/> fast	<input type="checkbox"/> without hesitation	<input type="checkbox"/> quiet	<input type="checkbox"/> stimulated	<input type="checkbox"/> not performed
Projection/next session	<input type="checkbox"/> Already done!	<input type="checkbox"/> I will	<input type="checkbox"/> Think again	<input type="checkbox"/> We will see	<input type="checkbox"/> I don't know

Assertiveness

Overall autonomy	<input type="checkbox"/> makes choices	<input type="checkbox"/> > instructions	<input type="checkbox"/> respects instruc.	<input type="checkbox"/> waiting for help	<input type="checkbox"/> passivity
Ability to make choices	<input type="checkbox"/> very easy	<input type="checkbox"/> easy	<input type="checkbox"/> hesitant	<input type="checkbox"/> difficult	<input type="checkbox"/> never
Expresses his/her tastes	<input type="checkbox"/> always	<input type="checkbox"/> frequently	<input type="checkbox"/> hesitations	<input type="checkbox"/> difficult	<input type="checkbox"/> never
Expresses his/her needs	<input type="checkbox"/> each time	<input type="checkbox"/> often	<input type="checkbox"/> on solicitation	<input type="checkbox"/> rarely	<input type="checkbox"/> never
Expresses his/her difficulties	<input type="checkbox"/> each time	<input type="checkbox"/> often	<input type="checkbox"/> on solicitation	<input type="checkbox"/> rarely	<input type="checkbox"/> never
Self-evaluation (production)	<input type="checkbox"/> very easy	<input type="checkbox"/> easy	<input type="checkbox"/> hesitations	<input type="checkbox"/> difficult	<input type="checkbox"/> refusal
Aesthetic pleasure	<input type="checkbox"/> delighted	<input type="checkbox"/> expressed	<input type="checkbox"/> little pleasure	<input type="checkbox"/> non expressed	<input type="checkbox"/> unpleasant
Smiles and laughs	<input type="checkbox"/> in joy	<input type="checkbox"/> often	<input type="checkbox"/> sometimes	<input type="checkbox"/> if justified	<input type="checkbox"/> never
Oral communication	<input type="checkbox"/> dialogue	<input type="checkbox"/> regular answer	<input type="checkbox"/> hesitant answer	<input type="checkbox"/> inappropriate	<input type="checkbox"/> unanswered

Appendix 2: Glossary of the items used to evaluate the four components of self-esteem.

Love of self

- Complaints about the activity: complaints that denigrate the artistic activity, art itself or denounce it all as imparting a feeling of worthlessness.
- Involvement in the activity: the personal investment the person makes in the activity (the goodwill).
- Duration of the activity: time spent by the person and related to his/her artistic intention in the sessions.
- Attention by the gestures: bodily way in which the person is involved during the artistic activity.
- Thyme (mood): thyme of the person during the session (mood on arrival not taken into account).
- Involvement in the relationship: the availability and commitment that the person places in the relationship with the therapist.
- Aesthetic intention (Art I/II): the letting go (raw art) that the person can have in his/her aesthetic intention (sophisticated art) [See note ¹].
- Care brought to the production: the care/respect that the person takes during the realization of his/her own production.
- Pride related to the production: pride physically shown (face and body) or verbally expressed.

Trust

- Somatic complaints: verbal complaints that serve as an excuse not to engage in the activity.
- Doubts of his/her abilities: verbally expressed doubt such as "I have never been good at anything".
- Devalues his/her production: argument that devalues the artistic quality of the production.
- Evokes past failures: the person relies on his/her past to justify his/her non-commitment.
- Searches validation: the person requires the validation of the therapist with regard to his/her artistic choices.
- Therapist speech/credit: the person's confidence in the arguments of the therapist.
- Expresses feelings/emotions: feelings and emotions verbalized according to the level of confidence.
- Shows curiosity: expressed curiosity that was most often verbalized during the activity (questions).
- Verbalizes his/her self-confidence: confidence expressed during the realization of the production (technical aspects most often).

Self-confidence

- Verbal anxiety about the activity: verbally expressed anxiety linked to the fear of embarking on the realization of a production.
- Gestural anxiety during the activity: evolution during the session of repetitive gestures related to anxiety (body, hands, feet, etc.)
- Attention related to the action: mental attention of the person to the activity and gesturally expressed.
- Follows the instructions/rules: how the person responds to the technical instructions.
- Takes technical initiatives: any technical choice made by the person (media choice, colours, shapes).
- Use of tenses in speech: ratio of speech only related to the past in the tenses used for the total speech.
- Body attitude: rating of the person's involvement through his/her body attitude.

¹ Modern art therapy distinguishes « Art I », an archaic and raw sensory expression only based on flavor and body use and « Art II » which requires technical skills and an aesthetic intention (see Forestier, 2009).

- Accomplishment (production): how the person realizes his/her production (quoted as “not performed” if the person stays passive and does nothing).
- Projection with regard to the next session: the way the person is projecting into the activity.

Assertiveness

- Overall autonomy: autonomy shown by the person during the session in his/her choices, most often technical.
- Ability to make choices: how the person expresses or makes his/her technical choices (rapidity, argumentation).
- Expresses his/her tastes: ability of the person to express what he/she likes.
- Expresses his/her needs: ability of the person to express his/her needs - technical needs most often.
- Expresses his/her difficulties: ability of the person to express his/her difficulties - technical difficulties most often.
- Self-evaluation of the production: ability of the person to criticize his/her production and to express his/her tastes.
- Aesthetic pleasure: how the person shows the pleasure felt during the session (attitudes and verbal).
- Smiles and laughs: smiles or laughs only related to the relationship and the activity and not to anxiety.
- Oral communication: how the person expresses his/her embarrassment in exchanging views about the artistic activity.

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