Art Therapy to Support Recovery from Substance Use Disorders

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Abstract

Would correlating the Stages of Change (SOC), Expressive Therapies Continuum (ETC), and 12-step recovery principles help a client gain insight and thus invest deeper in their Substance Use Disorder (SUD) recovery program? Research shows that for decades art therapy has been an accepted complimentary therapy to treatment center approaches for Substance Use Disorders (SUDs). This writer is specifically making a correlation between the SOC, ETC, and 12-step recovery principles forming an art therapy program model to support recovery from an SUD. This document is an exploration of literature to support the proposed art therapy program with a schedule template for integration with in-patient treatment programs.

keywords: art therapy, stages of change, expressive therapies continuum, 12-step recovery principles, substance use disorders
Acknowledgments/Dedication

I am grateful to my family, friends, professors, and staff at Adler Graduate School in their various roles assisting and encouraging me along this fruitful journey.

I dedicate this project to the future of holistic, integrated recovery programs and to individuals who are on their journey of long-term recovery.
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Art Therapy to Support Recovery from Substance Use Disorders

Individuals recovering from an SUD require a holistic transformation of mind-body-spirit. They must rediscover what is important in life, what changes in attitude and desire are needed, and what is going to replace alcohol or drugs as the center of that person’s life. An art therapy program provides an alternative format and creative outlet for expression to investigate and navigate the physical, emotional, cognitive, and spiritual health of the individual. Malchiodi (2007) said, “in making a drawing or painting, we begin the process of exploring our beliefs” (p. 21). The projective qualities of art therapy assist in revealing those beliefs. Thus, the artwork made by clients serve as a guide to somatic symptoms, give clues to mistaken beliefs, act as a container for explosive emotions, and provide a platform for spiritual awakenings. The collateral material could also be integral to treatment planning. Art therapy provides a holistic approach as individuals gain self-awareness during treatment, and as they progress in recovery. It also provides insight through metaphorical imagery in completed art works. Hass-Cohen and Carr (2008) said, “Completing the art therapy task requires the integration of higher cortical thinking, such as planning, attention, and mindful problem-solving with social-emotional investment” (p. 39). Investment and commitment are the keys to success. Feen-Calligan (1995) put it this way, “Recovery, art, and spirituality share certain qualities that lend support to the use of art as therapy in addiction treatment: Recovery, art, and spirituality all require commitment and consistent effort to know them” (p. 48). Art therapy may assist the individual with an SUD to view the entire treatment process through a more approachable lens.

The question becomes, would correlating the SOC, ETC, and 12-step recovery principles help a client gain insight and thus invest deeper in their SUD recovery program? This writer’s hypothesis is yes. In more detail, during participation in the proposed art therapy program, the
client will integrate verbal information and creative experiences from both hemispheres in the brain, in order to increase perceptual processing abilities. The result would increase a client’s self-awareness, increase behavioral changes, enhance movement through recovery principles and SOC, provide a vehicle for self-regulation, and serve as a relapse prevention method.

This document will explain variables of the proposed art therapy program to integrate with ongoing in-patient treatment programs. Terminology is identified and defined, peer-reviewed resources are employed, and a proposed schedule of participation is included.

**Art Therapy with Expressive Therapies Continuum (ETC)**

**Terminology**

The following terminology relates to art therapy:

- Media/mediums = the various materials and supplies used to make art.
- Studio = a designated space for art-making, clean-up and storage.
- Sublimation = transforming emotions and negative feelings into a creative process.
- Projection = the act of creating an art piece that reflects self, environment, and feelings.
- Catharsis = the cleansing or purging of emotions during the art making process.
- Integration = creating connectivity.
- Dichotomous thinking = black and white thinking, or representation of opposites.

**Art Therapy**

Art therapy is a unique profession wherein the therapist employs a knowledge base of art materials and the creative process along with the knowledge of psychology and psychotherapy. The American Art Therapy Association (2013) used the following as a definition,

Art therapy is a mental health profession in which clients, facilitated by the art therapist, use art media, the creative process, and the resulting artwork to explore their feelings,
reconcile emotional conflicts, foster self-awareness, manage behavior and addictions, develop social skills, improve reality orientation, reduce anxiety, and increase self-esteem. (2013, para. 1)

This work can be done in an office, an art studio, at a hospital bedside, in the client’s home, or at a treatment center.

Intentional cultivation of artistic perception and self-awareness is not an easy thing. Moon (2002) dispelled the romantic notion by saying, “As our engagement with the earth reminds us, cultivation involves dislodging, turning over, loosening, and experiencing brokenness. It involves uncovering that which has been hidden, settled, and comfortable” (p. 51). Intentional cultivation involves courage and hard work. Much of that work is subconscious. To illustrate, “Every person projects, in their artwork and their verbal communication, information that reflects their social, cultural, and familial context” (Riley, 1999, p. 33). This is a powerful emergence of mistaken beliefs developed during childhood and perhaps a maladaptive private logic as a non-productive way of perceiving the world and their movement in it.

Hass-Cohen and Carr (2008) said, “One of the advantages of art therapy is that it can provide relief by pairing fear-arousing emotions with positive new sensory experiences…Successfully coping with fear helps regulate and integrate affective experiences” (p. 33). This illustrates that sublimating the hidden and now unsettled with the art-making process can be a profoundly healing experience; a catharsis. Malchiodi (2007) said, “Catharsis literally means ‘cleansing’ or ‘purging’; in therapy it refers to the expression and discharge of strong emotions for relief” (p. 14). For the individual in early stages of recovery, being able to have a cathartic release in the art studio with a piece of clay or throwing paint on a canvas, is a productive method of purging strong emotions in lieu of self-injurious behavior, or harm to
others. As an act of sublimation, this process could allow a transformation from useless behavior which resulted in destruction, to useful behavior that leads to productive social interest.

By cultivating an art-making experience as a coping mechanism, the physical process can also alleviate stress and anxiety. Malchiodi (2007) stated, “For example, it is known that a creative activity can actually increase brain levels or serotonin, the chemical linked to depression” (p. 14). Thus, making art can be uplifting, stress relieving, and cleansing. As part of the cleansing and healing process, there is witness. She also mentioned, “In all forms of therapy, the presence of a facilitator or witness is central to healing, reparation, and recovery” (p. 17). The art therapist is the witness, providing a contained space for holding expression and stories. Additionally, Malchiodi (2007) added, “For many individuals, self-expression in the presence of a helping professional can be an important encounter because the therapist provides encouragement, motivation, acceptance, and positive affirmation that encourage personal growth and self-esteem” (p. 17). If clients keep an open door to expression during their treatment for an SUD, they may discover for the first time that art can be an enjoyable experience and that it can give them insight into other life concerns that they have been masking with their use. For example, “The most frequent response I get from participants is the recognition that something is missing in their lives that they had not previously realized” (Dreikurs, 1986, p. 58). The therapist is a witness to the client’s art-making, then the client becomes a witness to their own work. Block, Harris and Laing (2005) said, “Witnessing is not only about seeing and watching, visually sitting with one’s artwork, but also about being attentive and respectful of the art image. Witnessing allows participants to be nonjudgmental and noncritical” (p. 33). This can be a spiritual practice for many because it calls upon a deep sense of letting go of self-judgment and critical nature. Witnessing the art is also a powerful tool for building awareness with self-created
imagery. Once an image is created about circumstances, it is difficult to ignore the piece that is displayed. The art piece is a physical manifestation of their thoughts, often without the client’s knowledge while in the creation process. By careful interviewing about the piece, a therapist could encourage strengths, encourage awareness of abundance, and encourage a realistic view of circumstances.

Because of the phenomenon of projection and therapeutic benefits, art therapy is a productive compliment to current treatment practices for SUDs. Research confirms this in the responses of clients. For example, Allen (1985) shared, “Patients repeatedly reaffirmed that art has deep personal, emotional, and spiritual meaning” (p. 12). When clients are able to attribute meaning, doors are opened to deeper investment in the treatment for substance use disorders.

**Clinical Neuroscience**

In their book, *Art Therapy and Clinical Neuroscience*, Hass-Cohen and Carr (2008) gave this introduction, “The burgeoning of neuroscience findings have revolutionized clinical psychology, making it necessary to update art therapy perspectives” (p. 15), making new correlations and connections. Geracioti et al., Tanaka et al., Koob and Bloom, and Jacobsen et al. (as cited in Matto, 2005) discuss recent developments from research,

Recent neurobiological research points to specific similarities in the impact on biological systems for both PTSD and substance abuse disorders, beginning with a similar neural stress trajectory. Stress increases the release of norepinephrine to key areas of the brain, such as the amygdala and cerebral cortex which, in turn, increases the release of corticotropin-releasing hormone (CRH) from the hypothalamus into the pituitary system, triggering ACTH and the release of cortisol, causing acute neurophysiological dysregulation. (p. 531)
Neurophysiological dysregulation causes more stress which creates a vicious cycle. Because elevated levels of CRH are associated with increased anxiety and found in individuals undergoing withdrawal from substances, this is “…important biological understanding for why stress and problematic affect are identified as significant predictors of relapse to substance use” and “This physiological explanation suggests an intense need for effective psychosocial intervention at these times of heightened biological vulnerability during withdrawal and early recovery, as individuals are at significant relapse risk” (Matto, 2005, p. 531). Art therapy interventions using the Kinesthetic/Sensory level of the ETC and media at the fluid level would assist with ameliorating those high levels of anxiety. By sublimating anxiety into the sensory process of squeezing clay, coupled with the kinesthetic experience of kneading and possibly throwing the clay onto the table surface, the client may experience an increase in ability to regulate emotions through art therapy. Supporting that theory,

This suggests that verbally based therapies may not be the most appropriate method of treatment in early recovery, as the body is not physiologically ready for linguistic processing. Instead, a more effective method of early treatment, that matches the way the body has initially responded to the stress experiences, is use of visually expressive therapies that can gain access to this sensory-based material. (Matto, 2005, p. 532)

Brewin (as cited in Matto, 2005) agrees and describes the dual representation theory and a framework for intervention. Within this theory,

- verbally accessible memories (VAM), marked by conscious retrieval and temporally contextualized information.
• situationally accessible memory (SAM), marked by perceptually processed information (e.g., visuospatial, bodily/motor, and affective responses), with a paucity of conscious processing and without verbal coding. (pp. 531-532)

When clients recall intense affective memories, “Visual expression documents and permanently displays the client’s nonverbal message; whereby, physiological and emotional expression are divested before verbal editing occurs” (Matto, 2005, p. 535). Further evidence to support the coupling of SOC with the ETC continuum to consolidate the accessed SAM material into VAM representation when viewing the art work.

Regarding bi-lateral stimulation, “The neural right and left hemisphere integration that results from implementing expressive visual processing and cognitive processing activities is now being seen as a critical component of therapy” (Cozolino as cited in Matto, 2005, p. 533). The dual processing is assisting with awareness and modification of maladaptive beliefs, with an increase of self-efficacy, and to strengthen adaptive coping mechanisms. Once these sensory images are accessed and sublimated, treatment can focus on translating the SAM information into VAM by processing the image on a cognitive level.

Clinical neuroscience research is providing information for describing art therapy and the mind-body connection. Hass-Cohen and Carr (2008) said, “An example of mind-body connectivity is the social function of the vagal nerve (the tenth cranial nerve), which has connections to the brain as well as to the chest and abdominal areas” (p. 24). The popular phrase “gut feelings” could be the vagal nerve influencing the digestive system. Further regarding mind-body connections, Hass-Cohen and Carr (2008) stated, “It is a visual reiteration of the interplay between the person and their environment” (p. 21). The projective nature of art therapy interventions allow for that interplay to become a tangible image. The possibility of distancing
oneself from the image, and processing the emotions with a therapist mitigates fear of being re-traumatized. A neurologically based bilateral art intervention can integrate brain hemispheric right-left functions. The right hemisphere is more emotional, avoidant oriented, intuitive, and non-verbal, whereas the left hemisphere is more sequential, problem-solving, approach oriented, and language oriented (Hass-Cohen & Carr, 2008, p. 35). Asking clients to title work after creating an image, encourages clients to explore choices, cognitions, and emotions. This purposeful act of including language to images requires a response that engages self-regulation.

Part of the SUD recovery process is self-awareness and acquiring methods to self-soothe. Hass-Cohen and Carr (2008) said, “Emotion regulation skills increase a person’s ability to tolerate arousal from negative emotions, such as anger, and experience more of the positive kinds of emotions” (p. 297). Ameliorating intense emotions into art work is one way of consolidating new experiences. When the client gains the understanding of using art as a tool for emotion regulation, that same client may be open to translating regulation through art media, into self-regulation of emotion without the need of outside elements, thus increasing a strong internal locus of control.

Art Therapy is a novel learning experience for many in an SUD treatment center. Acetylcholine (ACh) activates neurotransmitter systems during learning to improve memory and understanding. Gil, Connors, and Amitai (as cited in Hass-Cohen & Carr, 2008) said, “ACh extensively adds to and alters arousal and attention processes in multiple anatomical regions supporting learning and memory” (p. 81). Later they added, “Art-making contexts involve novel sensory processing that would seem to activate the ACh system intrinsically. Arousal, attention, focus, visual processing and concentration engage synaptic plasticity, enhanced memory and learning functions” (p. 82). In addition, art-making could be considered a pleasure stimuli to
replace substances, they went on to say, “Because ACh is activated by visual and novel stimuli, this neurotransmitter may stimulate change process operating during art therapy” (p. 82). This information demonstrates how art-making activates the same pleasure center as do substances.

When discussing the limbic system, Hass-Cohen and Carr (2008) stated, “The limbic system within the center brain regions is responsible for social emotional processing. The amygdala triggers the fear response and the hippocampus holds emotional experiences in memory” (p. 25). Linking that with art therapy they said, “For example, the attraction to pleasure, dictated by the biological reward system, can be functional, as in art-making, or it can be dysfunctional, as in chemical abuse” (Hass-Cohen & Carr, 2008, p. 283).

The above mentioned clinical neuroscience research supports art therapy as a viable method of connecting expressive visual processing and cognitive processing for bi-lateral stimulation. The research showed how art therapy may reduce neurophysiological dysregulation, thus reducing potential relapse during early recovery from an SUD. By creating a social emotional response in the limbic system, art-making could be a substitute for chemicals of use for the individual with an SUD. Those therapeutic benefits also link art therapy to SUD treatment as a means to transfer some of the pleasure seeking activity into the art therapy studio rather than the streets.

Expressive Therapies Continuum

Art therapy is more than trusting the creative process and the projective qualities of the resulting art. As Malchiodi (2007) said, "It also requires knowing how to create an appropriate environment and understanding how art materials promote a wide range of expression" (p. 79). Specific properties of art media and qualities of surfaces are important for the art therapy experience, which often is a surprise to the lay-person and even those therapists who use art as a
therapeutic element in their talk therapy. As Hinz (2009) said, “Media were identified as fluid and likely to evoke emotion, or solid and likely to evoke internal structure during the creative act” (p. 30). Thus, assisting the art therapist to meet the client where they are, and to use art therapy directives in a prescriptive fashion. The ETC was conceptualized and published by Vija B. Lusebrink in 1978. The basic concept is,

The ETC organizes media interactions into a developmental sequence of information processing and image formation from simple to complex. Image formation and information processing are categorized in a hierarchical fashion from simple kinesthetic experiences at one end to complex symbolic images at the other. (Hinz, 2009, p. 5)

This framework provides structure for healing dimensions and, “This is a theoretical and practical guide, which provides a way to answer questions about what media to use, under what circumstances, and with which particular clients” (Hinz, 2009, p. 4). The art therapist’s guide to ETC and media use is displayed in a clear, simple format in Lisa D. Hinz’s book, Expressive Therapies Continuum: A Framework for Using Art in Therapy, Figure 1.1, on page 5. The ETC is made up of four levels of increasingly complex information processing. Beginning with the Kinesthetic/Sensory level, “Information gathered through these channels does not require words; it is rhythmic, tactile, and sensual” (Hinz, 2009, p. 6). The second level is called the Perceptual/Affective level. According to Hinz (2009),

Information processing may or may not need words at this level. It is beginning to take form or be absorbed in the creation of formed images. Information processing at this level can be emotional and raw, expressed in image without regard to form. (p. 6)

The third level is called Cognitive/Symbolic. Hinz (2009) described it this way,
Information processed on the Cognitive/Symbolic level of the ETC is complex and sophisticated; it requires planning, cognitive action, and intuitive recognition. Verbal input is often, but not always, required to gather meaning about complex cognitive operations or multidimensional symbols involved on this level. (p. 6)

The final level, called the creative level can exist in any or all of the previously mentioned levels. It is thought of to integrate information from both hemispheres of the brain and at each of the levels, a client could have a creative experience. For example, “A sense of calm can be created without the formation of an external image; the media experience itself can induce serenity” (Hinz, 2009, p. 7).

The kinesthetic/sensory level. This level in the ETC is similar to Piaget’s sensorimotor stage of cognitive development, where the processing of information is through movement and the senses (Feldman, 2011, p. 142). Pounding, pushing, or rolling clay, forming plasticene to music, painting to music, and tearing paper are examples of kinesthetic experiences. According to Hinz (2009), “As summarized in Table 3.1, the healing function of the Kinesthetic component has to do with finding an inner rhythm and the release of energy” and “Overuse of kinesthetic activity can be used as a defense or disorder. Either alteration of functioning can be the target of art therapy” (p. 56). For further information, see Table 3.1 on page 57 of Expressive Therapies Continuum by Lisa D. Hinz.

Finger painting, mixing paint while focusing on the blending of colors, and exploring objects with closed eyes are examples of sensory experiences. These types of input influence feedback loops to support learning and developing memory. “The healing function of the Sensory component includes the development of slow rhythm and an awareness of internal sensations” with “It can provide a way for those who are over- or under responsive to sensory
stimulation to organize their responses into appropriate behaviors” and, “Finally, art expression, especially using the perceptual component of the ETC, can provide a container for highly sensitive persons who need a way to express and contain overwhelming external and internal sensory stimulation” (Hinz, 2009, pp. 75-76). Words are few at this stage.

**The perceptual/affective level.** From Hinz (2009), “The Perceptual/Affective level is the second level of the Expressive Therapies Continuum, corresponding to the schematic stage of graphic development in which children are learning about the world and the forms around them” (p. 10). This stage is when images are infused with emotions, impulses, and images of perceived realities in diverse ways. Hinz (2009) remarked, “Individual perceptions of reality are neurologically based, culturally influenced, and different from other individuals’ perceptions” (p. 10). Being open to new perceptual experiences will broaden a client’s perspective and point of view through a new visual language. “Experiences on the Perceptual/Affective level can help clients identify emotions, facilitate discrimination among emotional states, and assist in the appropriate expression of emotions” (Hinz, 2009, p. 11). For example, drawings from reality, partners drawing on the same piece of paper with no verbal communication, drawing a current point of view then being directed to draw a close up-view and a bird’s-eye view, and inner-outer self portraits showing how they see themselves and how others see them, are all examples of art therapy directives on the perceptual level. Hinz (2009) described the perceptual experience as, “Clients are encouraged to view themselves and others in a new light, to see people or situations from another person’s perspective, and to change lifeline ways of perceiving the self and the world” (p. 98).

With regard to the affective component of the ETC, examples of art therapy directives would be, drawing or painting images depicting the basic emotions of anger, sadness, fear, and
happiness, creating a collage of various faces with identification of emotions expressed, and a body map of feelings. Like Hinz (2009) stated, “The healing function of the Affective component of the ETC is the increased awareness of appropriate affect and support for the constructive expression of affective impulses” and, “Clients can be taught that art provides a method of communicating feelings without experiencing the threat of emotional devastation or self-destruction” (p. 120). This stage can help to create a foundation of reality recognition.

**The cognitive/symbolic level.** This level is the most developmentally sophisticated, corresponding to Piaget’s formal operations stage of development, where people develop the ability to think abstractly (Feldman, 2011, p. 361). Art directives at this level can become more complex and personal symbols may be created to represent thoughts and events. “Art therapy experiences with the Symbolic component of the Expressive Therapies Continuum can aid clients in accessing the wisdom of their bodies or the wisdom of the world, neither of which speak in words” (Hinz, 2009, p. 12). Examples of art therapy directives are, topic directed collages, a lifeline or timeline of ups and downs, complex tasks with two or more steps, a floor plan of a childhood home, and an image of three things you would take with you for survival on an island. According to Hinz (2009), “The healing function of the Cognitive component is the ability to generalize from one concrete experience to other dissimilar situations” which is creative problem solving, and, “Creative problem solving encourages contact with healing inner wisdom, increases self-acceptance, and promotes peaceful self-understanding” (p. 142), both of which increase self-care abilities and improves other recovery processes.

Examples of art therapy directives could be a collage of archetypal images, mask making, a self-symbol in clay, bridge making, personal coat of arms, a self-portrait, and a road map of the client’s recovery journey. Lusebrink (as cited in Hinz, 2009) spoke of the healing dimension of
the symbolic component, “Understanding of personal symbols has been called symbol resolution. Resolution is a word with many meanings, and it is quite appropriate for the process of ‘unpacking’ symbolic meaning...Resolution can mean a thing resolved or solved; separation into component; conversion into another form; or increments of focus” (p. 147). Symbols can also be categorized as regressive or progressive. “Working with regressive symbols can help clients work through childhood conflicts. In contrast, progressive symbols are related to future strivings and may reveal new goals and personal options” (Hinz, 2009, p. 148). This section demonstrates a higher level of functioning in the client. Planning and action would be appropriate when a client demonstrates ability to recognize and articulate meaning of the metaphorical message of symbols, and see how they may integrate into their treatment plan. If the client is functional in the art therapy studio at this level, other treatment would progress.

**The creative level.** This may exist in all of the levels, as previously mentioned, and serves an important integrative function. Creative expression on its own has restorative and healing benefits; however there are challenges to this level as well. For example,

When using art media to promote creativity, it is important to remember that if the individual struggles too greatly to master the materials, she or he is less likely to experience the healing aspects of creativity, and more likely to experience frustration or anxiety. If the medium is so familiar as to be absolutely unchallenging, the individual will likely experience boredom and not creative flow. (Hinz, 2009, p. 173)

The creative experience and flow are noted by others, “Access to creative input allows one to feel the joy that infuses original imaginative experiences. Creative involvement itself can be healing without cognitive overlay or symbolic interpretation” (Lusebrink as cited in Hinz,
2009, p. 12). The Creative level is more than cognitive flow; it involves synthesis and self-
actualizing,

Synthesis takes into account at least three different types of fusion of information 
occuring during the artistic experience: the synthesis of inner experience and outer 
reality, the synthesis between the individual and the media utilized, and the synthesis 
between the different experiential and expressive components of the ETC. (Kagin & 
Lusebrink, as cited in Hinz, 2009, pp. 169-170)

Coupling the various types of fusion with the SOC in the containment of an art therapy 
studio in a treatment center provides the necessary psychosocial support for the individual as 
they experience the various levels of synthesis.

Media properties. Lusebrink and Kagin (as cited in Hinz, 2009) looked at the media 
properties and their influence of the art process and product in a different way than typical for 
the time. “Kagin and Lusebrink categorized two-dimensional and three-dimensional media on 
continua from fluid to resistive and discussed the influence of media choice on image formation 
and information processing” (p. 30). Further,

Figure 2.1 shows that materials with more inherent solidity or structure (e.g., wood in 
three-dimensional, pencil in two-dimensional) are called resistive because they require 
the application of pressure, and provide resistance to pressure to be used effectively. 
Media with less inherent structure called fluid (e.g., wet clay in three-dimensional, 
watercolor paint in two-dimensional) because they flow easily and quickly during the 
creative process. (Hinz, 2009, pp. 30-32)

Fluid media are likely to elicit emotional responses and resistive media are likely to 
evoked cognitive responses.
The above mentioned Figure 2.1 is an important quick glance reference tool for any art therapist during moment-to-moment therapeutic decisions. It lays out media from fluid with affective emotional responses to resistive with cognitive emotional responses. The media list is in the order from fluid to resistive; watercolor on wet paper, finger-paint on finger-paint paper, other paints on dry paper, chalk pastels, oil pastels, markers, soft water-based clay, crayons, collage, colored pencils/pencils, clay/plasticine, and stone/wood sculpture (Hinz, 2009, p. 31). By using this media properties list, in conjunction with the levels of ETC, an art therapist can be more precise with an art therapy directive in a prescriptive sense. Combining that even further with 12-step principles and SOC, this method of art therapy could have a powerful impact on a client’s acceptance and investment to SUD recovery. It also helps to develop a foundation for continued therapy outside of treatment to support a level of thriving beyond surviving.

**Substance Use Disorder**

**Definition of SUD**

According to the DSM-5, “The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems” (American Psychiatric Association, 2013, p. 483). Because of the direct effect to the brain’s reward system, continued use causes a negative ripple effect in the individual’s life and the lives of their loved ones. The DSM-5 has this to say about all addictive substances, “They produce such an intense activation of the reward system that normal activities may be neglected” (American Psychiatric Association, 2013, p. 481). In severe cases, individuals lose homes, jobs, families, and their lives. Alcoholics Anonymous (AA) (2001) said, “There are many situations which arise out of the phenomenon of
craving which cause men to make the supreme sacrifice rather than continue to fight” (p. xxx).

Supporting long-term care, the DSM-5 goes on to say,

An important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders. The behavioral effects of these brain changes may be exhibited in the repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli. These persistent drug effects may benefit from long-term approaches to treatment. (American Psychiatric Association, 2013, p. 483)

This statement gives support for an art therapy program after treatment, or in the community that supports long-term recovery, especially for those who have not gone to treatment, or do not connect with AA or other forms of recovery support groups.

Common Issues and Terminology

The DSM-5 identifies 10 separate classes of drugs and gives specific criteria based on the pathological patterns of behaviors related to the use of substances. Those criteria are,

- Impaired control. Taking larger amounts or over a longer period of time than intended, unsuccessful efforts to decrease or discontinue use; excessive time used to obtain, use, and recover from drug effects.
- Social impairment. Failure to fulfill major role obligations at work, school, or home; continued use despite social or interpersonal problems caused by effects of substance use; important social, occupational, or recreational actives may be given up; individual may withdraw from family activities and hobbies.
- Craving. Intense desire or urge to use the drug.
• Risky use. Recurrent substance use in situations where it is physically hazardous; continued use despite knowledge of physical or psychological problems as a result of substance use; key issue here is not the existence of the problem, but the failure to abstain despite consequences.

• Tolerance. Markedly increased dose of substance needed to achieve the desired effect, or markedly reduced effect when the usual dose is consumed.

• Withdrawal. A syndrome that occurs when blood or tissue concentrations of a substance decline after prolonged heavy substance use. (American Psychiatric Association, 2013, pp. 483-484)

A treatment center’s counselor and the art therapist would use these identified criterion to navigate and assess the broad range of severity and need for specific treatment goals.

Acceptance. This refers to the client’s ability to face reality and recognize their situation as a direct consequence of their behavior and substance use history. If acceptance is not possible, they are in denial.

We have a clear, concrete way of demonstrating acceptance, by accepting the client’s image. If I show you that I can sit with or be present to whatever shows up on the paper, chances are you will also understand that I can be present with your pain, your ‘ugly’ memories, your scary dreams, your deepest fears. (Schroder, 2005, p. 18)

This type of acceptance is not readily felt by clients with SUDs. Those individuals may purposely create graphic imagery as a test for unconditional acceptance. Experiencing that type of compassion in acceptance from the art therapist can become a powerful, emotional catharsis and may open the door to deeper healing which would lead to self-acceptance.
Anxiety and stress. In her study of stress and addiction, Eisch (2005) wrote, “Clinical evidence suggests a complex—perhaps correlative—relationship between stressful experiences and addiction” (p. 25). She describes stress as “First stress can be caused by exposure to something aversive or negative…Second, stress can be caused by deprivation of or limited access to something rewarding, positive, or necessary for survival” (Eisch, 2005, p. 28). When speaking about age with relation to exposure and influence, “While stress in early life can clearly influence drug response in adulthood, the converse is also true: early drug exposure can influence the stress axis in adulthood” also “Again, this bidirectional influence—early stress influences later drug taking, early drug taking influencing later stress responses—emphasize an area for potential clinical intervention” (Eisch, 2005, p. 35). In summation, “Stress and drug exposure produce common neuroadaptations in discrete brain regions, and have bidirectional influences on each other throughout establishment of drug taking and in drug withdrawal” (Eisch, 2005, p. 38). Stress can be expressed in art by quick scribbles, jagged marks, and use of intense color. “Structured art interventions can calm fear-based, subcortical, right hemispheric, survival-based stress responses” (Lusebrink as cited in Hass-Cohen & Carr, 2008, pp. 299-300), giving the client a tangible coping method. “Many clients report that the sense of well-being, pleasure and reward felt during and after the creation of art is profound and fundamental to their change process” also

Therefore, rather than reasoning or assigning a new cognitive meaning to an emotion, one can use the art to transform one emotion directly into another. Art-making results in positive and joyful responses facilitated by the brain’s natural reward systems. (Hass-Cohen & Carr, 2008, p. 298)

Positive emotions assist in physical well-being and recovery.
**Denial.** Mentioned earlier in this document, denial is the inability to accept truth and consequences as a result from personal actions and behavior. Denial in the individual with an SUD is often a deep level of mistaken beliefs, skewed private logic, and cognitive dissonance. “Distortions in thinking, especially denial, become part of how the addict keeps painful feelings and associations related to substance abuse at a distance” (Malchiodi, 2003, p. 281). For many individuals with an SUD, the tendency is to blame others and to claim no fault. Until denial is smashed and acceptance is achieved an individual effectively cannot move forward, as in AA, “We admitted we were powerless over alcohol—that our lives had become unmanageable” (Alcoholics Anonymous, 2001, p. 59). If an individual is not able to fully embrace the concept of step one, no matter what the substance of use is, they will not take in and apply new learning.

The Substance Abuse and Mental Health Services Administration (SAMSHA) (2004) published, “In substance abuse treatment, the term denial is generally used to describe a common and complex reaction of people with substance use disorders who, when confronted with the existence of those disorders, deny having the problem” (TIP Series 39, p. 7). Another approach to the description from an earlier publication by McDuff, Solounias, RachBeisel, and Johnson (1994) shared, “We conceptualize denial as having three levels that must be addressed: 1) basic identity: alcoholic vs nonalcoholic; 2) drinking control: abstainer vs social drinker; and 3) need for assistance: need help vs recovery without help” (p. 295). Art therapy directives bring out visual information attending to each of those levels of denial. When a client witnesses the images he or she made, it becomes more difficult to maintain that denial when evidence is staring them in the face. In Adlerian terms, this would be similar to spitting in their soup. As Adler (1956) said,
This rather distasteful phrase is a marvelous tactic that is efficient and effective. Put simply, clients are shown what their symptoms are providing them and then encouraged to keep using the symptoms. They may continue to have the symptoms, but they will not ‘taste’ as good any longer. (as cited in Carlson, Watts, & Maniaci, 2005, p. 142)

**Hope.** Hope is looking forward to goals, plans, and dreams. “From the perspective of emotional intelligence, having hope means that one will not give in to overwhelming anxiety, a defeatist attitude, or depression in the face of difficult challenges or setbacks” (Goleman, 1995, p. 87). Art therapy groups may be a safe format for expression of challenges. It also may facilitate a cohesiveness that was vacant in an individual’s family dynamics. Hass-Cohen and Carr (2008) said, “A higher order of reflective, supervisory psychosocial functions can emerge from shared experiences of art-making that involve mutual trust and bonds of hope” (p. 290). From the standpoint of group art therapy work, Jensen and Riley (as cited in Hinz, 2009) said, “Other benefits of group sensory experiences are that they promote primary motor and sensory functions, increase sociability and social skills, reinforce procedural memory and habitual skills, and heighten humorous experiences” (p. 245). Where there is laughter, there are glimpses of hope. Without hope, individuals with SUDs could practice self-neglect, a lack of self-care in other areas of life, engage in risky behavior, relapse, and possibly overuse to the point of overdose.

**Relapse.** When discussing relapse, Gorski (as cited in Smyth & Wiechelt, 2005) mentioned, “The medical model, which has been widely adopted in the substance abuse treatment field, conceptualizes relapse as any return to substance use after a period of abstinence” (p. 64).

SAMSHA (1996) defined relapse by the following,
Relapse is not an isolated event. Rather, it is a process of becoming unable to cope with life in sobriety. The process may lead to renewed alcohol or drug use, physical or emotional collapse, or suicide. The relapse process is marked by predictable and identifiable warning signs that begin long before a return to use or collapse occurs. Relapse prevention therapy teaches people to recognize and manage these warning signs so that they can interrupt the progression early and return to the process of recovery. (Tap Series 19, Ch. 3, para. 1)

The last definition describes warning signs and conditions for relapse. The vital piece is the client’s self-awareness, “Identifying the client’s high-risk situations and teaching them the skills necessary to cope with each situation increases their self-efficacy” (Smyth, & Wiechelt, 2005, p. 65). Lack of interpersonal functioning and emotion regulation are among the stressors which put an individual with a SUD at a higher risk for relapse. Frieder, Futterman, and Silverman (2006) described,

The behavioral technique of functional analysis teaches patients that relapse is not random, that there are many things that patients are unaware of, whether emotional states (i.e., anger at a lover) or physical circumstances (i.e., being near one’s favorite bar) that lead someone toward using drugs. This is, in effect, using a behavioral technique toward a psychoanalytic end which is to teach patients about the role of the unconscious. (p. 30)

As a practical application, “Patients are taught to pay attention to the patterns of relationships and behaviors that underlie their seemingly random and uncontrollable actions” (Frieder et al., 2006, p. 31). Once this is achieved, individuals are better able to see how their actions correlate to consequences, and identify relapse risks. “Often the people who relapse have stopped engaging in the recovery-oriented practices that served them well during their earlier
sobriety” (Manejwala, 2014, para. 7). Forgetting what works is dangerous to the individual with an SUD.

**Risk.** Negative life stress is important to consider for the individual with an SUD. Dealing with gangs, violence, peer use, availability of substances, and pressure to use, are risk factors for relapse (Anderson, Ramos, & Brown, 2006, p. 256). In addition to stress, a lack of adaptational inner resources increase the client’s susceptibility to relapse. “Coping emerged as a significant protective factor for a return to substance use for youth with substance use disorders and Axis I psychopathology” (Anderson et al., 2006, p. 262). A study done by Anderson, Frissell and Brown (2007) produced results related to negative life stress. “In concert, these findings suggest that there may be two types of relapse for comorbid youth: one related to temptation and social pressure, and the other related to stress and distress” and “Stress in the teen’s environment was associated with use in intrapersonal, interpersonal and social pressure contexts” (p. 78). Developed coping skills are critical for the client to maintain after treatment in order to prevent risky behavior which often leads to relapse.

**Shame.** Shame is painful awareness of wrong doing. “Although concepts of shame are not directly addressed in the literature, the self-affirming and life-giving nature of the creative process in humanistic theory is inherently shame reducing and corrective” (Malchiodi, 2003, p. 283). She went on to say, “Addicts must learn to recognize and identify their own shame response. By learning to label their shame, they can then separate reality from their feelings of shame, and in doing so, decrease cognitive distortions” and “Understanding alone is not sufficient to reduce shame since shame must be felt and reprocessed in order to reduce its impact on shaping perceptions and experiences” (Malchiodi, 2003, p. 292). Mistaken beliefs and extreme expectations fuel shame, “…creative experiences can destroy a “false self” developed in
response to shame, and can reinforce an authentic sense of self” (Johnson, as cited in Hinz, 2009, p. 12). Overcoming shame may be an arduous process which would be aided by using bi-lateral stimulation through the Perceptual/Affective level of the ETC during an art therapy session.

**Spirituality.** A spirit or soul connection with a Divine entity, Nature, or chosen Higher Power. A spiritual journey is as individual as each person on earth. For the majority of individuals in recovery, connecting with a Higher Power is a key factor for long-term recovery. According to AA (2001), “In nearly all cases, their ideals must be grounded in a power greater than themselves, if they are to re-create their lives” (p. xxviii). The book mentioned later, “…for we have been not only mentally and physically ill, we have been spiritually sick. When the spiritual malady is overcome, we straighten out mentally and physically” (p. 64). The straightening out of mental and physical, usually still takes work.

Another element of spirituality, is worship. When talking about the importance or worth of substances in a person’s life with a SUD, Bjorklund (as cited in Feen-Calligan, 1995) said, “The process of giving worth to something is called worth-ship or worship. When we worship something, we are talking about a god-like relationship with the object of worship” (p. 47); Bjorklund’s rationale for the spiritual disease concept of alcoholism. Clients in recovery must understand themselves and what they worship in order to understand spirituality. As Feen-Calligan (1995) put it, “Ironically, one must live spiritually before one understands what spirituality is, for spirituality is not something that can be learned through books” she went on to say, “Spiritual experiences may mean being creative: making art or music, writing, walking, fishing, or camping” (p. 47). Feen-Calligan (1995) also mentioned, “Art fosters spiritual development through both the creative process itself and in contemplating a work of art which
moves one to a higher level of understanding” (p. 46). The higher level of understanding could be called a spiritual awakening.

Spiritual pursuits often require trust and surrender; the difficult work of letting go. Feen-Calligan (1995) said, “This may also be true of recovery—there are no shortcuts, no instant transformations. Recovery becomes a way of life, realized with consistent, daily effort” and,

Terms such as letting go, powerlessness, and humility, understood by individuals in recovery also can be understood through making art. In art, letting go refers to the creative process, to a freedom required of working with media, or an openness to following new directions. (p. 48)

Along with letting go, allowing an art piece to happen can be an intimidating element as said by Stone and Stone (as cited in Feen-Calligan, 1995), “Self-criticism and fear of criticism by others can stem from a powerful internal critic. This critical voice engenders doubts about one’s abilities, especially when facing novel tasks” and “The inner critic can cause clients tremendous anxiety about their abilities to handle the media, even more anxiety about their abilities to express themselves in original ways” (p. 178). The inner critic and fear plague the individual with an SUD. With greater acceptance of self, and comfortability with the art making process, a client may have a spiritual awakening and explore their concept of “God as we understood Him” (Alcoholics Anonymous, 2001, p. 59). In depicting a Higher Power, “Patients in art therapy groups have at times objectified abstract images or ideas about God in their art. In this sense, art has helped recovery persons come to terms with their understanding of God” (Feen-Calligan, 1995, p. 49). A personal bias of this writer is that art-making is a spiritual experience all its own. Feen-Calligan (1995) seems to agree, “Recovery from addiction requires finding a spiritual basis
of living. Art therapy, a quiet, reflective, humbling, creative, and meaningful endeavor, may provide the means to assist with this process” (p. 50). Indeed.

12-Step Recovery Principles, SOC, and Adlerian Concepts

12-Step Recovery Principles

AA is a worldwide program of recovery and their 12-step model has inspired various other recovery programs. Along with the 12-steps of recovery, there are 12 principles of recovery. Those principles are,


Treatment center programs often have their roots in the 12-steps of AA, including the Minnesota Model (MM), “The main features of the MM have been described by Cook (1988a) as: (i) the possibility for change, (ii) the ‘disease concept’, (iii) treatment goals, and (iv) the principles of AA and NA” (as cited in Morojele & Stephenson, 1992, p. 25).

The principles of recovery are based on the 12-steps and could function for individuals even if they do not follow the 12-steps of AA.

The Guiding Principles of Recovery are inclusive of family, culture, and community. The following is a description of those principles,

There are many pathways to recovery; Recovery is self-directed and empowering;
Recovery involves a personal recognition of the need for change and transformation;
Recovery is holistic; Recovery has cultural dimensions; Recovery exists on a continuum of improved health and wellness; Recovery emerges from hope and gratitude; involves a
process of healing and self-redefinition; Recovery involves addressing discrimination and transcending shame and stigma; Recovery is supported by peers and allies; Recovery involves (re)joining and (re)building a life in the community; Recovery is a reality. It can, will, and does happen. (SAMSHA, 2011b)

This writer will be using the 12-step recovery principles from AA literature, along with synthesizing SAMSHA’s guiding principles and the SOC further along in this document. They both will be viewed through a lens of Individual Psychology.

Stages of Change

The Stages of Change (SOC) represent one of the fundamental dimensions of the Transtheoretical Model of intentional behavior change, developed by Prochaska and DiClemente in 1986. As stated,

The underlying perspective of the stages of change is that there is a multidimensional process of intentional behavior change that extends from the establishment of a stable pattern of abuse to the achievement of significant sustained change of the addictive behavior. (DiClemente as cited by DiClemente, Schlundt, & Gemmell, 2004, p. 104)

Those changes are represented in a directional movement through five stages, beginning with, the Precontemplation stage. In this stage, the client has little interest in changing and does not believe they have a problem with substances. Once there is concern and awareness of some need, the client can move throughout the Contemplation stage where the client will do some serious analysis of risk-reward to decision-making. That brings us to Preparation, which involves planning and commitment. The Action stage is when the client takes specific steps moving forward with a plan, where at the Maintenance stage, the client works to maintain long-term change (DiClemente et al., 2004, p. 104). A client in an SUD treatment center may stay in
the Precontemplation stage or move through all of the five stages. Coupling the client’s SOC, with the levels of the ETC, the art therapist would have a better understanding of what correlating media could assist that client in a forward trajectory.

**Adlerian Concepts**

The following is a brief description of Adlerian concepts used in this document.

**Encouragement.** This is one of the basic tenants of Individual Psychology. As Dreikurs (1964) said, “Encouragement is more important than any other aspect of child-raising” and later, “A misbehaving child is a discouraged child. Each child needs continuous encouragement just as a plant needs water” (p. 36). The lack of encouragement as a child has significant effects on an individual that is later manifested into lack of trust and maladaptive behavior.

Adler took an equal, instead of superior position with his clients. He discussed his stance that the client would be curing him or herself, and that he would be helping them along, encouraging them as they took responsibility for changing their life’s problems. Ansbacher and Ansbacher (1979) shared,

From the start they were safe from the misunderstanding, frequent in critics but sometimes also in would-be followers of Adler, that encouragement at any price was the key of his treatment. Adler never encouraged without laying open the problem for the solution of which courage was to be used. Not encouragement in itself, but balance of encouragement and responsibility was Adler’s formula, if formula there has to be. (pp. 358-359)

The key to Adler’s encouragement was his way of engaging the client to cure himself. Adler would shed light on the problem, then encouraged the client to do the work.
Holism. It is said, “Adlerians postulate that the person is an indivisible unit. That a person needs to be understood in his or her totality” (Mosak & Maniacci, 1999, p. 14). The totality of the person is mind-body-spirit, a holistic awareness of all elements involved with various interactions. For example, “Mind-body approaches link nervous, endocrine and immune systems with physiological and psychological changes” (Hass-Cohen & Carr, 2008, p. 21). Individual Psychology is a holistic approach to treating and caring for the individual.

Inferiority feelings. An individual could find themselves in a situation where they are physically shorter or smaller than another individual, but that does not make them an inferior person. If that individual feels inferior as a result of the difference, then the person would have inferiority feelings. As Mosak and Maniacci (1999) said, “Inferiority is context-dependent and situationally determined. It is not necessarily a value judgment” (p. 56). Inferiority feelings on the other hand, are subjectively appraised inferiorities resulting in negative self-image and justifications for stagnation. The client could claim inferiority as an excuse for under-performance.

Life tasks. Life tasks are the main areas of life where individuals are challenged and interact with the world. Mosak and Maniacci (1999) discuss Adler’s delineation of these areas. They mention that Adler pointed out the main areas being work, social relations or community, and family relationships and love. They also mentioned that Adler addressed self and spirituality as important life tasks without writing about them. This writer will be using all five of the life tasks in further discussions.

Mistaken beliefs. The construction of a number of inappropriate, strange, or dysfunctional ideas in one’s personal, cognitive schema describe mistaken beliefs. Everyone does this, everyone has them and they sometimes cause trouble as a person moves through life
Mistaken beliefs can be on a spectrum from high expectations with grandiosity, to low expectations with feelings of inferiority. Some examples are, life isn’t fair, you need to take care of me, I am supposed to be good, I have to look like I’ve got it all together, I am not supposed to show my emotions, we’ll never amount to much, that’s for rich kids, I have to suck it up, it’s not ok to cry, everything breaks, we’re the fortunate ones, things come easy for us, love isn’t for me, conflict is bad and I end up getting hurt, I’m not worth the effort, etc. Adlerians say these are perceptions of life that are developed before the age of 10, and assist in a person’s lifestyle, influencing their movement through life as a reaction to those mistaken beliefs.

**Private logic.** Private logic is a personally held concept of life. “Private logic is composed of ideas conceived in childhood, which may or may not be appropriate to later life” (Carlson et al., 2005, p. 12). In other words, “If using common sense, we know what the general opinion is and what the useful thing to do is; if using private logic, we follow our own biased, idiosyncratic thinking, which may not have much to do with common sense” (Mosak & Maniacci, 1999, p. 121). Everyone to some extent creates a private logic. Often based in mistaken beliefs, private logic can become maladaptive behavior with destructive consequences. In the case of an individual with an SUD, private logic may include a concept that life is better, and the individual is better off, if everything can be numbed away by substances. Then they don’t have to really feel anything.

**Social interest.** Social interest is a positive community feeling. “It is about how a person is concerned with others and not only self-oriented. Adler (1930) said, “Lack of social interest is equivalent to being oriented towards the useless side of life” (p. 40). He also mentioned, “The individual becomes an individual only in a social context” (Adler, 1930, p. 199). Carlson et al.
(2005) discussed Adler’s view of social interest, “Human behavior was seen by Adler as goal oriented and socially embedded. Nobody exists outside society” and later “Through studying interactions with others we can understand how someone is fitting in or seeking to be known in the social world” (p. 11). Often individuals with SUDs isolate from the rest of society and have low social interest during their active use. Sometimes family members and friends prefer it that way, if the individual causes a ripple effect of destruction, creating further isolation.

**Teleology.** This is a direction of striving, a goal directed movement. Adler (1930) spoke of the creative power of life, “This power is teleological—it expresses itself in the striving after a goal, and in this striving every bodily and psychic movement is made to co-operate” (p. 32). He also mentioned, “The important thing is to understand the individual context—the goal of an individual’s life which marks the line of direction for all his acts and movements” (pp. 32-33). These unconscious movements are based on a goal established in our first years of life. Adler (1930) said, “Without the sense of a goal individual activity would cease to have any meaning” (p. 34). Often this is exactly what happens to an individual with an SUD, a life goal is interrupted for various reasons and at first substances can serve as an escape and a temporary comfort.

“Self will run riot” is a term fondly used in the circles of AA. That particular phrase runs against the Adlerian concept of social interest; and investment in community. When viewing an individual in an SUD treatment center through an Adlerian lens, discouragement, inferiority feelings, mistaken beliefs, skewed private logic, and lack of social interest are among the many symptoms or conditions possibly leading a person to use substances in the first place. Understanding an individual’s teleological line through an assessment of five life tasks, and using art therapy as a holistic, encouraging, creative therapy, this writer believes the client will gain a stronger sense of hope and willingness to make significant, lasting, life changes.
Methodology

Connecting Art Therapy, Substance Use Disorders, and Recovery Principals

People are inherently creative. Using art therapy within the focus of Individual Psychology uses Adler’s description of the creative self-wherein the client is both the painting and the artist to a literal sense. Carlson et al. (2005) found, “Still, there is another factor most theories leave out of their assumptions: creativity. The use people make of their circumstances is as important as, and often more important than, the circumstances themselves” (p. 83). Clients are able to explore their circumstances in the art studio. Some hesitating clients will complain of art being too hard, “For most individuals, being asked to use art media, perhaps for the first time in many years, brings up overwhelming feelings of uncertainty and insecurity. Claiming lack of artistic ability may be the only way clients think they can control these uncomfortable emotions” (Hinz, 2009, p. 233). The inner critic interrupts their courage, “The inner critic can cause clients tremendous anxiety about their abilities to handle the media, and even more anxiety about their abilities to express themselves in original ways” (Hinz, 2009, p. 178). These are real and strong anxieties about beginning in an art therapy session. In this writer’s proposed art therapy program, clients will be introduced to materials at a sensory level with a semi-structured schedule which includes freedom of choice. “This type of environment contains diverse art media, fosters curiosity, encourages perceptual openness, and stimulates all the senses. Interestingly, a supportive environment also includes well-defined limits” (Hinz, 2009, p. 174). In this program, the well-defined limits are the material options for that particular week, the specific theme of the week, and the art therapy directive.

This writer proposes using the appropriate media and image formation processing level on the Expressive Therapies Continuum, to match the appropriate Stage of Change in recovery.
Clients will be encouraged to explore media at a stage that fits their development in treatment. This will allow for expressive release of their denial, a possible lowering of inferiority feelings, an increase in self-awareness, and an ability to regulate emotions may improve. Art therapy in this way may also address some of their mistaken beliefs about not being creative, and transfer some useless destructive behavior into useful productive behavior. Perhaps by meeting the client where they are in the various stages could assist in their forward movement and increase their level of social interest as they create with others in the studio environment. Del Vecchio (2012) described the group role as such,

- Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. (para. 11)

By using this group process of creativity and making the correlation to the recovery principles, art therapy may increase the client’s depth of investment into their extended recovery program. There could also be a ripple effect into other parts of their life and interaction with others which would touch on the guiding principles from SAMSHA.

From an Individual Psychology approach, the produced art work could give clues to the teleology of the client by noticing recurring striving themes and similar problem solving techniques. This information would be helpful for adaptations in a treatment plan.

**Art Therapy Program Model**

The proposed art therapy program model would be a semi-structured program that correlates the five Stages of Change, 12-step recovery principles, and the Expressive Therapies
Continuum to provide a complementary and alternative modality for SUD treatment. Structure is an important element, along with some flexibility within the structure. Hinz (2009) mentioned, 

Adolescents and adults could be overcome with inner critical voices when faced with unlimited materials and choices. By providing a structured task, the art therapist can lend needed ego strength to overcome forces that previously have undermined the motivation or concentration needed for project completion. (p. 175)

This semi-structured program would be integrated with the treatment center programming and the client’s personal treatment plan. SAMHSA (2011a) provides a Technical Assistance Publication Series called TAPs. Within TAP 21 the following information was given regarding treatment planning.

Treatment Planning Definition: A collaborative process in which professionals and the client develop a written document that identifies important treatment goals; describes measurable, time-sensitive action steps toward achieving those goals with expected outcomes; and reflects a verbal agreement between a counselor and client. At a minimum an individualized treatment plan addresses the identified substance use disorder(s), as well as issues related to treatment progress, including relationships with family and significant others, potential mental conditions, employment, education, spirituality, health concerns, and social and legal needs. (p. 55)

This identifies a holistic approach which the art therapy program supports. The ideal art therapy program design would utilize a separate studio space designated only for art therapy that has storage space and a sink included in the space, with movable tables and chairs. Wood (2000) said, “Being set apart from the everyday provides the physical space needed for mental reflection” (p. 40). Later in the same article,
The life difficulties experienced by many clients are extreme yet the availability of a studio can add to their capacity to face what they feel. This is because the actual making of art can engender a sense of thoughtful absorption and this can make it possible to reflect upon what is felt and then possibly even see the feelings in the artwork. (p. 43)

The art therapy program suggests each client have two hours per day in the studio and use that time as their primary therapy, or in conjunction with talk therapy.

This model provides a structured theme per week utilizing the 12-step recovery principles, and an option of five different media choices for that week. Each of the media items are expected to be used within that respective week in order for the client to gain experience in a variety of art materials. The first week specifically is set on the Kinesthetic/Sensory level of the ETC in order to introduce the client to art materials in a literal, physical way,

Instead of focusing on breaking down denial and resistance, the construct of building up motivation helps place the work of therapy in a more positive light. These authors suggested that by fostering clients’ imagination, experiential encounters, and psychodramatic role play, addicted individuals are helped to more effectively reevaluate the self through stimulation of affective arousal. (Connors, Donovan, & DiClemente, as cited in Horay, 2006, p. 16).

Because this art therapy model is structured by week for 12-weeks, utilizing the 12-step recovery principles as the theme per week, it is a natural fit for a 30-day, 60-day, or 90-day treatment stay. Each week the choices of art materials move through the continuum from the affective and fluid media properties, to those of cognitive and resistive properties. A new art medium would be available per day to increase the novel experience and hopefully a level of curiosity. As the client moves through the weeks in recovery, they would also likely move
forward in the SOC, and move to a higher level of cognitive functioning on the ETC level of image and information processing. That movement would be matched with the media inherent with the same properties. Each level of media could engage an emotional response to create a physical release with a cognitive response and perhaps propel forward movement.

By gathering collateral material in the form of art-work, clinicians could have the information for further assistance with monitoring the SOC. Patterson, Wolf and Nochaski (2010) discussed some behavioral changes seen during the SOC,

- Precontemplation: Acknowledge problem; Increase awareness of negatives of problem; evaluate self-regulatory activities
- Contemplation: Make decision to act; Engage in preliminary action
- Preparation: Develop a change plan; Set goals and priorities to achieve change
- Action: Apply behavior change methods for average of 6 months; increase self-efficacy to perform the behavior change
- Maintenance: Maintain supportive contacts (p. 226)

Since the SOC is a difficult thing to accurately track, this writer is using an approximate level, given the research.

Once the client has successfully completed all four weeks of the 30-day treatment schedule, they will have become familiarized with 20 varieties of media. In subsequent weeks, the SOC will continue to be monitored through assessment instruments and the recovery principle is structured on the schedule. What is unique about the 60 and 90-day versions of this program, is that it then becomes an open studio regarding media, and the clients may work in successive days with the media of their choosing in order to achieve a sense of mastery. What
stays constant is the recovery principle as the theme specific to each of the 12 weeks. As Allen (1985) said,

Among my cherished beliefs are these: art-making requires involvement over time; patients ought to be as free as possible to choose materials and subject matter; and patients need time to get acquainted with art-making before they can be expected to take risks in imagery. (p. 10)

This proposed art therapy program is in line with the description of her beliefs. She went on to say the following about those in an in-patient SUD treatment facility, “Patients repeatedly reaffirmed that art has deep personal, emotional, and spiritual meanings” (Allen, 1985, p. 12). This is another testament to holism. A schedule of the proposed art therapy program is available further in this document.

Assessments

Using an assessment instrument for the SOC will help the art therapist understand where the client is in their treatment program, but it will not necessarily give them the most information for their art therapy treatment goals. Also, answering questions on an assessment may not be the best approach for an individual who might not be completely honest. The imagery itself may be honest for them. “We naturally have a tendency to project or transfer our beliefs, impressions, ideas, and feelings onto images we see” (Malchiodi, 2007, p. 8). This also holds true for images individuals create. Thus, this writer believes that a short assessment instrument to approximately place the client in the SOC will be one measure, in addition to a holistic based assessment instrument that will give risk and resiliency information in the five life task areas will be more helpful. That assessment is the Art Therapy Assessment for Risk and Resiliency by Lounsbury, Overcash & Comty-Charmock (2014). By asking clients to make images about each of the five
life tasks based on the same three prompts for each task, the art therapist will gain much more collateral material for treatment planning, areas where there might be lack of support, areas where there exists problem-solving capabilities, and areas where strengths are highlighted. The following prompts are,

1. Life Task: Work

   Create an image about, how you feel about work.

   Create an image about, what do you need?

   Create an image about, what is in your way?

   Please give it a title.

2. Life Task: Community

   Create an image about, how you feel about community.

   Create an image about, what do you need?

   Create an image about, what is in your way?

   Please give it a title.

3. Life Task: Relationships

   Create an image about, how you feel about relationships.

   Create an image about, what do you need?

   Create an image about, what is in your way?

   Please give it a title.

4. Life Task: Self

   Create an image about, how you feel about yourself.

   Create an image about, what do you need?

   Create an image about, what is in your way?
Please give it a title.

5. Life Task: Spirituality

Create an image about, how you feel about spirituality.
Create an image about, what do you need?
Create an image about, what is in your way?

Please give it a title. (Lounsbury et al., 2014)

Lounsbury et al. (2014) discussed the following as items for measure on a rating rubric; “For Risk: Dichotomous thinking; Evidence of stress; Disproportionate scaling; Impoverishment; and perseveration. For Resilience: Presence of articulated figure or subject matter; Clear composition and orientation; Integration; Spatial progression from left to right; Congruency of image and title” (n.p.). This assessment gives a holistic view of the client’s outlook on the five life tasks. Horay (2006) expanded, “Prochaska recommended implementation of consciousness raising, increased emotional arousal, reevaluation of the environment, and accurate assessment of one’s life pre- and post-change” (p. 16). With that idea, applying the same assessment prior to graduation from treatment could identify the client’s level of risk for relapse, and resiliency for long-term recovery including their after-care and beyond.

Dickman, Dunn, and Wolf (1996) initiated a study after art therapists, psychiatrists and counselors identified recurring themes, styles and symbols in drawings of patients with SUDs. After the study, they identified 11 items that would be predictors of relapse. Those items were as follows,

1. Stereotypical Drawing—an oversimplified drawing lacking originality and not including personal information about the patient
2. Presence of Psychoactive Substances/Paraphernalia of Use
3. Placement of Psychoactive Substances Near (within 4 inches) a Human Figure

4. Enlarged Scale of Psychoactive Substances—substances proportionally large, or covering 1/6 of the page

5. Lack of Self/Lack of Any Articulated Figure—lack of self-representation or lack of any figure or face articulation

6. Steps—stairs inaccessible or nonfunctional relative to the drawing

7. Spatial Progression Toward the Left (viewer’s left) Side of the Page—roads, footprints, or stairways progressing clearly toward the left

8. Dichotomous Thinking—representation of opposites, or picture divided into two halves

9. Presence of Water—body of water (not including rain or clouds)

10. Abstract or Geometric Drawing Style—picture is predominately (at least 66%) abstract

11. Despair/Helplessness—with no help present

While this writer agrees that most of the elements on the above list are indicators of potential risk, using abstract or a geometric drawing style with no articulate figure could also indicate a higher cognitive functioning and greater artistic ability. Including water could also indicate a connection with the calming and soothing properties of water, not only an indication of a liquid escape.

**Target Population**

The population targeted for this program is anyone on a journey of recovery from an SUD who is physically able to manipulate art mediums, and who is cognitively able to process
the art-making with a therapist. This could include adolescents, young adults, and mature adults currently receiving services at an in-patient or out-patient SUD treatment facility.

Assumptions and Limitations

Being a person in recovery, an artist, and art therapy student, this writer is making a biased assumption that art therapy does have a positive effect on individuals in long-term recovery. A personal, daily art journal has been this writer’s on-going practice as a conscious contact with God. In those moments of art-making, there have been profound discoveries of solutions, enlightenment, and increased self-awareness. Instead of going to a drink for solution, this writer is able to sublimate those feelings through art-making.

This writer also has a positive bias toward art therapy’s success because of the last six years working with the SUD population in a teaching artist capacity, and then transferring to an art therapy process in the last two and a half years. In those years of creating art side by side with adolescents and adults, this writer has witnessed emotionally cathartic experiences and heard reports from clients about profound epiphanies as a direct result of the art-making experience.

Art Therapy directives are asking the clients to make images which by their very nature are projecting their lifestyle, strivings, and mistaken beliefs. For that reason, it may cause some distress as individuals are spontaneously exposing powerful thoughts and feelings. As Malchioti (2007) said, “While art can externalize conflicts, powerful feelings, and painful experiences, it does not automatically transform them. Modifying behavior, emotional responses, and life circumstances is often harder than transforming images in drawings and paintings” she also said, “Art therapy is not a ‘magic bullet.’ Like any process for change, it requires time, an intention to change, and active participation” (p. 62). Like any therapeutic modality used for change, it takes work and not all individuals in SUD treatment have a desire to put effort into their recovery.
Another element of limitation in art therapy is a possible aversion to materials. The sound materials make, the smell of certain materials, and the sight of intense colors may adversely affect clients. Chalk is a medium that is avoided by some because of the dry nature of the material. “Work with clay, plasticene, glue, or other tacky substances can evoke disgust and attention to other negative affective states” (Hinz, 2009, p. 67). Tactile stimulation is not always soothing.

Not every treatment facility will have the space for a full art therapy studio. In these cases, this writer suggests that a closet be converted as storage for supplies and perhaps a cafeteria or larger group room becomes the make-shift studio for art therapy sessions. This writer has been working with treatment centers facilitating groups by using a double-decker tool box on wheels and a large portfolio with shoulder straps. It serves the purpose for travel and use where no studio available.

With respect to the SOC, measurement of the five stages has presented challenges. According to DiClemente et al. (2004), “However, the bad news is that no consistent, single measure of stage status has been used with even one addictive behavior like smoking cessation, let alone across all addictive behaviors” (p. 106). Where the SOC themselves are useful, being able to accurately place which stage a client is in, proves less likely.

Conclusion and Recommendations

Conclusion

Referring back to this writer's original question would correlating the SOC, ETC, and 12-step recovery principles help a client gain insight and thus invest deeper in their recovery program? To answer that question, this writer would say yes. By correlating the above three variables, a client in an SUD treatment center would have the opportunity to ameliorate their
situation, and sublimate their intense and negative feelings into the art-making process. They would move through the levels of the ETC from Kinesthetic/Sensory to Cognitive/Symbolic and gain coping skills for self-efficacy.

Art therapy is not new, and has been a viable compliment to integrate with SUD treatment programs for decades, at least since 1985 when Allen wrote about her experience. What was not available in database searches was published research on the connection between those three variables. This writer believes that further research could support a positive cause and effect for individuals in SUD treatment.

Recommendations

This writer’s recommendation is an application of this comprehensive art therapy program into required in-patient or out-patient SUD programming in order to improve the clients’ level of investment into their recovery process as a whole. This writer also recommends that clients are referred to an art therapist for individual services once leaving the treatment center, and also are given references to art therapy group studios as part of their after-care, and long-term recovery support.

Further research into the correlation of the SOC, ETC, and 12-step recovery principles could reveal a positive cause and effect. The recovery community could benefit from a clinical trial that measures the difference between clients who integrate this art therapy model with their regular treatment program, and clients who did not receive art therapy as part of their regular treatment program. Applying this art therapy concept to further research, clinical trials, considering a variety of populations, and developing a standard of measure, could possibly be implications for an evidence based practice. This writer believes further research into the correlation of these three variables could be a great doctoral topic for study.
References


APPENDIX A

Description of Art Therapy Program Model

Would correlating the Stages of Change (SOC), Expressive Therapies Continuum (ETC), and 12-step recovery principles help a client gain insight and thus invest deeper in their Substance Use Disorder (SUD) recovery program? Research shows that for decades art therapy has been an accepted complimentary therapy to treatment center approaches for Substance Use Disorders (SUDs). This writer is specifically making a correlation between the SOC, ETC, and 12-step recovery principles.

The following is the art therapy program model schedule which would complement typical 30-day, 60-day, or 90-day treatment plan programs. This program model utilizes a blend of the Expressive Therapies Continuum and the Stages of Change, while keeping the 12-step recovery principles as a constant.
# APPENDIX B

Art Therapy Treatment Program Model Schedule

<table>
<thead>
<tr>
<th>Week</th>
<th>SOC</th>
<th>ETC Level</th>
<th>Recovery Principle</th>
<th>Media Choices</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Precontemplation</td>
<td>Kinesthetic/ Sensory</td>
<td>Honesty</td>
<td>watercolor on wet paper</td>
</tr>
<tr>
<td></td>
<td>Contemplation</td>
<td>Perceptual/ Affective</td>
<td></td>
<td>Finger Paint on Finger Paint paper</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Water-based Paint on Dry Paper</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Chalk Pastel</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Soft Water-based Clay</td>
</tr>
<tr>
<td>2</td>
<td>Precontemplation</td>
<td>Kinesthetic/ Sensory</td>
<td>Hope</td>
<td>Oil Pastels</td>
</tr>
<tr>
<td></td>
<td>Contemplation</td>
<td>Perceptual/ Affective</td>
<td></td>
<td>Charcoal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cognitive/S Symbolic</td>
<td>Markers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Large Graphite Sticks</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Collage</td>
</tr>
<tr>
<td>3</td>
<td>Precontemplation</td>
<td>Kinesthetic/ Sensory</td>
<td>Faith</td>
<td>Colored Pencils / Drawing Pencils</td>
</tr>
<tr>
<td></td>
<td>Contemplation</td>
<td>Perceptual/ Affective</td>
<td></td>
<td>Plasticine / Model Magic</td>
</tr>
<tr>
<td></td>
<td>Preparation</td>
<td>Cognitive/S Symbolic</td>
<td></td>
<td>Wood Sculpture</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fabric / Felt Soft Sculpture</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mask Making</td>
</tr>
<tr>
<td>4</td>
<td>Contemplation</td>
<td>Perceptual/ Affective</td>
<td>Courage</td>
<td>Wire sculpture</td>
</tr>
<tr>
<td></td>
<td>Preparation</td>
<td>Cognitive/S Symbolic</td>
<td></td>
<td>Mosaics</td>
</tr>
<tr>
<td></td>
<td>Action</td>
<td></td>
<td></td>
<td>Book-making</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Metal Relief Sculpture</td>
</tr>
<tr>
<td></td>
<td>P/C/P/A</td>
<td>Potentially All Levels</td>
<td></td>
<td>Open Studio with Intention</td>
</tr>
<tr>
<td>---</td>
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<td>-----------------------</td>
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<td>---------------------------</td>
</tr>
<tr>
<td>5</td>
<td>P/C/P/A</td>
<td>Integrity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>P/C/P/A</td>
<td>Willingness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>P/C/P/A</td>
<td>Humility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>P/C/P/A</td>
<td>Compassion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>P/C/P/A</td>
<td>Justice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>P/C/P/A</td>
<td>Perseverance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>P/C/P/A</td>
<td>Spiritual Awareness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>P/C/P/A</td>
<td>Service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

After-care and long-term recovery = Continued work with an Art Therapist or independent work at a community art studio doing open studio with intention.