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Expanding the Theoretical Lenses of Addiction Treatment

Through Art Therapy Practice

by

Lily Braverman

A research paper presented to the

Faculty of the Department of
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Signature Page

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Dedication

This paper is dedicated to the four clients whose openness and authentic experiences in treatment formed its basis. I have been humbled, moved, joyful, and saddened in my various moments with these individuals, and I have learned invaluable lessons through my work with them. If ever I doubted the power of art therapy, the moments I have been privileged to share with these courageous and genuine people wholly dissolved my skepticism.

Abstract

This research explores the connection and interaction between literature describing addiction theory and clinical art therapy practice. Literature spanning a wide variety of theoretical understandings of addiction and recovery was reviewed, as well as literature published on the use of art therapy with the substance abuse population. Using the review of the substance abuse literature as a base, key theoretical concepts were identified and formatted into a table that came to serve as a data coding system. Applying case study methodology, this coding system was then utilized as an analysis tool for the art therapy process and artwork of four clients in residential substance abuse treatment. Analysis of the data resulted in the emergence of five prominent themes amongst those listed in the coding system: 1) Intolerance of negative emotion 2) Problematic family dynamics 3) Traumatic experiences 4) Schemas and restructured cognitions and 5) Cultural issues. These findings were then examined in the context of the art therapy literature on substance abuse. The meanings derived from these findings make a case for greater integration between substance abuse literature and art therapy literature, illustrating the utility of clear and organized incorporation of theoretical ideas about addiction into art therapy with substance abuse clients.

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Introduction

The Study Topic

The objective of this research is to investigate how art therapy has been and is currently being used to treat substance abuse, highlighting the substance abuse theories that form the bases of these applications. This research demonstrates the potential of art therapy practice to interweave varied and sometimes conflicting understandings of addiction and recovery.

Significance of the Study

This work's relevance to clinical practice lies in its potential to guide art therapy practitioners into an understanding of theories of addiction and recovery that is both informed and fluid, and within which they can allow the artwork to shape their conceptions of the client's experience. Considering the widespread relevance of substance abuse in the mental health field, an expanded understanding of models of addiction and their relationship to art therapy practice is valuable to any art therapist. This research also helps identify strengths and shortcomings in the art therapy literature.

Background of the Study Topic

There are many differing theories and models that describe the nature of substance abuse, and many related approaches to treating it. The moral model, the disease model, spiritual models, behavioral models, psychoanalytic theory, family models, and integrative models all describe the condition of addiction differently, each with its own implications for treatment and recovery.

Published accounts of art therapy with substance abusers have most often situated the problem in one of two ways. The first, likely related to the psychoanalytic roots of many of art therapy's pioneers, relies heavily on psychodynamic concepts to understand and treat addiction. The second is the shaping of art therapy treatment as a deliberate complement to the 12-Step approach, likely related to the need for art therapists to work within the bounds of 12-Step-based substance abuse treatment programs. Still, other accounts of art therapy with addicted persons have different theoretical underpinnings, mixed theoretical influences, or lack reference to a model of addiction altogether.

Literature Review

This review of the literature begins with a discussion of terminology, and then outlines a variety of theoretical understandings of addiction and corresponding approaches to recovery as represented in scholarly articles from the substance abuse field. I highlight the relationship between theoretical understanding and proposed treatment by clustering articles that discuss interrelated theories and treatment approaches.

The second section of the review examines literature published within the art therapy field on work with substance abuse. I organize the art therapy literature by the same principle as the substance abuse literature, grouping based on theory of addiction and related treatment approaches. This process is imperfect with the art therapy literature on substance abuse, as many of the articles available do not seem to hold to a particular understanding of addiction.

Substance Abuse Literature

The substance abuse literature dealing with addiction theory and recovery approaches is too plentiful to review here in its entirety. I selected the literature reviewed in this paper not as a comprehensive picture of addiction literature, but for its diversity of ideas. Though not exhaustive of all models and treatment approaches, the articles I discuss represent both a variety of theoretical understandings of addiction and a variety of recommendations for treatment.

In this portion of the literature review I first address the definition of relevant terminology, discussing the literature that deals with the complexity of these definitions. I then move into a discussion of addiction and recovery models. Though some of these

concepts deal primarily with conceptualizing the condition of addiction and others deal primarily with treatment, most take integrated positions on the cause of addiction and the proposed treatment. Therefore, rather than sorting the literature into addiction theories and treatment approaches, this paper moves through ideas in a way that links treatment approach with underlying theory, simultaneously acknowledging the chronological development of addiction theory.

In organizing these clusters I acknowledge the chronology of ideas in the life of the substance abuse field by moving through the review's sections in an order that mirrors the field's evolution. In places where the flow of ideas does not correspond to chronology, this inconsistency is noted. Though I consider chronology in my analysis of the literature, most of the sources reviewed were published within the last two decades, and therefore discuss older ideas about addiction within the context of the field's current state. The exceptions to this rule are the inclusion of *Alcoholics Anonymous*, which I reference in its original form because its original text continues to be widely utilized, Jellinek's (1960) significant publication on the disease model of alcoholism, and some older literature on psychoanalytic theories of addiction relevant to the later exploration of art therapy literature.

Defining key terms. There is a lack of consensus about terminology in literature describing substance abuse. The sources reviewed use many key terms that describe overlapping concepts related to substance abuse and recovery, some originating in the addictions field, some in the wider mental health field, and others grounded in non-clinical recovery communities.

Defining addiction. The terms *addict* and *addiction* have no universally accepted meaning, but Morse (2004) defines them phenomenologically based on the felt experience of addiction as a persistent and intense craving to use psychoactive substances. Adding to this description, Margolis and Zweben (2011) explain addiction as the habitual consumption of alcohol and drugs in spite of increasingly problematic results. The authors suggest that the phrase "alcohol and other drug disorders," abbreviated AOD disorders, is synonymous with the term "addiction."

Within the 12-Step recovery community, "alcoholic" is used to describe AA members, while "addict" is used to describe members of NA and other substance-specific 12-Step programs. Alternative labels are not accepted within this community, which holds tightly to these terms.

Although the American Psychiatric Association (APA) has made recent changes to its terminology of choice, the Diagnostic and Statistical Manual of Mental Disorders (DSM) has consistently categorized substance use disorders according to the specific substance(s) of use. Within each substance category, the DSM-IV-TR allowed for diagnosis of dependence or abuse. The DSM-5, currently transitioning into use, does not differentiate between abuse and dependence, requiring instead a specifier of mild, moderate, or severe substance use disorder. The DSM-5 names the key feature of substance use disorders as "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems." The APA also describes these disorders as "alcohol and other drug (AOD) problems" in separate publications.

For the purposes of this paper, I use the terms "addiction," "substance abuse," and "substance use disorders," treating these as interchangeable descriptions of the same phenomenon. I do not use the term "alcoholism" outside of my discussion of Alcoholics Anonymous, though I implicitly include alcohol dependence under the umbrella of "addiction."

Defining recovery. (BFI Consensus Panel, 2007; White, 2007) The Betty Ford Institute Consensus Panel convened in 2007 to co-author a definition of *recovery*, aiming to create a measurable concept that would open the door for more research about how to support the recovery process. The consensus panel's published statement defines recovery as "a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship," emphasizing the position that recovery is more than simply abstaining from substances. Elaborating on this definition, the statement defines *sobriety* as "abstinence from alcohol and all other non-prescribed drugs," excepting tobacco. The published statement, attempting to quantify likelihood of relapse in relation to time frame of maintained sobriety, also defines *early sobriety* as sobriety lasting 1 to 12 months, *sustained sobriety* as sobriety lasting 1 to 5 years, and *stable sobriety* as sobriety lasting 5 years or more (BFI Consensus Panel, 2007).

Published alongside the BFI Consensus Panel's article defining recovery was White's (2007) discussion of the important factors in authoring such a definition, and his own working definition. White suggests that the definition of *recovery* should be specific to those who once met DSM-IV criteria for substance abuse or dependence. He also suggests that this term should be inclusive of many types of recovery experiences, and descriptive of the total relationship with psychoactive drugs rather than with one particular

substance. He suggests the use of modifying phrases as descriptors of recovery in cases where individuals moderate alcohol and drug problems without discontinuing use, become abstinent but continue to be functionally impaired, take prescription medications to aid in their recovery process, or become abstinent in a coerced circumstances.

White's proposed working definition of recovery demonstrates a broader perspective than that proposed by the BFI Consensus Panel, attempting to integrate into the term both family-level and community-level recovery processes (White, 2007). For the purposes of this paper, which examines the individual experience of addiction and recovery, the term *recovery* is defined in congruence with the definition provided by the Betty Ford Institute Consensus panel.

Implications of terminology. Many of the commonly used terms to describe persons dealing with or recovering from substance abuse carry a negative association, making stigma an issue of consideration in the discussion of terminology (BFI Consensus Panel, 2007). White (2007) asserts that it is precisely the "fuzziness" of the term *recovery* that allows it to carry such a stigma, and advocates for clarification of this key term's meaning. White (2007) cautions that the authoring of such a definition is in itself political, as whether or not person qualifies may have widespread ramifications in this individual's personal relationships, employment, legal standing, social status, and access to services.

White observed a challenge in the treatment of addiction that constituted a radical perspective at the time of publication. He noted that, though drug and alcohol problems have long been recognized by both the mental health field and the addictions field, the mental health field has focused on providing services to those in partial recovery (either

reduced substance use or continued functional impairment in spite of abstinence), while the addictions field has delegitimized the notion of partial recovery, focusing only on the recovery as a state of complete abstinence and continual character-building (White, 2007).

  Theories in discord. The parsing out of these different terms and their areas of use sets the tone for discussion of the different perspectives on the nature of substance abuse and recovery. Just as the distinct origins and implications of the terminology discussed reflect the state of the addiction treatment field, so do the origins and implications of the field's many models, theories, and treatment approaches.

  Shaffer (1986) describes the field of substance abuse treatment as "a field beset by problems of disciplinary identity and the absence of guiding paradigmatic principles." He takes a philosophy of science perspective in critiquing the reductionism of substance abuse theories, noting that reductionist theories refuse to acknowledge the subtle interplay between social context and individual personality in their understandings of substance abuse. Shaffer situates the addiction treatment field in an "identity crisis," which he attributes to its early developmental stage. Shaffer's perspective is that the lack of accepted paradigm in the addiction treatment field has led to a crisis of categories, in which new ideas form alongside one another rather than serving to validate or disprove their predecessors. Shaffer's critique of the state of the field comes alongside his proposal that substance abuse be examined in an integrated fashion, viewing the problem biologically, socially, psychodynamically, and behaviorally. It is worth noting that Shaffer was forward-thinking; the current state of the addiction treatment field mirrors the same dynamics he described in 1986.

Some of the specific controversies Shaffer (1986) cites are relevant to the literature that is reviewed in the following pages. Shaffer names disagreements about abstinence-based recovery, the effectiveness of psychotherapy without abstinence, and the morality of treating active drug users as fundamental points of contention within the field. With regards to the origin of addiction, he points out the drastic difference in focus and opinion of pharmacologists, psychologists, psychiatrists, physiologists, sociologists, politicians, and law enforcement officials.

Marlatt (1992) notes similar key arguments within the field in the introduction to his proposed comprehensive model. He identifies three central controversies that divide theories of substance abuse from one another: voluntary versus involuntary cause of substance abuse, ability of substance abusers to discontinue use independently as opposed to needing self-help or treatment, and understanding etiology versus focus on behavioral change in the treatment process. Keeping in mind the disputes outlined by both Shaffer (1986) and Marlatt as a starting point for exploration, this paper expands upon a variety of theories and models that offer distinct explanations of the phenomenon of addiction and recommend distinct methods of treatment.

The moral model. Morse (2004) describes the moral model as the position that addiction is a condition resulting from moral failure. The author contrasts the moral model with the disease model in an exploration of the responsibility of addicted persons for their problematic use patterns. Following from the basis of responsibility, Morse describes the moral model's stance that those who are addicted must simply assume blame and take moral responsibility for themselves in order to discontinue addictive behavior, making the notion of "treatment" a non-issue. Given the emphasis on personal

responsibility, Morse explains the influence of the moral model in criminal consequences for addiction. Similarly, Marlatt (1992) identifies the moral model as the cornerstone of the "War on Drugs." Morse's exploration of responsibility in the two models aims to contextualize decisions of legal responsibility and public policy dealing with drug abuse. Marlatt describes the problematic stance of blaming the victim inherent in the moral model, causing those with substance use disorders to be faulted for having them, held responsible for remedying them, and demonized when their efforts to do so are unsuccessful.

   The disease model. Though the disease model was popularized by Jellinek (1960) decades after the 12-Step model, it is presented first in order to highlight its contrast with the moral model. The previously discussed Morse (2004) article regarding personal responsibility in addiction discusses the disease model as a general conceptual framework for addiction, comparing it to the moral model. Citing studies that verify significant brain differences between addicted persons and non-addicted persons, Morse describes the disease model, also called the medical model, as the situation of addiction as a disorder from which behavioral symptoms arise. This definition is consistent with Jellinek's much earlier explanation of the "disease" of addiction as a concrete change in physiology that produces the phenomenon of craving.

   Morse emphasizes the implications this model has for personal responsibility, pointing out that the term "disease" itself suggests lack of responsibility for having the disorder of addiction and lack of responsibility for its behavioral symptoms. In contrast, Margolis and Zweben (2011) assert that addicted persons, while perhaps not responsible for their predisposition to becoming addicted, are indeed responsible for maintaining their

recovery through abstinence. Morse explains the treatment approach that grows from the

disease model as therapeutic and nonjudgmental, a drastically different tact than the

punishing perspective of the moral model. Marlatt (1992) commends the disease model

for breaking down blame, which enables many people to enter treatment without feeling

weak in their need for help. Conversely, he notes the reverse side of this coin, citing the

characterization of substance abusers as perpetually ill victims as disempowering.

  The 12-Step model. Significant in its widespread and longstanding success in

treating addiction outside of the clinical realm, the 12-Step approach arose in response to

the failure of psychoanalytic treatment to help alcoholics recover. Introduced with the

publication of Alcoholics Anonymous (1939), this approach presented a radical integrative

conceptualization of alcoholism in 1939. Alcoholics Anonymous (AA) situates

alcoholism as a condition that needs to be treated behaviorally, emotionally, and

spiritually.

  In 1939, Alcoholics Anonymous published the statement of a prominent medical

specialist, Dr. William Silkworth, who wrote that alcoholism as he had witnessed it in

many of his patients involved a physical allergy of certain persons to alcohol that

produced abnormal results upon ingestion (Alcoholics Anonymous, 1939).

  Though this concept encouraged the popularization of the disease model,

Alcoholics Anonymous (1939) stressed the additional characterization of alcoholism as a

spiritual malady that required a spiritual solution (Margolis & Zweben, 2011). Alcoholics

Anonymous describes alcoholism as the state of powerlessness over alcohol and inability

to manage one's life, and prescribes the 12 steps as a practical program of spiritual growth

grounded in cognitive and behavioral changes that promised to alleviate these conditions.

The 12 steps commence with acknowledgement of powerlessness and unmanageability in Step 1, then suggest the development of belief in and reliance upon a personal Higher Power in Steps 2 and 3, though they specify that this power may have any definition (Alcoholics Anonymous, 1939). Steps 4 through 9 assign active processes of examining, sharing, and making amends for one's history of problematic behavior, character defects, and interpersonal conflicts. Steps 10, 11, and 12 explain the daily self-reflective, spiritual, and service actions alcoholics should take to continually renew their reprieve from alcoholism (Alcoholics Anonymous, 1939).

Newer literature seeks to interpret the effectiveness of 12-Step programs through alternate lenses. Neff and MacMaster (2005) write about the social learning principles at work in 12-Step programs, noting that the interdependence required of 12-Step program members is an important piece of this approach to recovery. Bristow-Braitman (1995) asserts that involvement in the fellowship of 12-Step programs through meeting attendance and social networking provides an antidote for feelings of isolation that may have characterized active addiction and/or life prior to active addiction. She also proposes that altruistic mission of helping others recover and assisting in the operation of meetings provides a sense of purpose and self-esteem to those who previously had neither (Bristow-Braitman, 1995).

In an exploration of the intersection between the 12-Step approach to addiction treatment and psychotherapy, Humphreys (1993) evaluates the points of compatibility and points of discord between the two. He notes that some of the helping strategies of 12-Step programs can be effectively integrated into psychotherapy. Humphreys cites the group format, use of verbal contracts, confronting denial, abstinence as a prerequisite for insight,

and treating addiction as the primary rather than secondary problem as among these

compatible strategies. Humphreys asserts that it is the helping values of the 12-Step

approach that resist integration into psychotherapy. He names peer direction rather than

professional leadership, personal experience rather than professional knowledge, effacing

of ego rather than ego strengthening, spiritual focus rather than avoidance of spirituality,

and free rather than billed services as the central opposed values.

   Other spiritual models. Compatible with the 12-Step model, the Buddhist model

and existential model also conceptualize addiction as a spiritual condition that is rooted in

self-centeredness and absence of a sense of purpose in the lives of substance abusers

(Chen, 2010). This common base informs these models' common emphasis on a spiritual

solution to the condition (Alcoholics Anonymous, 1939; Chen, 2010).

   Chen (2010) examines the importance of suffering in the experience of addiction

and recovery and its relevance to Buddhism, existentialism, and 12-Step principles, while

Brewer (2014) discusses the Buddhist model of addiction in relation to Mindfulness

Training. Both Chen and Brewer frame addiction in the Buddhist model as an instance of

universal human suffering, a phenomenon created by attachment and the desire to fulfill

thirst for pleasure. Chen finds agreement in the existential model agrees, framing

suffering in a spiritual context and linking it to the meaning of life. Chen asserts that

suffering is linked inextricably to addiction, as both a cause of drug use and a motivator

for initiating recovery. She describes *primary suffering* as the psychic discomfort that

makes drug use appealing and initially effective, and *secondary suffering* as the

multidimensional collapse, also known as "hitting bottom" in addiction, that brings about

recovery. The *secondary suffering* that Chen identifies as a catalyst for change is

analogous to Step 1 in the 12-Step approach, in which admitting powerlessness and unmanageability opens the door to sobriety (Alcoholics Anonymous, 1939, Chen, 2010). Chen's explanation of suffering in the existential model also includes the attribution of positive meaning to suffering as a way to initiate self-change.

Brewer (2014) conducted a study that utilized the Buddhist model of addiction, evaluating the potential of Mindfulness Training (MT) as a treatment approach. Though Brewer focused particularly on the case of nicotine, a substance not considered under the umbrella of addictions selected for this paper, he also considered MT as a treatment for other addictions. Brewer cites the preliminary success of MT when integrated with cognitive-behavioral treatment approaches.

Brewer (2014) explains craving in the Buddhist model as a process involving body, affect, cognition, volition and consciousness. In this process, an environmental cue leads to a pleasant or unpleasant affective response, a response informed by associations from past experiences (Brewer, 2014). A craving emerges as a desire to either continue pleasant or stop unpleasant affect (Brewer, 2014). The behavior is reinforced by repetition, and creates an attachment to the experience (Brewer, 2014).   Finally, interruption of the experience or inability to return to it creates a feeling of despair (Brewer, 2014).

Brewer (2014) expands on the mechanism of this attachment to build a rationale for using mindfulness to interrupt this process. By practicing a heightened awareness of their affective experiences in MT, people increase their ability to observe their cravings without rushing to escape discomfort by acting on them (Brewer, 2014).

Behavioral and cognitive-behavioral models. Brewer's (2014) breakdown of the process of craving and attachment is situated within the Buddhist model, but bears striking resemblance to a behavioral breakdown of addiction formation. Through the lens of classical and operant conditioning, Brewer's description of addiction can be seen as a behavioral loop in which a person comes to associate using with both positive reinforcement (something enjoyable happening) and negative reinforcement (something unpleasant failing to happen). The enjoyable thing that happens might be a euphoric feeling, or the conviviality of social interaction. The unpleasant thing that is warded off might be overwhelming anxiety, loneliness, or the symptoms of physical withdrawal (Brewer, 2014).

Brewer's (2014) description of addiction formation as a cycle of behavioral reinforcement is analogous to the explanation of addiction as a matter of reinforced habit patterns provided by Rawson, Obert, McCann, and Marinelli-Casey (1993) in their description of the underlying theory behind early relapse prevention models. Rawson et al. (1993) discuss relapse prevention methodologies and their applications to substance abuse treatment, explaining the origin of these strategies as a welcome shift toward measurable and standardized substance abuse treatment that took hold in the 1980's.

Rawson et al. describe relapse prevention models as derivative of the principles of social learning theories and structured according to a cognitive-behavioral framework. They identify the following categories of relapse prevention strategies: psychoeducation, identification of high-risk situations and relapse warning signs, development of coping skills, development of new lifestyle behaviors, increase in self-efficacy, and dealing with relapse effectively. Keeping in mind these categories, the authors go on to describe the

three types of relapse prevention protocols. In each of these three categories, Rawson et al. explain various available models, each of which employs distinct combinations of the strategies listed above.

Though the theory of addiction held by the pioneers of relapse prevention do not incorporate spiritual and medical understandings of the condition, other relapse prevention models described by Rawson et al. (1993) encourage simultaneous participation in a 12-Step program. The authors' description of this willingness to incorporate alternate theoretical approaches suggests that relapse prevention as a model is less concerned with causality than with measurable results.

Intersections with behavioral principles. A significant body of literature focuses on the application of behavioral principles to various understandings of addiction and recovery. There may be differences in emphasis between the 12-Step approach and the cognitive-behavioral orientation of most treatment programs, some of the substance abuse literature attempts to bridge this gap by locating points of intersection between spiritual and behavioral treatment models in addiction recovery (Bristow-Braitman, 1995; Neff & MacMaster, 2005).

Neff and MacMaster (2005) locate behavioral principles at work in many popular addiction treatment approaches. Neff and MacMaster note the lack of empirical support for the phenomenon of spiritual transformation as a foundation of recovery. They prefer to explain the success of this phenomenon by analyzing it in terms of behavioral models. The authors go on to identify behavioral strategies in 12-Step recovery as well as other common treatment approaches, such as role modeling, social reinforcement, and social support as agents of change in many of these treatment approaches, particularly within the

12-Step subculture. They specifically identify attending meetings, finding a sponsor,

working the steps, and reading the "Big Book" as cognitive and behavioral tools that play

a key role in 12-Step recovery. With regards to other spiritual approaches, Neff and

MacMaster reframe radical personal transformation as behavioral adaptations.

Bristow-Braitman (1995) examines various aspects of the 12-Step model, drawing

parallels between each of these and their related counterparts in cognitive-behavioral

psychology. Though she acknowledges that spirituality is an integral part of the 12-Step

approach, she notes that it is defined in open terms and is oriented behaviorally,

emphasizing altruism and interpersonal relationships. The concept of "spiritual

awakening" in Alcoholics Anonymous is also discussed as a "psychic change," a shift in

thoughts, feelings and actions that removes from an alcoholic the obsession to drink

(Alcoholics Anonymous, 1939; Bristow-Braitman, 1995). The requirement of admitting

powerlessness over alcohol or drugs seems to be incongruent with academic approaches,

in which self-efficacy is the cornerstone of resiliency against relapse. Bristow-Braitman

offers an alternate framing of this admission, classifying the interdependence of the

recovering addict on others (and perhaps a Higher Power) as an effective coping strategy

in the face of triggers. She also discusses 12-Step themes of personal responsibility,

affirmations, ritual, forgiveness, and fellowship, highlighting aspects of each that are

conceptually compatible with cognitive-behavioral concepts (Bristow-Braitman, 1995).

While the previously discussed authors have highlighted some of the applications

of behavioral concepts to the 12-Step approach, the literature also houses an instance of

the application of 12-Step practices to a cognitive-behavioral treatment approach. In their

presentation of many different relapse prevention approaches, Rawson et al. (1993)

describe one protocol that seems interested in finding use for some of the behaviorally significant pieces of 12-Step programs, though it does so without association to the 12-Step approach. The authors explain McAuliffe's Recovery Training and Self-Help Model as a combination of professionally facilitated group sessions and peer-run program components. Regular self-help group sessions provide a sense of community support, recreational activities encourage participants to incorporate new non-using behaviors, and the "senior network," a system of mentoring, seems to mirror 12-Step sponsorship (Rawson et al., 1993). These particular applications of social learning theory to the program structure echo some of the behavioral elements Neff and MacMaster (2005) identify as operational in the success of 12-Step programs.

Brewer's (2014) previously detailed explanation of addiction formation in the Buddhist model might also fit in this section, as the author seems to merge behavioral principles with Buddhist ideas in his description of this process.

Neurobiological process. Everitt and Robbins (2005) echo Brewer's (2004) explanation of drug habit formation, combining it with a detailed neurobiological framework for understanding how the habit is developed and maintained, highlighting the brain structures involved in this process. Everitt and Robbins focus their explanation of drug addiction on systems of reinforcement. They emphasizing the points where voluntary drug-taking shifts to habitual drug-taking, and where habitual drug-taking shifts to compulsive drug-taking, asserting that these shifts correspond to a structural and/or chemical change in the brain. The authors suggest that neuroplasticity of the cortical and striatal structures may relate to these neural shifts.

Psychodynamic theories. In their article on psychoanalytic theories of addiction, Matusow and Rosenblum (2013) question the extent to which these theories have a place in the contemporary addiction treatment world. Outlining the history of the psychoanalytic understanding of addiction, the authors explain its early linkage to sexual conflicts in the work of founding theorists. Matusow and Rosenblum describe the early psychoanalytic comparison of the ingestion of substances to simulated sexual acts, providing simulated sexual gratification. Though the authors describe this thinking as antiquated and lacking empirical support, they acknowledge the significance of early theorists' understanding of the physiological component of addiction.

 Morgenstern and Leeds (1993) review the uses and limits of several psychoanalytic understandings of the pathology of addiction that were born in the next era of psychoanalytic thought: neurotic conflict, self deficit, impaired object relations, and psychosomatic disturbance.

Wurmser's (1984) neurotic conflict model situates addiction, in the classic psychoanalytic understanding, as a symptom of underlying conflict within persons who deeply doubt their own value and ability to meet the expectations of others. Wurmser characterizes substance use as a temporary mutiny against the superego, which reflects the addicted person's overall inability to accept limitations. Wurmser describes the felt experience of this conflict as overwhelming negative affect, from which substance intoxication offers a welcome reprieve. The author describes a process by which substance use creates an artificial ego-ideal, providing versions of strength and well-being that deliver a sense of self-satisfaction. This method of functioning is described as regressive because of its similarity to magical or hallucinatory thinking. Wurmser

explains addiction as the result of trauma, and proposes psychoanalysis as a treatment, with emphasis on a warm and empathic therapeutic presence rather than a challenging one to avoid replicating the client's struggle with superego.

Rather than situating addiction as a matter of internal conflict, Khantzian (1980) situates addiction as a deficit of self. The author suggests that substance abusers select drugs that provide a synthesized version of a self-regulatory force they inherently lack, presenting substance abuse as a desperate attempt at self-care rather than a pathological behavior. Khantzian explains the origin of addiction as either a deficient nurturing or excessive attention and coddling in early childhood, and proposes a signature model of group psychotherapy as the optimal treatment.

Krystal's (1982) model of substance abuse seems to touch on both of the aforementioned ideas, identifying problems in two key areas: affect and object relations. Within the first category, Krystal notes the inability on the part of many addicted persons to recognize their emotions, making it impossible for them to interpret these feelings in a meaningful way or understand their own needs. Further, Krystal extends affect disturbance to include poor tolerance of both positive and negative affect, making substances an appealing tool for regulation of affect.

Though Krystal (1982) presents a thorough examination of affect difficulties in substance abusers, he describes disturbed object relations as the primary cause of substance abuse. Imbalance in the dynamics of early relationships influence the structuring of the self, making intimate relations into idealized figures who will inevitably disappoint, and rendering autonomy impossible. Krystal focuses on infantile trauma as the root cause of both the ambivalent object relations and the affect problems that

characterize the psyche of addicted persons. With regards to treatment, Krystal proposes

psychoeducation on identification of affect, followed by team treatment in a program

setting to dilute the effect of transference. Krystal characterizes substance abuse as

severely pathological compared to the authors of the aforementioned psychodynamic

models.

McDougall (1989) classifies addiction as a psychosomatic illness, identifying

addictive behaviors as externalized expressions of affect. She presents the common thread

between these types of conditions as the inability to contain and process affect

appropriately. McDougall emphasizes the same affect problems discussed by Krystal, but

she views these problems as means of avoiding inner turmoil rather than a legitimate

deficit, and connects this defense strategy to the formation of a false self. McDougall, like

others mentioned, argues that a disturbed mother-infant relationship is the cause of

addictions, specifically when it is one that denies the child's individual and separate

emotional experience.

Morgenstern and Leeds (1993) note the diversity of these psychoanalytic models

of addiction, suggesting that the weakness of the psychodynamic perspective on substance

abuse may be its tendency to ignore the multidimensional nature of substance use

disorders. In spite of the variety of perspectives they present, Morgenstern and Leeds

point out several themes that dominate psychoanalytic understandings of substance abuse.

These themes include problems with affect tolerance, externalization of internal problems,

and the intrapersonal and interpersonal dynamics of substance abusers.

Matusow and Rosenblum (2013) note the challenge in integrating the etiology-

based psychoanalytic theories into the measurable results-oriented space that constitutes

the contemporary substance abuse treatment field. Exploring addiction from an object relations perspective, the authors discuss the therapeutic alliance in the context of transference and countertransference. Matusow and Rosenblum point out that, in spite of the diminished relevance of some psychoanalytic ideas about addiction, emphasis on the quality of the therapeutic relationship remains a strong factor in the success of treatment.

Emotion-based models. Emotion plays a key role in many concepts relevant to the understanding of substance abuse. Quirk (2001) describes the specific ways that emotion is involved in different theoretical models. In the behavioral model, he highlights emotional experiences as either positive or negative reinforcement for substance use. In the psychodynamic model, he identifies emotion as a factor in the intrapsychic effects of substances. In affect-based and personality models of addiction, he names emotion as the central concept. Ultimately he proposes an emotion-based integrative model, suggesting that emotion may be an organizing principle around which many discordant models of addiction can rally.

Chen's (2010) exploration of suffering in the experience of addiction and recovery discusses negative affect as a motivator for substance use. Chen introduces the concept of *primary suffering* to describe the anxiety, anger, pain, and other negative emotional states that motivate a person to escape through use of substances. Chen asserts that substances are used as a self-prescribed medication to relieve these discomforts, and come to be relied upon by the user as a means of coping with emotional life (Chen, 2010). This explanation of motivation to use substances forms the basis of affect-based models of substance abuse.

Two studies reviewed evaluate the relationship between negative affect and substance use. The first, conducted by Dermody, Cheong and Manuck (2013), examined

the stress-negative affect model as an explanation for alcohol use. The authors describe

the stress-negative affect model as the notion that alcohol is consumed in an effort to

reduce the negative affect brought on by stressors. With the aim of clarifying inconsistent

results from previous studies of this model, the authors utilized self-report measures to

analyze the relationship between negative life events, negative affect, coping strategies

and alcohol use in adults and college students. The results of their study suggest that

adults may drink to alleviate stress-related negative affect, but emphasized the importance

of personal coping style, specific affect considered, and developmental stage.

Specifically, the study found that adult participants may drink to relieve feelings of

sadness and guilt. The study did not find stress to be a significant factor in alcohol

consumption for college students.

The second study, conducted by Measelle, Stice and Springer (2006) successfully

linked trait-based negative emotionality to increased risk of initiating substance abuse in

adolescent girls, and established that perceived social support did not effectively

counteract this factor. Though not the intention of the research design, the authors note

that the results of their study seem to support theories that tie personality traits to

development of substance abuse, specifically the trait of negative affective temperament.

Personality models. In his discussion of personality-based models of addiction,

Quirk (2001) mentions the popular notion of the "addictive personality," stating that while

research has not supported a specific personality type as a precursor to substance abuse,

specific personality traits have been successfully linked to development of substance use

disorders. He cites studies that find correlation between substance abuse and high levels

of emotionality and impulsivity, as well as between substance abuse and low levels of agreeableness and conscientiousness.

Littlefield, Vergés, Wood and Sher (2012) present related findings from their study of the relationship between personality and alcohol use. Littlefield et al. evaluate both personality as a predictor of change in alcohol use patterns and alcohol use as a predictor of change in personality traits. Results of their study indicate a significant correlation between personality and increased alcohol consumption, though the authors caution that consideration of timeframe and developmental stage are crucial to understanding the relationship between these variables.

Family models. Saatcioglu, Erim, and Cakmak (2006) present substance abuse as a family disease requiring family treatment. Utilizing the framework of systems theory, the authors discuss boundaries and subsystems in families with an alcoholic or addicted member, proposing that the addicted person is merely the visible manifestation of family dysfunction. They review literature describing such families, dividing it into descriptions of families with an alcoholic member and descriptions of families with a drug-abusing member.

In their discussion of alcoholic families, Saatcioglu et al. explain that alcohol becomes the organizing principle of the alcoholic family's development, and that the sobriety status of the alcoholic member dictates family functioning. Family crises become a cause of further drinking, and conflict between members is often mediated by alcohol. The authors offer specific characterizations of families with an alcoholic father, noting struggles for dominance, shirking of responsibility, and high incidence of negative interactions as patterns in these parental relationships. Saatcioglu et al. discuss the

additional stresses of stigmatization when the mother is the alcoholic parent, and describe both communication challenges and identity and role confusion as common characteristics of the children of alcoholic families.

Saatcioglu et al. (2006) describe substance abuse in the family system primarily in the situation where the child is the substance abuser, noting patterns of dysfunction in the parental relationship. The authors also describe a typical relationship pattern for female substance abusers in which use is initiated in the company of a male substance abuser, situating the couples' using behavior as a replacement for sexual interest. The authors conclude that many of the family dynamics seen in alcoholic families are also present in substance abusing families, leading them to suggest that family treatment modalities that are effective with alcoholic families might also be used effectively with addicts' families.

Adding another dimension to the issues raised by Saatcioglu et al. (2006), Rowe (2012) discusses the reciprocal nature of the relationship between family dysfunction and substance abuse, providing a rationale for the use of family therapy as a treatment for substance use disorders. Rowe names family factors that predict substance abuse, such as parent mental illness, relational conflict or distance, and lack of parenting skills. She also discusses the impact of substance use on the family system, pointing to the high rate of child removal from addicted mothers and the frequency of intimate partner violence in families with substance abusing parents.

Rowe (2012) notes that family members may provide the most powerful motivation for a substance abuser to discontinue use, and names family support as a key factor in predicting treatment completion and continued recovery. If unaddressed, family-related stressors can provoke relapse (Rowe, 2012; Tuten, Jones, Schaeffer & Stitzer,

2012). Furthermore, Rowe proposes that family members require their own supportive services to deal effectively with the using family members as well as address their own needs in the family.

Rowe (2012) reviews significant recent research in family-based treatment approaches. She notes the promise of specific models such as Multidimensional Family Therapy, Multisystemic Therapy, Ecologically Based Family Therapy, Functional Family Therapy, Brief Strategic Family Therapy, Integrated Family Cognitive Behavioral Therapy, Behavioral Couples Therapy, and Behavioral Family Counseling. She points to multiple systems-oriented approaches as the most effective family treatment model for adolescent substance abusers, and behavioral models as the most effective for adults.

Tuten, Jones, Schaeffer and Stitzer (2012) also examine the role of family members in substance abuse treatment, looking specifically at family participation in Reinforcement-Based Treatment (RBT), an individual substance abuse treatment model involving collateral work with the client's significant other. Tuten et al. give attention to the couples relationship as it relates to substance abuse, noting that significant others may unwittingly (or intentionally) reinforce using behavior in their partners. Thus, they propose RBT as a means of shifting the reinforcement offered by the partner so that it supports the client's treatment goals. The authors include positive communication strategies, goal-setting, partner drug monitoring, the appointment of a "family sponsor," and family reconnection as important aspects of family treatment in this model. They also discuss situations in which significant others or families are unsupportive of recovery due to their own drug or alcohol use patterns, proposing that clients in these situations locate other close relationships which can support their recovery in a similar capacity.

The Transtheoretical Model. The Transtheoretical Model (TTM), a general

model created to describe the process behavior change, is featured in a significant section

of the literature on substance abuse, with emphasis on the stages of change dimension

(DiClemente, 1999; Lam, Hilburger, Kornbleuth, & Jenkins, 1996; Marlatt, 1992;

Migneault, Adams, & Read, 2005). The stages of change serve as a framework for the

understanding the process an individual moves through when considering a behavior

change, such as discontinuing substance use.   The first stage, *precontemplation*, applies to

individuals who are not considering making a change in the targeted behavior within the

foreseeable future. *Contemplation* is a stage of considering change within the next 6

months, and *preparation* is the stage in which individuals are preparing to make the

change within the next month. The *action* stage is the first 6 months after the change is

made, and *maintenance* is the time period after that (DiClemente, 1999; Lam, Hilburger,

Kornbleuth, & Jenkins, 1996; Marlatt, 1992; Migneault, Adams, & Read, 2005). Marlatt

(1992) provides the addition of the *relapse* stage as a period in which individuals slip back

into using behavior, either temporarily or permanently.

Migneault, Adams, and Read (2005) discuss the challenges of measuring stage of

change, noting inconsistent results in studies attempting to identify the stage of change of

persons with substance use disorders. The authors also evaluate the applications of other

dimensions of the TTM to substance abuse, using the categories of process, decisional

balance, and self-efficacy to define treatment goals in their own theoretical language.

DiClemente (1999) situates the stages of change within his exploration of how

motivation to change affects the recovery process. Alongside the TTM's stages of change

concept, he compares intrinsic to extrinsic motivation, imposed change to intentional

change, and readiness for change to readiness for treatment. DiClemente emphasizes the

importance of conceptualizing treatment with consideration of these dimensions of client

motivation, and cautions against assuming that individuals who present in treatment are

motivated.

DiClemente's emphasis on the practice of treatment matching is not unique in the

literature. A study conducted by Giovazolias and Davis (2005) utilized questionnaires to

establish the relationship between motivational stage and preference of therapeutic

interventions. The authors found that, irrespective of gender and prior treatment

experience, participants in early stages of motivation preferred non action-oriented

interventions, while those in later stages of motivation preferred action-oriented

interventions. They note that for those in early motivational stages, empathic attitude

emerged as the most desirable feature in the therapeutic space, and interventions that

aimed to raise conscious and encourage self-evaluation were most successful. In contrast,

the study reflected that those in later motivational stages responded best to behavioral

interventions such as counter-conditioning, stimulus control, and contingency

management.

Lam, Hilburger, Kornbleuth, and Jenkins (1996) also stress the importance of

congruence between individual stage of change and treatment approach. The authors

propose a model for treatment matching, recommending specific types of interventions

and strategies for clients in each stage. For those in *precontemplation*, the authors

recommend interventions that address treatment goals of consciousness raising, dramatic

relief, and environmental reevaluation. In *contemplation*, they suggest that clinicians

utilize psychoeducation and techniques. They advise focus on coping skills and stress

management during the *action* stage, and emphasis on relapse prevention in the *maintenance* stage. The authors conclude that, while these recommendations are in need of more empirical support, clinicians provide optimal services when they are cognizant of clients' stage of change during treatment planning.

   Harm reduction framework. The literature describes the harm reduction framework as a guideline for work with individuals without the volition or ability to discontinue substance use. Tatarsky and Marlatt (2010) note the importance of harm reduction in serving a population that is otherwise untreated, and outline ways that the harm reduction philosophy can be utilized to improve quality of life for these clients. The authors identify the human rights orientation of this framework, emphasizing its aim of aiding marginalized populations. They identify naltrexone and opiate substitution programs and needle exchange programs as the most prevalent examples of harm reduction strategies, noting the effect these programs have on the incidence of overdose and the spread of HIV, respectively.

   Tatarsky and Marlatt go on to explain the application of harm reduction principles to psychotherapy, characterizing this approach as flexible, inclusive, and mindful of individuality. The authors outline the clinical principles of harm reduction psychotherapy, noting that they constitute a departure from earlier addiction treatment principles.   The principles they identify emphasize the following qualities in clinical practice: treatment of the client as an individual, consideration of context, challenging stigmatization, supporting strengths, depathologizing drug use, and prioritizing treatment engagement and therapeutic relationship over all else.

The biopsychosocial model and other integrative theories. Multiple authors describe comprehensive models that attempt to integrate many different theories. Piazza and Deroche-Gamonet (2013) propose a general theory of transition to addiction intended to synthesize knowledge from different theories. The authors assert that addiction formation occurs as the result of interplay between individual predisposition and use patterns, and separate the process into three steps. They describe the first step, recreational use, in behavioral and neurobiological terms. They propose that operant conditioning causes the user to classify the substance as a rewarding stimulus, a process facilitated by excessive neurotransmitter activity. The authors explain the second step, when use escalates and becomes regular, in neurobiological terms, identifying neurological abnormalities that predispose certain persons to reach this stage. Piazza and Deroche-Gamonet describe the final stage, fully formed addiction, as a loss-of-control state caused by crystallized brain changes and brought on by continued drug use. The authors focus on behavioral and neurobiological processes and limit their theory to the initial formation of addiction, making it less comprehensive than other proposed integrative theories.

Marlatt (1992) takes a broader view, describing the integrative biopsychosocial model of addiction as a combined consideration of biological, psychological, and sociocultural factors. He describes the interplay between genetics and environmental factors in addiction formation, also mentioning the biological relevance of drug pharmacology, use-related physical disorders, and physical withdrawal symptoms. In the psychological dimension, the author asserts that the development and course of substance abuse relates to personal beliefs and expectations about drug and alcohol use,

coping skills, and motivation. He also references personality traits that correlate with the development of substance use disorders, in accordance with Quirk (2001) and Measelle, Stice and Springer (2006). Marlatt cites social factors of peer influence and family dynamics in substance abuse, noting many of the same family situations mentioned by Rowe (2012) as predictors of substance use disorders. He also explores larger cultural reliance on alcohol, tobacco and prescription medications for immediate gratification and relief, and media representation of substance use.

Marlatt (2012) presents a comprehensive review of treatment options, starting with macro-level prevention strategies, moving into stages of change, motivation for change, spontaneous remission, and self-help groups, and ending in professional treatment settings and modalities. His discussion of these topics concludes with his recommendation of treatment matching, a practice which assesses the preferences, beliefs and situation of each individual presenting with substance abuse to determine the best treatment approach for this individual.

Margolis and Zweben (2011) present a similar integrated understanding of addiction, naming it a "biobehavioral disorder," which they define as a combination of the disease model, learning theory models, psychoanalytic theory, and family models into a synthesized biopsychosocial model. Asserting that addiction results from a combination of biological predisposition and environmental factors, Margolis and Zweben (2011) cite studies examining the biological component of predisposition to developing addictions.

Incorporating the neurobiology of addiction, Margolis & Zweben (2011) explain the concept of *neuroadaptation*, the process by which those who begin habitual substance use modify the structures of their brains in such a way they ensure a continuous urge to

keep using. The authors' explanation of this primary mechanism of addiction echoes descriptions provided by Everitt and Robbins (2005), and Piazza and Deroche-Gamonet (2013). Related to this process is their presentation of research on relapse, which suggests that the permanent brain changes caused by habitual substance use are the reason that individuals with significant periods of recovery return to using. In keeping with the disease model, Margolis and Zweben assert that once an individual has crossed the threshold of addiction, it is extremely unlikely that this person will return to previous patterns of use. Operating from this basis, Margolis and Zweben identify the first goal in the treatment of addiction as complete abstinence from alcohol and drugs.

In their discussion of the biopsychosocial model, Margolis and Zweben (2011) seek to correct two widely spread notions about addiction that they assert have been proven inaccurate. The first of these is the differentiation between physical and psychological addiction, which the authors debunk as an outdated distinction. The second is the use-to-addiction continuum, which the authors deem unhelpful because of its implication that an individual can move freely between use, abuse, and addiction.

Kovac (2013) discusses the problem of addiction in terms of macro-level systems, behavioral science, predispositions, neurobiology, and underlying processes, and posits that the various interactions between these systems mandates the treatment of addicted persons as individual cases. He suggests that, while many models focus on singular mechanisms within the addictive process, these mechanisms are not mutually exclusive and should inform one another. This multiplicity is what makes addiction equally challenging and complex for both clinician and addicted person (Kovac, 2013). Kovac's multi-sourced model of addiction sees no factor as primary, and suggests that inclusively

mapping the interactions of all of them may lead to a greater understanding of the inconsistencies in addiction treatment outcomes.

Art Therapy Literature

Much of the literature that deals specifically with the use of art therapy with addicted persons seems to perceive this population within older non-integrative theoretical frameworks. Published accounts of art therapy with substance abusers have most often situated the problem in one of two ways. The first, likely related to the psychoanalytic roots of many of art therapy's pioneers, relies heavily on psychodynamic concepts to understand and treat addiction. The second is the shaping of art therapy treatment as a deliberate complement to the 12-Step approach, likely related to the need for art therapists to work within the bounds of substance abuse treatment programs. Still, other accounts of art therapy with addicted persons have different theoretical underpinnings, mixed theoretical influences, or lack reference to a model of addiction altogether. Notably absent from the art therapy literature are articles naming adherence to the moral model, the harm-reduction model and the neurobiological model. Cognitive and behavioral understandings of addiction, frequently discussed in the substance abuse literature, are much less prominent in the art therapy literature, appearing only in the literature on combined or integrative approaches.

In this section of the literature review I outline the art therapy literature published on work with addicted persons. I group the literature according to the theoretical model of addiction utilized in the work, acknowledging instances where multiple models are utilized as well as instances where no model is mentioned. Considering the dearth of literature on art therapy with this population, I include articles dating back to art therapy's

inception. I attempt to acknowledge the link between publication date and the chronology of addiction theory in my discussion. I also highlight differences in treatment setting and structure, acknowledging the relationship these may have to the theoretical model of addiction utilized in the work.

In my efforts to organize the art therapy literature according to the theoretical model of addiction underlying the work presented, I found that it was quite difficult in some cases to ascertain the model being utilized. In cases where I perceived a heavy reliance on certain ideas about addiction within the writing, I chose the placement that matched these ideas even if no model was named explicitly. In other instances, I could make no clear connection to any specific model of addiction or combination thereof. I grouped these cases into a section outlining literature that fails to identify a theoretical model of addiction.

Psychodynamic concepts. Much of the art therapy literature on substance abuse treatment applies psychodynamic concepts in the treatment of substance use disorders, though not all of these explicitly state a psychodynamic orientation and adhere rigidly to this model of addiction. Mahoney and Waller (1992), who present a thorough review of the literature with special consideration of the relationship between addiction theory and practice, also note this trend. In their own case presentation of a male client in outpatient treatment, the authors illustrate addiction treatment from an object relations framework. They pay close attention to transference and countertransference in their description of this client's treatment progression, elements that they find worrisomely absent from much of the other literature that seems to rely on psychodynamic concepts. Mahony and Waller outline this client's progression through patronizing the therapist, challenging her, and

ultimately using her as a protector and a secure base from which he was able to explore his

art process. They note the importance of an object relations framework in utilizing the

therapeutic relationship as a vehicle for change in treatment.

Mahoney and Waller (1992) make special note of Albert-Puleo (1980) for her clear

and comprehensive consideration of theory and practice. Albert-Puleo presents the

modern psychoanalytical approach to art therapy and advocates for its usefulness with

substance abusers, framing substance abuse as a narcissistic defense in which addicts

retreat into euphoria to prevent unleashing their rage on those around them. She discusses

narcissistic transference as a key dynamic for substance abusers, in which patients tend to

identify the therapist as similar to themselves, rather than assigning the therapist to a

parental role. In order to progress in therapy, Albert-Puleo asserts that clients with

substance use disorders must express and then resolve this narcissistic transference,

pushing the therapist out of the self and into the role of the externalized parental introject.

Albert-Puleo (1980) presents patient artwork from both individual sessions and

group art therapy that exemplifies psychoanalytic concepts such as splitting, narcissistic

transference, and reaction formation, though she does not identify the setting of these

sessions. In one case she describes a client's sculpture of a necklace for the therapist that

could be either benevolent or violent depending on her conduct. In this situation, Albert-

Puleo characterizes the client's artwork as an expression of his parent-directed anger,

identifying his art production as a safe step in the direction of appropriate verbal

expression.

Albert-Puleo (1980) recommends certain modifications of standard art therapy

practice, informed by psychoanalytic theory. She suggests that the therapist support and

encourage artistic defenses such as refusing to draw, not completing work, copying artwork, or insisting that the therapist draw, asserting that this strategy will eventually result in the client electing independently to drop the d1efense, and possibly encourage expression of parent-directed frustration. In spite of this suggestion, she recommends that clients be prevented from acting out violently by destroying artwork, biting pencils, kicking easels, and other such acts. She argues that these destructive behaviors constitute refusals to express emotions through imagery or words, and bear too much similarity to destructive drug using behaviors. Albert-Puleo also recommends that the client sit in front of an easel (lit from above with other lights extinguished), with the therapist positioned behind and to the side of the client. She likens this arrangement to the couch in traditional psychoanalysis in its minimization of distraction and awareness of the therapist, concealment of the therapist's facial expression, and encouragement of imaginative projection onto the "blank screen."

Albert-Puleo (1980) suggests that art therapy provides an ideal plane for the non-threatening interaction required by psychoanalysis by limiting contact with the client's ego. Though she encourages asking questions about the art object, she warns against any interpretation of clients' artwork until they have worked through narcissistic transference. She also advises minimizing verbal interaction overall, and exploring the true questions behind any contact initiated by the client in an open-ended manner rather than answering directly.

A significant portion of the literature identifies addiction as a result of insecure attachment. Among these examples are Cooper and Milton (2003), who present a case study of group art therapy work with female clients in a residential substance abuse

treatment facility. The authors claim an object relations and ego psychology orientation, discussing treatment issues of substance abuse, self-harm and eating disorders conjointly under the theme of self-destructive behavior. They posit that these self-destructive behaviors take root in infancy when basic needs were not met by primary care givers.

Cooper and Milton (2003) identify the primary goal of art therapy with this population as the development of ego strength via engaging and making sense of emotional material. They assert that verbal expression of the artistic creation is essential to ego building, as the words constitute the clients' responses to the visually represented object relations evident in their artwork. In keeping with the goal of ego development, Cooper and Milton structure the group art therapy experience as one that acknowledges the underdeveloped egos of group members and provides containment and structure within which they can safely explore emotions.

In their descriptive presentation of key moments in individual group members' experiences, Cooper and Milton (2003) emphasize the qualities of the art-making process as they relate to ego strengthening and safe exploration of affect. They also discuss the therapeutic relationship as a corrective re-parenting experience. The authors link both of these topics to their strong recommendation that art directives be structured in response to real-time assessment of group dynamics and emergent concerns rather than pre-planned.

In agreement with Cooper and Milton (2003), Siporin (2010) also cites attachment deficits as potential factors in the development of substance use disorders, proposing that addiction is essentially an attachment disorder. Siporin clearly aligns himself with psychoanalytic theory and defends his use of psychodynamic psychotherapy with substance abusers, noting the substance abuse treatment field's preference for CBT over

psychoanalytic work. Referencing attachment theory and Winnicott's (1971) concept of the "good enough mother," Siporin asserts that reparative attachment relationships are crucial to recovery from addiction. He describes his intention to provide a secure base and a safe holding space for affective expression in the art groups he ran with clients at an outpatient substance abuse clinic. Siporin emphasizes the importance of client-therapist interaction, characterizing his role as relating experientially to clients rather than interpreting the content of their artwork. His discussion of specific clients' processes in this art group focuses on transference, the creation of a play space, and the holding environment. Though Siporin identifies this art group as distinct from art therapy in its structure and billing category, he nonetheless uses it as a rationale for the value of certain psychodynamic concepts in substance abuse treatment.

Luzzatto (1989) is another author who focuses on attachment in her paper on short-term art therapy with alcohol abusers. Luzzatto identifies her approach as psychodynamic art therapy, examining themes of withdrawal and clinging in the artwork through an object relations perspective. Luzzatto identifies problem drinking as a withdrawal behavior that replicates the withdrawal required in childhood to survive a dysfunctional parenting dynamic.

Luzzatto (1989) illustrates the themes of withdrawal and clinging through detailed case presentations of her work with two male clients in a London-based alcohol treatment day clinic. Though one of these cases demonstrates the theme of withdrawal and the other the theme of clinging, Luzzatto's work with both men follows a similar trajectory. In both cases she describes the client's interpretation of his work as descriptive of a current relationship. Luzzatto then describes the process of facilitating free association to the

imagery, leading to the clients' connection of the picture with early family relationships.

Finally, Luzzatto describes encouraging exploration of alternate images, ultimately

resulting in each man visualizing and considering alternatives to his pattern of withdrawal

or clinging, respectively.

In their study of a specific drawing assignment in relationship to substance abuse,

Francis, Kaiser and Deaver (2003) utilize an attachment framework to describe the

features of addiction. Though they do not assert a causal relationship between insecure

attachment and substance use disorders, they suggest that substance abuse may serve as a

means of controlling the uncomfortable emotional experience of insecurely attached

persons.

The authors asked both veterans with substance use disorders and veterans without

diagnosis to draw a bird's nest, an assessment they termed the Bird's Nest Drawing

(BND). The authors consider the features of the BND with the aim of exploring potential

connections between the qualities of the image created, the individual's attachment

history, and the individual's use or non-use of substances. Francis et al. (2003) state that

the qualities of the nest and the characteristics and placement of any birds or eggs present

in the drawing may function as metaphors for the artist's home and family dynamic. By

comparing specific formal elements of the BND and a short story participants composed

about these drawings to the results of a questionnaire about relationships, the authors drew

conclusions about attachment in relationship to substance abuse as evidenced by the BND.

Results of the study indicated that secure attachment was significantly less common in the

substance abuse group (18.6%) compared to the non-substance abuse group (63%).

Notable features of the BND in the substance abuse were use of fewer colors, lack of the

color green, tilted or bottomless nests, and the absence of birds to protect any eggs present. In the stories composed by the substance abuse group, themes of abandonment were prevalent. The authors conclude that the BND is indeed a valuable assessment tool for determining attachment style, and that both insecure attachment and accompanying qualities in the BND correlate with the presence of substance use disorders.

Also concerned with deficits in early life, Virshup (1985) situates addiction in a psychoanalytic framework, identifying substance abuse as an attempt to regulate challenges resulting from problems in the pre-verbal developmental stage. Instead of focusing on attachment, she asserts that substances abusers as a group have early narcissistic conflict, and identifies the population as generally resistant to verbally-based therapy.

Utilizing this analytic framework, Virshup (1985) discusses her use of group art therapy in the milieu setting of a methadone clinic lobby, presenting an illustrative case study. Virshup outlines her observations about the effects of the art therapy group, specifically describing the power of art as language, the healing power of the group process, the projective qualities of the string-and-ink methodology used in her groups, and the self-esteem boost provided by art display.

Elaborating on one of the same psychoanalytic concepts emphasized by Virshup, Springham (1998) focuses on the narcissistic characteristics of addicted persons, specifically exploring their manifestations in group art therapy. In his case presentation of a group of five substance abuse clients, Springham (1998) notes the utility of the art as a paradoxical intervention that allows narcissistic clients to maintain distance from the therapist as they engage with transference material. The author touts the ability of the art

to hold this transference material, allowing it to be reintroduced into the group discussion once art-making is complete. Springham notes that this function of art is particularly important in group work with substance abusers because of the tendency of such groups to alienate and reject the therapist.

Vickers (2004) references Albert-Puleo (1980) and Springham (1998) in her discussion of addiction, presenting it as a narcissistic disorder. Vickers outlines key considerations in the adaptation of psychodynamic work to substance abuse treatment. She then reviews themes in the artwork created by clients at an in-patient detoxification program in her one-off art therapy groups. Vickers notes themes of death, story-telling narrative pictures, and idyllic landscapes in the artwork, discussing this content as it relates to fear of ambivalence, accountability, and reality. She notes the particular use of art therapy with this defensive population, as the art permits clients to maintain their defenses by providing an external metaphor about which discussion can take place.

Glover (1999) discusses the relationship between incest victimization and substance abuse, noting that childhood trauma is a key piece of addiction and recovery for individuals affected by both experiences. Though she does not specifically reference a psychodynamic model of addiction, her focus on trauma as the cause of self-medicating substance use behavior is consistent with the psychological model. She critiques the standard approach to addiction treatment, noting that its emphasis on powerlessness may be especially problematic for survivors of incest, and asserts that this mismatch may be partially responsible for high treatment dropout rates among incest survivors.

Glover (1999) looks at the potential of art therapy and play therapy in working with this population, noting that the shame, self-loathing, and self-blame caused by incest

act as barriers in primarily verbal treatment modalities. Glover recommends art and play therapies as methods of contacting the child within an adult incest survivor, though her discussion of these approaches is structured as a rationale for their use rather than an illustration of their effectiveness.

Within art therapy literature on substance abuse treatment there is also a significant body of work that states goals consistent with the psychodynamic framework of addiction without explicitly claiming this theoretical model of addiction (Mahony & Waller, 1992). In a publication predating Albert-Puleo's (1980) article on modern psychoanalytic art therapy, Albert-Puleo and Osha (1976) describe the methodology and findings of the art therapy department of a grant-funded 30-day residential treatment program for men. The authors identify the goals of their work with these men as emotional release and the unearthing of internal conflicts, fears and desires, aligning them with a psychodynamic treatment approach.

Albert-Puleo and Osha (1976) describe the structure of group art therapy sessions they offered, noting that they gave minimal instruction on the use of available art materials and provided assignments only to the newest group members, allowing others to draw and paint spontaneously. In keeping with psychodynamic orientation, they acknowledge encouraging lines of group discussion that exposed defensive tactics.

Albert-Puleo and Osha (1976) outline recurring symbols they observed in the artwork of their group members. Noting the prevalence of water imagery, the authors identify water as a symbol of regression into the womb, pointing out that alcoholism constitutes a similar escape from consciousness into the comfort of the bottle. Taking an object relations mindset, the authors compare alcohol to a domineering yet comforting

mother, both overwhelming and soothing to the alcoholic. Albert-Puleo and Osha note the function of water in the images, developing a hypothesis about the relationship between the water itself and boats, a common feature in water imagery. In the images of boats, they identify water as both a support an isolative factor, drawing a parallel to alcoholics' use of alcohol as a coping mechanism even as it detaches them from others. The authors also discuss noted themes of isolated objects or beings, slighted and self-pitying creatures, symbols of repressed anger, and the characterization of women as manipulative seductresses. The authors do not discuss peer influence in their presentation of identified patterns in subject matter depicted during group sessions.

Like Albert-Puleo and Osha (1976), Forrest (1975) seems to rely on psychodynamic ideas in case conceptualization and therapeutic goals, but does not name a psychodynamic orientation or specify her adherence to a model of addiction. Forrest presents an expansive case study of a 26-year-old male client in outpatient treatment for alcohol and drug abuse at the Bronx-Lebanon Hospital, noting themes in his artwork that reflect a psychodynamic understanding of his case. She emphasizes fear of losing control, sexual problems, mother-directed blame, and internal conflict between two parts of the self. She also discusses themes of low self-esteem, identity confusion, lack of accountability, and choosing between divergent paths.

In spite of an unfavorable treatment outcome to her case presentation, Forrest (1975) presents her client's experience in art therapy as a success in the following ways: Art proved non-threatening enough to encourage his engagement and expression when other treatment attempts had failed, he gained self-awareness about his destructive

behavior and low self-esteem through the art, and the art revealed potential undiagnosed mental illness.

Marinow (1980) presents a case study of a client in inpatient treatment, discussing this client's spontaneous drawing productions created outside of therapy sessions. She notes the significant themes in this client's artwork, identifying these as the psychedelic experience and human weakness. In her exploration of this client's art productions, Marinow presents the psychedelic experience as a space of disconnection from ego functions, suggesting a psychoanalytic understanding of this particular type of drug experience. She also uses a psychoanalytic rationale for the utility of art therapy, claiming that the art allowed this client's ego to make contact with his unconscious, allowing previously suppressed conflicts to surface and resolve.

The 12-Step model. The link between the 12-Step model and the use of art therapy is explored in much American art therapy literature, likely because the inception of Alcoholics Anonymous took place in the United States (Alcoholics Anonymous, 1939). The practice of art therapy within this theoretical model inherently involves the heavy emphasis on 12-Step programs that characterizes most hospital treatment programs (Feen-Calligan, 1995). When art therapy, usually in a group setting, is utilized within such programs, much of the literature advises that art therapists be mindful in structuring the therapy as a deliberate complement to this spiritual approach to recovery (Feen-Calligan, 1995; Johnson, D., 1990; Johnson, L., 1990; Miller, 1995).

In his introduction to a special issue on substance abuse published by *The Arts in Psychotherapy*, D. Johnson (1990) names a central challenge of art therapy's collaboration with the basic philosophies of the 12-Step approach. The author describes some of the

key principles of Alcoholics Anonymous, characterizing many of these as methods for shifting focus away from the self and onto either a Higher Power or altruistic work with others. D. Johnson notes the contrast between this evasion of self and the self-exploration that lies at the heart of art therapy, cautioning art therapists to approach their work with this population in a manner that complements 12-Step work rather than undercutting it. He suggests that art therapy with the addicted population seek to contain emotion rather than provoke it, recommending both the use of structured interventions designed to work alongside the 12 steps and art activities following the relapse prevention model.

Within the same special issue, L. Johnson (1990) explores the concept of shame, situating herself as a spiritual healer in her role as art therapist. While D. Johnson cautioned about the disconnects between the 12-Step approach and the traditional practice of art therapy, L. Johnson asserts that the two are a natural match given her perception of creativity as an inherently spiritual endeavor. L. Johnson's self-created role is unique in its transparency; she specifies that she makes art with clients, sharing her own struggles as a fellow human. This self-disclosure is reminiscent of the guideline for work with others in the program of Alcoholics Anonymous, in which the sharing of personal experience and is essential (Alcoholics Anonymous, 1939).

L. Johnson's (1990) goal in her use of creative therapies with substance abusers is the facilitation of spirituality. She utilizes poetry, music, dance, and drama therapies in addition to art therapy, identifying all of these creative processes as spiritually healing. She approaches therapy with the goal of removing shame, which she perceives as a blockage against spiritual connection. In her presentation of client artwork, L. Johnson highlights visual evidence of this client's evolution from shame to spiritual awakening.

Though she does so with a different therapeutic style and role, Feen-Calligan (1995) proposes a model for using art therapy with the same goal of facilitating the spiritual recovery that forms the basis of the 12-Step approach. Feen-Calligan outlines the central concepts of the first three steps of Alcoholics Anonymous, noting that these are the steps typically emphasized in substance abuse treatment programs. She situates powerlessness, belief in a Higher Power, and surrendering to the will of a Higher Power as relevant to the creative process, asserting a powerful connection between art and spirituality.

Feen-Calligan (1995) describes her art therapy groups in an inpatient substance abuse unit as meditative, structured to encourage members to commune quietly with their personal spiritual beliefs. She emphasizes the quietness of the space as spiritual in nature, valuing this absence of busyness over the production of insight. Feen-Calligan discusses the use of art activities that illustrate powerlessness and humility, specifically mentioning drawing with the non-dominant hand, collaborative silent artworks, and drawing with eyes closed. Primarily, she is concerned with utilizing art therapy as a reflective, quiet and meditative exercise that has the power to cultivate inner peace in those who are beginning their recovery from addiction. Her use of art therapy is distinct in its strict adherence to 12-Step principles.

Miller (1995) also outlines an art therapy approach designed to encourage and develop spirituality. Describing the art therapy groups she conducted at a hospital-based chemical dependency center based on the 12-Step model of addiction, she explains her deliberate choice to complement the 12-Step emphasis on belief in a Higher Power through a specific art activity. Miller explains her process as the group facilitator, noting

that she first shares readings and videos relating to various types of spiritual practices and experiences, facilitating a group discussion about clients' relationships to spirituality in the context of "close calls," dreams, rituals, and value systems, then encourages clients to create artwork in response to the topic.

Miller (1995) dedicates little space to the exploration of the art produced by her clients in the art-making session that follows these discussions. Her analysis of the imagery seems to focus on a literal identification of the various conceptions of spirituality clients represent in their artworks, and she neglects to include any discussion of art process or formal qualities. Miller notes a prominent theme of mountains and other nature imagery, noting that this symbol may relate to the cultural background of the client population, primarily Caucasian males. Miller emphasizes the results of a questionnaire administered after the project, indicating that 90% of group participants felt that their personal understanding of spirituality was improved by the group experience.

Potocek and Wilder (1989) describe the use of art therapy in combination with movement therapy as an experiential method of exploring each of the first four steps of Alcoholics Anonymous. The authors outline a structured series of art and movement activities utilized in a 12-Step based inpatient treatment program. They present case study anecdotes that illustrate experiential exploration of the principle at the core of each of the first four steps, proposing these activities as an additional method of internalizing these key concepts.

The disease model. Intertwined with the 12-Step model in treatment programs, the disease model forms the basis of most addiction treatment centers. As the literature written by art therapists practicing within treatment programs generally represents

perspectives compatible with the theoretical model of the treatment program, most of the art therapy literature that describes addiction as a disease discusses the integration of art therapy into treatment program settings. In general, the authors of these papers advise that group art therapy in short-term treatment settings be simplified and highly structured in order to best complement the structure of the programs that house them (Allen, 1985; Matto, 2002).

Allen (1985) discusses her use of art therapy within a disease-model inpatient alcoholism treatment program, explaining her decision to alter her typical practice in order to work within the theoretical bounds of this treatment program. Supporting the disease model, Allen criticizes psychotherapists who perceive substance use as merely symptomatic of depression, validating it as an illness in its own right. In her discussion of her work within the treatment program, she notes the agency's aim of breaking down resistance through the use of confrontational strategies, and describes her use of highly structured group activities as a means of assimilating her practice into the program's treatment style. Allen explains the structure of her art therapy groups as art-making prompted by a certain recovery-related concept, followed by group discussion of artwork. Deemphasizing transference and confidentiality, Allen describes her decision to assume a more confrontational style in the interest of uniting the presentation of the agency staff.

Matto (2002) also discusses the integration of art therapy methodology into a brief inpatient substance abuse treatment program operating from the disease model (Minnesota model) of addiction. Like most other authors of art therapy literature naming the disease model as their theoretical base, Matto dedicates significant space to outlining considerations for the provision of art therapy in the treatment setting. She proposes an

integrated approach to treatment, noting the ability of group art therapy to address cognitive, emotional and relational aspects of addiction. The author also points out the usefulness of group art therapy in facilitating emotional processing of the ever-changing treatment census, in which companions are constantly arriving and leaving.

Matto (2002) discusses themes in the art process and art products from her groups, noting common symbols. She identifies trees and placid landscapes as popular in the art content, noting a connection between depictions of cliffs or destructive natural forces and fear of powerlessness over addiction. Matto characterizes the group art therapy process as a healthy risk-taking experience that affords participants an opportunity for self-exploration.

Confrontation-based treatment programs. Other art therapy literature that addresses this same challenge of integrating the practice into highly structured and confrontational treatment settings does so without citing the disease model as the theoretical base. One such paper is Wittenberg's (1974) early account of her experience working as the consultant in art therapy at a residential adolescent drug treatment center. Wittenberg describes two different art groups that she ran at the program, one held at the facility and the other at her private studio, the latter restricted to residents who were advanced in their treatment progress. Wittenberg's stated goals for her work with the program were to provide an opportunity for emotional release and to strengthen the ego through creative productivity, goals that seem to align with a psychodynamic approach.

Wittenberg (1974) identifies patterns in the art content and behavior of this first group comprised of newly admitted residents. She describes participants as extremely tentative with materials, interpreting this fearfulness as a complete lack of self-esteem and

self worth. She also notes that the newest members of the group often included sexual and drug-related content in their imagery, but this tendency usually receded as they became more comfortable.

Wittenberg (1974) then describes the art workshop that took place at her studio, asserting that this non-traditional group structure and setting increased clients' self-worth through the creative process and the building of artistic skills. She describes not only increased autonomy but also extremely respectful group conduct in this workshop. Wittenberg discusses her unconventional handling of the therapist role in this setting, explaining her use of her own role as a means of validating her adolescent clients as respected adults and self-sufficient individuals.

Breaking through denial. Tied into the theme of confrontation-based treatment is another prominent theme in the art therapy literature, the notion that breaking down denial is the foundation of successful recovery. Though the art therapy literature discusses this idea frequently, the various theoretical backgrounds represented within it give way to different language around overlapping concepts in this area. Head (1975) refers to the utility of the art product as a weapon against denial, pointing out that once clients have put something into a physical form through the art process, they are unable to deny its existence. Other authors seem to describe this same technique within the vernacular of the 12-Step model, framing it as a way to support an addict's admission of powerlessness (Cox & Price, 1990; Feen-Calligan, 1995; Wadeson, 2010). Interestingly, the practice of coercing an admission of powerlessness is incompatible with the voluntary basis of the 12-Step approach, though this confrontational practice is a standard in treatment programs that incorporate 12-Step programs (Alcoholics Anonymous, 1939; Feen-Calligan, 1995).

Citing the first step of Alcoholics Anonymous as their guiding principle, Cox and Price (1990) describe the use of Incident Drawings with adolescents in substance abuse treatment as a means of breaking through denial. The authors define Incident Drawings as detailed visual presentations of an incident related to a client's substance use. They describe the regular production and presentation of such drawings in a group format within an adolescent treatment program, with the aim of coaxing participants into recognizing the devastating effects of substances on their lives. Similarly to Feen-Calligan (1995), who presents specific art processes as illustrations of powerlessness, Cox and Price describe their deliberate choice of art materials that create physical unmanageability in the art process. The authors situate this specific art therapy protocol as an aid in early recovery that prepares adolescent substance abusers to work the Twelve Steps.

Wadeson (2010) opens her chapter on substance abuse by acknowledging the efficacy of the 12-Step approach, and describes her art therapy group in a court-ordered alcohol treatment program as a format that seems to complement the admission of powerlessness required in the first step of Alcoholics Anonymous. She identifies group art therapy as a method by which clients confront the consequences of their drinking, reporting that the group often allowed clients to experience the emotional ramifications of their drinking where other treatment activities did not. Wadeson reports themes in the art creations of this group, noting loss, the passage of time, ambivalence about sobriety, and scenes of drinking-related catastrophes as common subject matter.

Hanes (2007) also focuses her exploration of art therapy in substance abuse treatments on denial, noting that mechanisms of denial are an inevitable element in the life

of a substance user, as they permit addicted persons to continue destructive behaviors.

Hanes presents two case studies from her work in an inpatient psychiatric hospital, both of

which feature artwork created in an art therapy group non-specific to substance abuse. For

both of the individuals described, Hanes notes that spontaneous frontal self-portraits

functioned as a means of self-confrontation, a reconsidering of the reality of addiction that

is essential to recovery. Unlike Cox and Price (1990) or Wadeson (2010), Hanes is not

concerned with inciting this self-confrontation, instead describing its spontaneous

occurrence as an artistic event.

     Personality theories. Some of the older art therapy literature on work with

addiction emphasizes the personality characteristics of addicted persons. Donnenberg

(1978) describes the use of group art therapy in a structured therapeutic community

offering long-term court-mandated substance abuse treatment, identifying the program's

theoretical model of addiction as personality-based. She notes the program's

classification of addiction as a personality disorder, linking this to its emphasis on peer

accountability and group process as the foundations of recovery.

     Donnenberg (1978) focuses on the unique ability of art activities to articulate

group dynamics, a feature that makes it especially useful within this group-focused

treatment setting. She uses Piaget's descriptions of childhood play to analyze the group's

art process in creating team murals, identifying parallel egocentric art-making in many

cases and more sophisticated teamwork in very few. She discusses the group's murals as

illustrations of group dynamics, noting a power struggle for the leadership role in the

group, one resident's assumed role of peace-maker/unifier, and a dramatic division within

the community that formed along cultural lines. Donnenberg outlines her use of the group

murals as an opener into the discussion of racial subgroups within the community, outing a highly charged and carefully guarded group issue. She notes that once group murals revealed previously masked interactional patterns, the group became more willing to engage in verbal processing.

Though she does not name a theoretical model of addiction, Devine's (1970) preliminary study of the artwork of alcoholics discusses the personality characteristics of alcoholics as evidenced in their artwork, suggesting a personality-based understanding of alcoholism. Though Devine's observations about the artwork considered in her study provide useful information about the relationship between alcoholics' personality traits and their art processes, her methodology is imperfect. She explains that five alcoholics painted half of the paintings in a mixed diagnosis ongoing art therapy group, while the other half of the images were generated by 45 male alcoholics brought in from other hospital units in a single "painting session."

Devine (1970) outlines observations about the artwork created in both of these settings, noting differences and similarities. In both the single session paintings and the early artwork of the ongoing group, Devine describes rigidity in the brushwork and highly conventional subject matter, both suggesting anxiety about controlling emotion. She notes that those who participated in the single session tended to render an isolated generic form, such as a person, house, tree or boat, while the five alcoholic members of the ongoing group, who had more experience with art, favored standardized landscape scenes as their subject matter. The author characterizes these paintings as artistic escapes into an idealized version of the world, which she likens to the alcoholic's propensity to escape through drinking.

Devine (1970) also reports patterns in the behavior of the participants within each group. She notes the power of the peer group in the single painting session, both as a key factor in who chose to participate and as a cause of defensive behavior. Devine describes participants belittling the art therapy process, reducing the potential for vulnerability by joking loudly, and seeking out approval of their creations. She compares these dynamics to the early phase of treatment for the alcoholic members of the ongoing art therapy group, noting that the alcoholic group members chose impersonal and brief descriptions of their artwork rather than discussing it openly. Devine identifies the effect of ongoing art therapy for the alcoholic members of the long-term group as an increased readiness to release and confront overwhelming emotions. She notes that, though landscapes persisted as subject matter, they transitioned from placid to ominous and unstable. Devine asserts that this change in style and emotional tone corresponded with the alcoholic patients opening up verbally about their struggles to the non-alcoholic members of the group.

Devine (1970) presents hypotheses about the meanings of her observations in relation to the traits and experiences of alcoholics. She notes the theme of isolated figures, positing that this trend reflects the lack of deep relationships and the feeling of isolation that characterize alcoholism. Like Albert Puleo and Osha (1976), Devine notes the prevalence of water in the paintings (found in 40 of the images), and links this content to regressive fantasy. She also describes a theme of contrived subject matter and highly controlled technique, which she links to a rigid defensive system and the alcoholic's struggle for control. Devine notes that, when this highly-controlled artistic defense broke down, wild and terrifying forces of nature emerged in the paintings, forces that she interprets as representations of the uncontrollable power of the alcoholic's own impulses.

Emotion-based models. Though Devine's primary interest in investigating the art of alcoholics seems to lie in linking thematic elements to the personality characteristics of alcoholics, she also seems to reference an emotion-based model of addiction in her discussion of the emotionally avoidant tendencies of addicted persons. Similarly, Foulke and Keller (1976) identify the use of alcohol and drugs as an attempt at warding off overwhelming affect in their case presentation of art therapy with a resident in inpatient substance abuse treatment. They present addiction as a self-destructive cycle in which addicted persons seek immediate gratification at all costs, leaving a wake of practical and interpersonal problems behind them as they continue to evade their emotions through substance use. Foulke and Keller name self-loathing as the natural result of this process, which in turn fuels more self-sabotaging behavior. The authors contest the notion that addiction is anti-social, as they view lack of self-esteem as the core issue behind destructive patterns of substance use.

Situating the inability to tolerate strong emotional experience as the primary cause for drug use, Foulke and Keller (1976) propose art therapy as a means of connecting addicted individuals to their affective experiences. The authors present art therapy as an opportunity for the integration of feelings, thoughts and actions. They also note the utility of art therapy as a method by which addicted persons can safely discharge intense anger, thereby enforcing self-control.

Like many of the authors of art therapy literature with substance abusers, Foulke and Keller (1976) identify key advantages art therapy holds over verbal therapy when working with the addict population. They note that subject matter that this population

finds intimidating to discuss directly might appear readily in the art, and that art naturally resists manipulation, evading intellectualization and rationalization.

Foulke and Keller (1976) seem to reference the psychodynamic understanding of addiction in their explanation of the structure of their art therapy groups. The authors specify that their method of conducting group art therapy encourages addicted persons to increase their tolerance of unpleasant affect while maintaining full ego control. They state the primary goal of their groups as an increase in tolerance of strong feelings and awareness of emotion, noting that the achievement of these goals lead to increased self-esteem, bolstered by both a newfound emotional capacity and the ability to express feelings creatively. In contention with the literature that recommends the use of art therapy as a tool for breaking through denial, the authors caution against assigning art activities that force addicted persons to confront their despair, as they believe this process must occur organically.

The other articles reviewed that reference an emotion-based model of addiction do so obliquely, without naming this orientation outright. Though Head (1975) identifies her treatment model as dynamically oriented group psychotherapy within a Rogerian/eclectic mode, she does not clearly identify a model of addiction utilized in this work. She does, however, situate addiction as an avoidant strategy symptomatic of a larger pattern of avoidance in life, a characterization consistent with affect-intolerance models of addiction. Head uses this basic understanding of addiction as a rationale for group art therapy, noting that the group format often sparks insight through identification with expressions in the artwork of other group members.

Like many authors of the art therapy literature, Head (1975) frames her discussion as a pitch for the use of art therapy in general, touting the visual output humans produce in art therapy as invaluable sources of information about their experiences and identity. With regards to the treatment of addicted persons, she praises art therapy as an alternative means of communication, a non-threatening way to process experiences, and a physically engaging activity that may combat the depression that often accompanies early recovery. Head presents the art process as an opportunity for addicted clients to detach from their defenses and conflicts so that they are able to view these aspects of themselves with new clarity. Given the avoidant tendencies of addicted persons, Head names art therapy ideally suited to unearthing internal struggles that might not surface in verbal therapy.

Head (1975) outlines her use of group art therapy in an outpatient day clinic for addiction treatment. She notes six emergent themes in this group: The disliked self, the mask the individual presents to others, work, family, intimate partnership, and the conflict between living life and disengaging from it. She points out the value of encouraging peers to interpret one another's artwork in the group setting, noting that peer interpretations can be quite astute and are often better received than the interpretations of an authority figure. Though Head presents a large sampling of artwork from this group, she includes very limited discussion of these images and no case information about the individuals who created them, which gives the artwork little context.

Though she does not explicitly name a model of addiction at the base of her work, Kaplan (1978) opens her paper on the use of face painting in adolescent drug treatment by situating substance use as the result of identity confusion and inability to express affect. She outlines her facilitation of the group face painting activity, asserting that this non-

verbal communication increases group members' ability to enact and experience trust and

connection.

Family models. The art therapy literature that conceptualizes and treats substance

abuse as a family issue is limited. Within this paper, Wadeson's (2010) chapter on

substance abuse is the only art therapy-based exploration of the family process in

substance use disorders. Wadeson outlines the three-part art evaluation she used to

explore the intergenerational transmission of alcoholism in the family system. She

identifies this work as an outgrowth of research indicating the transmission of alcoholism

through families without genetic cause, identifying the theoretical basis as family systems.

Wadeson (2010) describes three parts to her protocol for the family art evaluation

utilized in this study, which she administered to five families with an alcoholic parent and

adult children. In the first part, she directed each family member to depict the family

symbolically. In the second, she directed each family member to divide their paper in

half, symbolically depicting the maternal grandparents' family on one side and the

paternal grandparents' family on the other. For this drawing she requested that each

individual mark which side of the image bore more resemblance to their first image. In

the last drawing, Wadeson directed each family member to depict the effects of alcohol

use in their family on their lives.

Wadeson (2010) describes the aim of the study as the identification of the heritage

dominance of alcoholism as maternal, paternal, or mixed, and reports that the art

evaluation was effective as a means of identification. Wadeson describes the observation

and discussion of chosen symbols and formal qualities in the first two drawings as

effective in identifying family roles and intergenerational patterns. Wadeson also outlines

observations about the artwork that fall outside of the study's intended data set. She notes

a difference in the third drawings between the alcoholic fathers, all of whom were sober

members of Alcoholics Anonymous and indicated gratitude for their identities as

alcoholics, and their spouses, who depicted memories of pain and alienation during their

husbands' active drinking. She also notes that each family's drawings as a group seemed

to reflect the family's overall character, as patterns in tone, composition, and specific

symbols were visible in each family's art.

Combined and integrative models. Several articles within the body of art

therapy literature propose the use of art therapy in the context of combined theoretical

models of addiction. In general, these papers propose methods for managing the

integration of multiple models, asserting that art therapy provides a useful meeting space

for these different theories (Dickson, 2007, Horay, 2006).

Dickson (2007) discusses her use of art therapy in an addiction treatment program

that integrates the disease model and the 12-Step model, evaluating the effectiveness of

using a psychodynamic non-directive style of art therapy in this context. Dickson cautions

that, in order to effectively utilize this open-structure variety of art therapy within a

structured treatment program, special attention must be paid to clearly informing

participants about the boundaries of the art therapy space and its differences from the

space found in other groups.

Dickson (2007) presents anecdotes from her group with the aim of illustrating that

the openness of the art therapy group was indeed therapeutically effective in spite of its

contrast from the overall tone of the program. Utilizing the example of a mask-making,

Dickson discusses themes in client work that reflect the benefits of psychodynamic

patient-led art therapy work. Dickson notes the prominence of oversimplified recovery narratives, dichotomous thinking, and false presentations of the self, all of which group members were able to expand and explore through the discussion that formed around the masks. Ultimately, Dickson characterizes her art therapy groups in this program as a space where clients can integrate the emotional experience of the profound changes they are implementing through their work in the program's structured groups and through 12-Step work.

Horay (2006) discusses Motivational Interviewing (MI) and the Stages of Change model, proposing art therapy as the ideal bridge between these strategies and the traditional psychodynamic conception of addiction as a narcissistic disorder. Horay criticizes art therapy done in deliberate collaboration with the 12-Steps for its emphasis on driving home powerlessness and encouraging saccharine pictures of recovery. Instead, he proposes that art therapy be used in a manner that accepts and explores ambivalence about recovery. Horay provides an illustrative case study of a 40-year-old man in outpatient treatment, highlighting ambiguity in the art directives and the resulting artwork. Throughout this case presentation, Horay points out his client's pattern of creating idealized images of recovery, underscoring the ability of art therapy to thicken this rosy and oversimplified narrative.

Unlike Horay (2006), Holt and Kaiser (2009) characterize the 12-Step approach and MI techniques as compatible. Holt and Kaiser discuss the use of art therapy within a blended theoretical framework utilizing both the 12-Step approach and MI strategies. The authors describe their use of the First Step Series, a drawing directive designed to facilitate admission of powerlessness over addiction. They structure these art activities around the

principles of MI in an effort to help participants activate their own intrinsic motivation to surrender rather than forcefully breaking through their defenses.

Holt and Kaiser (2009) describe the five art directives that comprise the First Step Series. The Crisis Directive, in which clients depict the crisis that brought them into treatment, bears close resemblance to the Incident Drawing in the work of Cox and Price (1990). The Recovery Bridge Drawing is a depiction of the past-present-future continuum of addiction, and the Costs-Benefits Collage urges clients to consider the costs and benefits of both maintaining the status quo and changing their behavior.
In the Year from Now Directive and the Barriers to Recovery Directive, clients conceptualize hopes and anticipated challenges in their ongoing recovery (Holt & Kaiser, 2009). Holt and Kaiser note that ambivalence toward the prospect of recovery is often evident in the images created in response to these directives, and propose that clinicians utilize MI techniques of affirmation, reflective listening, and open-ended questions to further client consideration of change through discussion of the art.

Feen-Calligan (2007) outlines the contribution art therapy can make in the detoxification phase of substance abuse treatment, punctuating the lack of literature on this subtopic. In her exploration of using art to facilitate a humane detoxification experience she incorporates 12-Step philosophy, detoxification goals, self-psychology, social interest theory, and group therapeutic factors. The art activities Feen-Calligan describes are variously based in 12-Step concepts, relapse prevention strategies, healthy life practices, and strengths-based approaches. Feen-Calligan specifies that art therapy in detoxification be structured to ensure stability given the short-term nature of the work, and calls attention to the medical vulnerability of the clients in this early phase of recovery.

Taking a broad scope on substance abuse, Carolan (2007) introduces the topic from a multi-level perspective, discussing substance use statistics, the anthropological history of substance use, Erikson's developmental stages in relation to adolescent substance abuse, the imaginal process, and identity-seeking through mind-altering substances. Carolan references both psychological and spiritual models of addiction in his exploration of addiction and identity formation in adolescents. He asserts that substance use in the psychological model of addiction is a destructive act toward the self. Paradoxically, he also notes that the surrender of self is the crux of recovery from the perspective of the spiritual model.

Though his theoretical introduction is lengthy and elaborate, Carolan's (2007) case presentation of individual art therapy with a 16-year-old male resident in inpatient substance abuse treatment is straightforward. Focusing on issues of identity formation, he celebrates the ability of the art to engage this client without activating ego defenses. Carolan notes key moments in the art process, discussing alternate versions of the self in the artwork and identity exploration through creation of externalized characters.

Atheoretical discussions of addiction. Much of the literature available on art therapy in the treatment of substance use disorders does not identify a theoretical understanding of addiction underlying the treatment approach. Perhaps this relates to the insular nature of the art therapy field, or perhaps to the exploratory attitude that seems to underlie much of the field's work. The latter of these two hypotheses seems evident in some of the literature that does not discuss a model of addiction. Rather than purporting to understand the condition of addiction, certain papers seem to be utilizing the art of

addicted persons as a means of gathering information about the experience of being addicted and attempting to recover.

One such paper is Tyszkiewicz's (1975) analysis of the spontaneous art productions of an amateur artist in treatment for drug addiction, in which she compares his productions to the work of famous artists. The author presents this man's technically skilled artworks as evidence of his attitude during treatment, noting a shift from pessimism to a more joyful tone that suggests a therapeutic function of the artwork. Though Tyszkiewicz does not discuss art therapy in the pure clinical setting, the author takes an exploratory stance on the investigation of the art of persons with substance use disorders, using this art as data that speaks to the lived experience of addiction. Tyszkiewicz notes that shifts in formal style or content in clients' artwork may signify treatment progression.

Another author whose aim seems to be exploratory, Naitove (1978) presents a pilot study of the symbols used in the artwork of 26 habitual drug users in treatment for acute depression. She does not make reference to a specific theoretical model for understanding substance abuse, choosing instead to focus on themes in the content of artwork produced by these individuals.

Naitove (1978) notes repetitive symbols in the 100 drawings these clients created during group art session, listing and describing dominant imagery according to its prevalence. She describes the most prominent symbols in this artwork, using the artists' descriptions of their work to make meaning of its content. Naitove explains clients' interest in the captivating process of creating the swirling and psychedelic patterning featured in a large number of the artworks, though she also noted that clients

acknowledged self-involvement as a theme related to concentric patterning. She relays client descriptions of geometric patterning as representative of both the confinement and depersonalization of modern society and attempts to contain and control different aspects of their lives.

Naitove (1978) notes that client explanation of blood droplets centered on fear and pain, discussion of eyes tied into paranoia, and tooth-filled mouths connected to paranoia, fear and primitive anger. She notes that cross and grave imagery had many associations for the patients: Death, crucifixion, the spirituality of the drug experience, and the death of individuality through conformity. She characterizes arrows as descriptive of movement, monsters as the personification of paranoia, and spider webs as linked to "bad trips" and the feeling of enmeshment with using. Naitove cites pills and other drug imagery as directly representational according to client description, and long-haired figures as indicative of non-violence and identification with the drug and music culture of the time period.

Naitove acknowledges the limited sample size of her study as well as the influence that the group setting may have had on the repetition of certain symbols given the importance of peer acceptance within the drug culture. She also names the influence of then-current youth culture in the symbols patients chose, noting that long hair, non-violence, psychedelic rock, LSD culture and non-conformity were all cultural features of the era this study captured.

Other articles seem to focus on justifying art therapy as a valid piece of addiction treatment, particularly those published early in the field's development. The earliest article reviewed on art therapy in the treatment of substance abuse, Ulman's (1953)

account of her use of art workshops in the first occupational and recreational therapy department of an outpatient alcoholic rehabilitation clinic, seems to fall into this category.

Given the early publication date of this account relative to the development of art therapy as a discipline, it is not surprising that Ulman (1953) focuses more on the presentation of art therapy as a valuable addition to treatment than on her theoretical understanding of addiction. She also uses the article as a venue for making recommendations about how other clinicians might approach art therapy with this population, asserting that art therapy must be concerned with not only the art-making process, but also the art product. She identifies the building of technical skill as an opportunity to increase the client's sense of freedom. Ulman criticizes the assumption that creative productions are useful merely as articulations of pathology, insisting that art is a representation of instincts toward health as well as illness.

Ulman (1953) describes features of the artwork created in this workshop, noting that, while participants initially appeared drawn to realism, continued participation in the group increased their appreciation of abstract and emotional content in their own artwork and the work of others. She describes participants' interest in loose line, scribble and circle drawings, pointing out the healing quality of the physicality of these motions.

Yet another instance in which no guiding theory of addiction is mentioned is Harms' (1973) case presentation of a freshman premedical student in court-mandated treatment. Like many other authors reviewed, Harms focuses on the promotion of art therapy as a useful treatment modality. He describes the addicted person's psyche as chaotic, proposing that artistic and aesthetic experiences can provide a much-needed sense

of balance. He points out that many addicted residents in institutions create art independently, proving that they find this pastime worthwhile and engaging.

In order to illustrate the potential of art therapy to change the abnormal psychological processes characteristic of addiction, Harms (1973) describes his client's immediate aptitude for expressing his emotions through art materials, and notes continued self-motivated expression through the course of art psychotherapy treatment with increasing passion for the art-making process. Harms reports that the client stated upon termination that art had saved him from his heroin addiction. In spite of the high-functioning background of the individual Harms discusses, the author's language disparages the intellectual and creative capacity of addicted persons.

Harms (1973) identifies key transitional points in the process of art psychotherapy with addicts. Seeming to equate investment in the art process with success in treatment, he identifies the first important transition as the moment when the client moves from spontaneous creation to planning and executing an artistic idea. The author names the second phase of treatment as the point when the client becomes independently occupied with planning his projects outside of therapy sessions. Controversially, Harms asserts that the addict at this point becomes so committed to the creative process that drugs no longer hold interest, as they interfere with the artistic impulse.

Matto, Corcoran and Fassler (2003) provide a framework for integrating solution-focused therapy and art therapy in the treatment of substance use disorders. The authors do not identify a model of addiction, though they identify functional impairments in physical, psychological, and social areas that typically characterize these disorders. Naming this integrated approach as strengths-based rather than deficit-focused, they

propose the use of art therapy as an interactive application of classic solution-focused interventions. In this case, the decision to omit a theoretical model of addiction seems to relate to the solution-focused base of the work.

Conclusion. The art therapy literature as a body places a strong emphasis on justifying art therapy as a valid treatment for substance abuse. There is a consensus among all authors that art functions as an alternative to verbal communication, offering individuals in recovery a less threatening means of expressing feelings. Though these accounts on the whole suggest that art therapy can be a meaningful process that contributes to recovery, they also illustrate the lack of cohesion in the field with regards to theoretical understanding of addiction itself as well as framework for using art therapy in treatment. The testaments featured in the literature lend credence to art therapy as a discipline, but their repetition in the literature on substance abuse also functions in some cases as a distraction from theory. Perhaps the general paucity of art therapy literature and research lies at the heart of this challenge, as the field still finds itself defending its validity with each new publication.

Conversely, the general literature on addiction is plentiful and varied, offering a multitude of new studies and ever-expanding information about the neurobiological processes involved in addiction and recovery. The general literature offers a variety of theoretical understandings of substance use disorders and models of recovery, which perhaps contributes to the trend of avoiding addiction theory altogether in much of the art therapy literature. If the field of addiction itself holds no theoretical consensus and continues to utilize different theoretical models within its different subsections and

subcultures, it is not surprising that this discord has translated into a muddled incorporation of addiction theory into the art therapy literature.

My review of the literature leads me to conclude that art therapy literature on addiction stands to benefit from greater mindfulness about building upon the field's own literature rather than publishing redundantly. Though the art therapy literature indeed makes a captivating case for the use of art with the substance abuse population, the insular quality of the art therapy literature does not serve to expand the frontiers of the field's work with this population.

In a broader context, the art therapy literature on substance abuse can be enriched by an understanding of the theoretical models of addiction underlying the work. Because much of the art therapy literature does not identify models of addiction explicitly, this information might be discovered through exploration of the background, historical period, and setting in which the treating art therapist practiced. Though theoretical underpinnings may not be clearly named within the art therapy literature, these writings invariably contain embedded theoretical ideas about addiction. The search for these embedded ideas presents an exciting opportunity to integrate them into a fuller use of art therapy in the substance abuse field.

As art therapy is used with increasing popularity in substance abuse treatment settings, the need to consider the theory underlying this work intensifies. Though previous moments have not necessitated the careful consideration of which theories of addiction art therapy practices support or contradict, this paper initiates a call to the field of art therapy to do so. An art therapist has an opportunity to enrich the field profoundly by blending art

therapy technique with substance abuse theory -- a chance to expand the theoretical lenses of treatment.

Research Approach

This research analyzes case study data, evaluating case material and art pieces as they illuminate different theories of addiction and recovery. I selected a qualitative approach to this topic because this type of inquiry does not predetermine what variables to evaluate, instead allowing themes to naturally emerge and exploring these theoretically (Cresswell, 2014). I was interested in case study methodology specifically because the process of my study requires a rich body of artwork within which points of relevance to multiple models of addiction may surface, and case studies offer this richness and depth of material. I also noted in my review of the literature that case presentation is particularly effective means of illustrating a theoretical concept, as in Horay's (2006) exploration of supporting ambivalence in substance abuse treatment. Finally, I selected case study research in alignment with a client-centered approach, allowing the lived experience of addiction and recovery as observed through art therapy to form the foundation from which connections are built (Kapitan, 2010).

Methods

Definition of terms. For the purpose of this study, the term *addiction* is used synonymously with the term *substance abuse*, both describing a physically, psychologically, and socially destructive pattern of excessive use of alcohol and/or other drugs. The term *alcoholism* is used only in reference to literature dealing specifically with this form of substance abuse, as alcohol abuse is considered under the umbrella of substance abuse. I offer a more detailed description of the implications of terminology within my review of the substance abuse literature.

Addiction. "[Compulsive consumption] of alcohol or drugs despite increasingly negative consequences" (Margolis & Zweben, 2011, p.27).

Substance abuse. "A maladaptive pattern of use manifested by recurrent and significant adverse consequences related to the repeated use of substances" (American Psychiatric Association, 2000, p.198).

Recovery. "A voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship" (BFI Consensus Panel, 2007, p.222).

Sobriety. "Abstinence from alcohol and all other non-prescribed drugs." (BFI Consensus Panel, 2007, p.222).

Design of study. The case study data collected serves as a representation of the experience of clients with substance use disorders in art therapy. From this data I note connections to theoretical understandings of substance abuse found in the literature. Study questions for data analysis include the following:

a) Which concepts from addiction theory literature are noted in art therapy with substance abuse clients?

b) Which concepts from addiction theory literature are not noted in art therapy with substance abuse clients?

c) What themes appear in art therapy with substance abuse clients that are not represented in the literature? What other factors might contribute to the appearance of these themes?

d) To what extent can art therapy with substance abuse clients demonstrate the relevance of multiple models of addiction? How does this apply with contradictory models?

Sampling. Data presented is representative of the entirety of my second year practicum traineeship at a 30-week practicum traineeship at a 6-month residential substance abuse treatment center. The agency provides integrated primary medical and behavioral healthcare, operating ten substance abuse treatment facilities that specialize in particular treatment structures or populations. Funding comes from contract awards with DMH, Dependency Court, Calworks and Veteran's Administration (VA), and occasionally from private health insurance. The location at which I provide art therapy offers services specifically tailored to women referred to treatment in compliance with Department of Child and Family Services (DCFS) cases, though the facility also accepts men and women from other referral sources.

Gathering and analysis of data. I invited four of the individual clients in my caseload to participate in the study, focusing on those whose course of treatment was long enough at the time of data collection to have a significant body of artwork for analysis. Each of the cases presented in this paper represents between 9 and 14 weeks of therapy. I chose not to invite certain clients whose course of treatment was highly disrupted by scheduling challenges, as these individuals did not receive regular therapy sessions in accordance with a treatment plan. The four clients selected for data analysis represent cases in which I believe treatment goals were clear and consistent. I considered excluding clients who demonstrated resistance to the art process or made art sparingly in sessions, but ultimately decided to include one such case with the aim of accurately representing my caseload.

Data consists of the images created by clients in weekly art therapy sessions provided as a normal part of treatment, as well as information about each client's

background and course of treatment. In cases where art directives were given in sessions, these directives aligned with treatment goals. For the four clients discussed in this paper, all art created in the course of therapy is discussed, again with the aim of accurately representing the process of therapy.

Three of the four clients included in this research also participated in art therapy groups with me concurrent with individual therapy. Though the artwork these clients created exclusively in the group setting is not included in the data, two of these individuals chose to incorporate artwork originally created in group into their individual therapy sessions, as these pieces contained metaphors that were powerful for them. In these situations, the client transformed the group-originated artwork into a more developed piece by continuing to work on it in individual sessions. Such pieces are included in the data set considered for this paper because they constitute a significant part of the individual therapy process.

My process of data analysis consisted of the creation and application of a coding system that identifies key concepts from the literature on models of addiction and recovery. Once I had created this tool, I utilized it to count and organize my understandings of these concepts in relationship to art therapy with the four clients participating in the research. After completing the coding process for all sessions with these four clients, I analyzed the prevalence of the different theoretical concepts in my cases according to the study questions identified above.

Results

Presentation of Data

In this section, I first present a general case summary for each of the four participating clients. I discuss key features of each client's case, outlining presenting problems, history, treatment goals, therapeutic process, and relationship to the art process. I then present images of each art piece created in the course of treatment for each client, providing a brief description of the significance of the art piece in my conceptualization of the client's case. In composing these descriptions, my aim was to provide information that best reflected my understanding of these individuals in their unique processes, choosing authenticity to the case as my guiding principle. All names and key pieces of identifying information have been altered to protect client confidentiality.

Introduction of Participating Clients

Tracy, 49. Tracy is a 49-year-old Caucasian female of low SES referred to treatment by the social worker on her DCFS case. She was referred to treatment due to methamphetamine use in an attempt to regain custody of her three youngest children, who have been in foster placement for two years. She reports that her methamphetamine use began at 12 years of age and was sporadic, and reports that she never used or sold in the presence of her children. Tracy's DCFS case was opened 2 years prior to entering treatment after she transported her three children across state lines in a circumstance that qualified as kidnapping. Tracy has four children total, three of whom are involved in her DCFS case. These children are 8, 9, and 11, the oldest of whom has Autism Spectrum Disorder and recently attempted suicide.

Tracy is a survivor of extensive trauma. She reports head trauma from ongoing physical abuse by her stepfather from ages 7-10 and being raped and stabbed in incident she identifies as attempted murder at age 13. At the outset of treatment she reported

nightmares, flashbacks, intrusive thoughts, and panic attacks when confronted with trauma triggers. She complained of difficulty sleeping due to excessive worry about the safety of her children and nightmares about her trauma. She is also a double cancer survivor who has incurred significant internal damage from radiation treatment, though she is now cancer-free.

My case formulation supposes that Tracy's multitude of traumatic experiences in early life and lack of nurturance or stability are at the root of the problems she has experienced in later life. Her experiences of violation and lack of safety seem to have created an empty sense of self which she is eager to fill with her identity a as a mother. Tragically, Tracy's obsessive efforts to ensure the safety of her own children and be a good mother have been ineffective, possibly because they originate from a desperate effort to negate her own trauma. Both her focus on her own parental role and her methamphetamine use have likely functioned as methods of suppressing her trauma. I began quickly to perceive a profound insecurity and a deep longing for human connection in Tracy's interactions with me as her therapist, which I also guessed were related to her lack of nurturance in childhood.

The primary treatment goal Tracy and I established early on was reducing the frequency and intensity of trauma-related nightmares by implementing immediate coping strategies as well as creating outlets for her trauma narrative in the art process. A later emergent treatment goal was improving Tracy's self-care, including both personal hygiene and emotional self-care via advocacy and boundary-setting.

At the outset of treatment Tracy was unable to discus her children at all without becoming emotionally flooded, which often triggered a panic attack. Tracy indicated

wariness about art therapy from the beginning because of the strong associations she holds

between art activities and her children, and her engagement with the art process was

halting, taking time to develop into a shape that suited her particular needs as a client.

Tracy is the only participating client for which treatment has not yet terminated at

the time of compiling data, meaning that her treatment outcomes are yet to be determined.

At the time of writing, Tracy is experiencing drastically reduced frequency of trauma-

related nightmares and has made significant changes in her personal care. Tracy is a

model member of the treatment community, holding many positions of responsibility, and

frequently receives awards for group attendance and volunteering her time to help out

within the treatment program. Due to her outstanding treatment progress, the court

recently allowed Tracy a further extension of her parental reunification program, to be

reevaluated after completion of treatment.

Figure 1. Folder by Tracy (Sessions 1 and 2)

Tracy's art folder (*Figure 1*), her first project, features nature and camping-related imagery that she later explained was linked for her to many memories of "Watson family adventures," a title that served as a euphemism for activities undertaken with her children as a result of the general lack of stability, safety and financial means in the family that she re-labeled and re-authored for the benefit of her children. As such, this seemingly placid collage held powerfully triggering associations for Tracy, validating her wariness about the art process. Tracy's deliberate choice to tape only a single side of her folder seems to mirror a later disclosure about her need to always have a clear way out of a space, reflecting her trauma history.
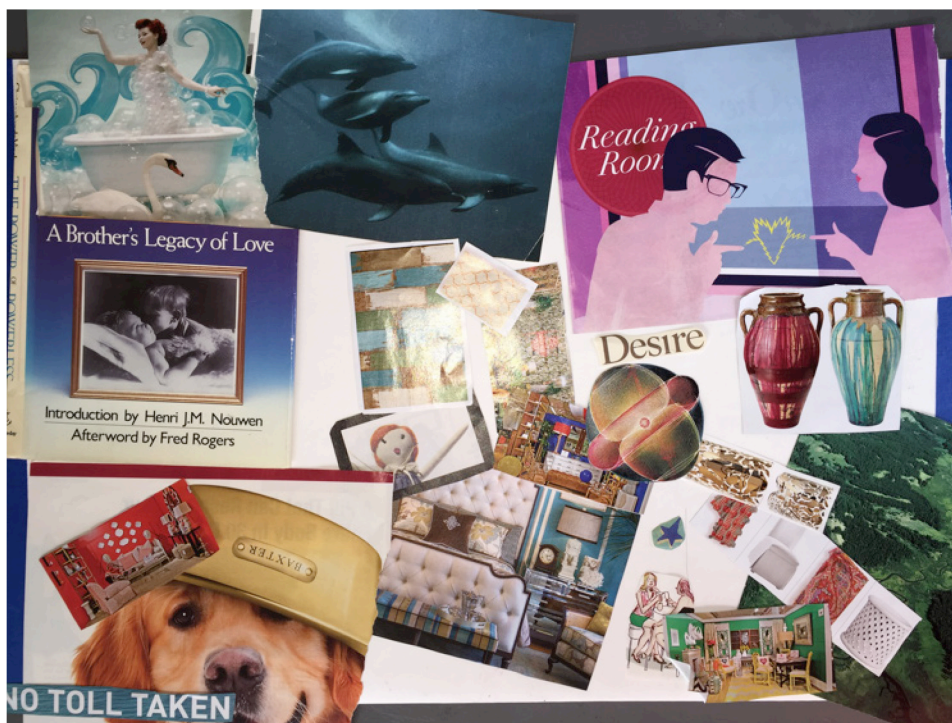
Figure 2. Collage images selected by Tracy (Session 3)

After Tracy's emotionally intense first encounter with the art process, I attempted to pull back by encouraging her to create a collage of images relating to her personal strengths and interests. Tracy identified many of the collage images Tracy selected for use

in this collage (*Figure 2*) as items "I could sell," relating to the survivalist entrepreneurial

skills she has honed throughout her lifetime. The scattered and acquisition-focused

process she used to amass these images mirrors the means by which Tracy has managed to

survive financially, by gathering and reselling a variety of items to generate a living

income. Though Tracy selected and stockpiled these images, she never proceeded to trim

or glue them (the above image features the selected images laid over a blank page in a

random arrangement). After initiating this process, Tracy expressed to me that she did not

want to continue to make art in therapy, as its association with her children was too

emotionally triggering for her to tolerate.

Figure 3. Modeling clay sculpture by Tracy (Session 4)

Hoping to introduce a more experiential variety of art-making into therapy that

might meet Tracy's needs without relinquishing the centrality of the art process, I offered

modeling clay in the next session. Tracy created a green flattened heart-shape that

dialogue suggested was a self-symbol, then topped it with a blue non-flattened heart that

her dialogue suggested was a symbol for her son, who recently attempted suicide. The

resulting sculpture (*Figure 3)* seems to embody Tracy's desperate efforts to support her

children while allowing herself to become "flattened."
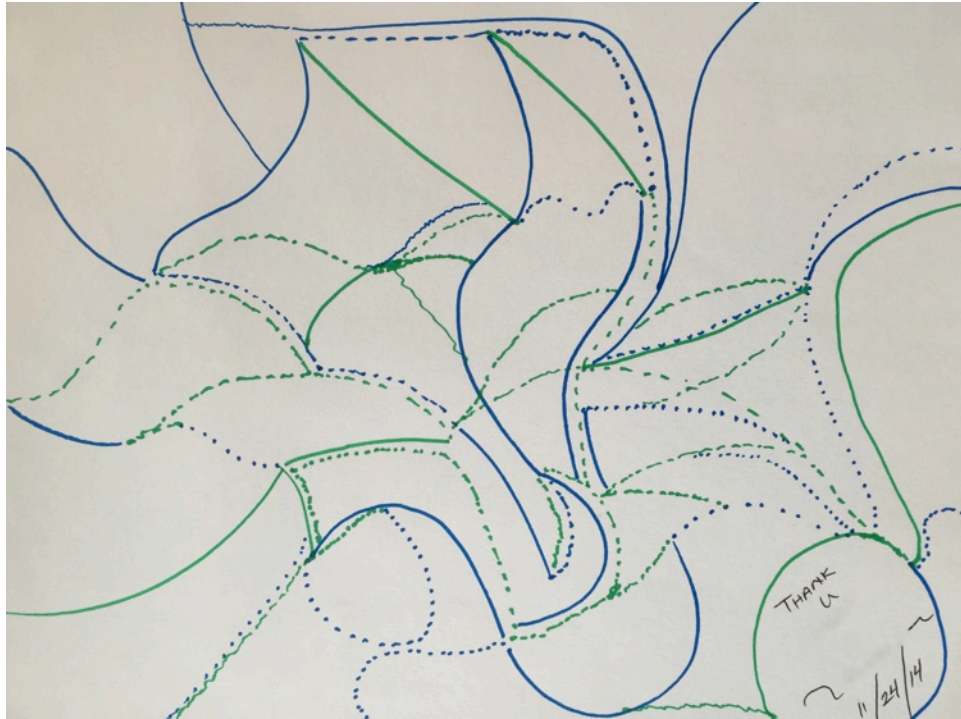
Figure 4. Collaborative drawing by Tracy and therapist (Session 4)

Following the return to the emotionally triggering topic of her children, Tracy's

affect indicated that she was unable to tolerate further exploration of this subject. I

initiated a collaborative drawing activity in which each of us selected a marker, then

alternated adding a line to the image (*Figure 4)*. Tracy began the drawing in green, and I

followed in blue, attempting to add lines that complemented and built off of hers. The

resulting image serves as a representation of the dance of the therapeutic relationship,

demonstrating the playfulness and experimentation with closeness that I experienced from

Tracy in our early sessions. Her final addition was to write "Thank u [my name]" and

sign her own, supporting this theme.
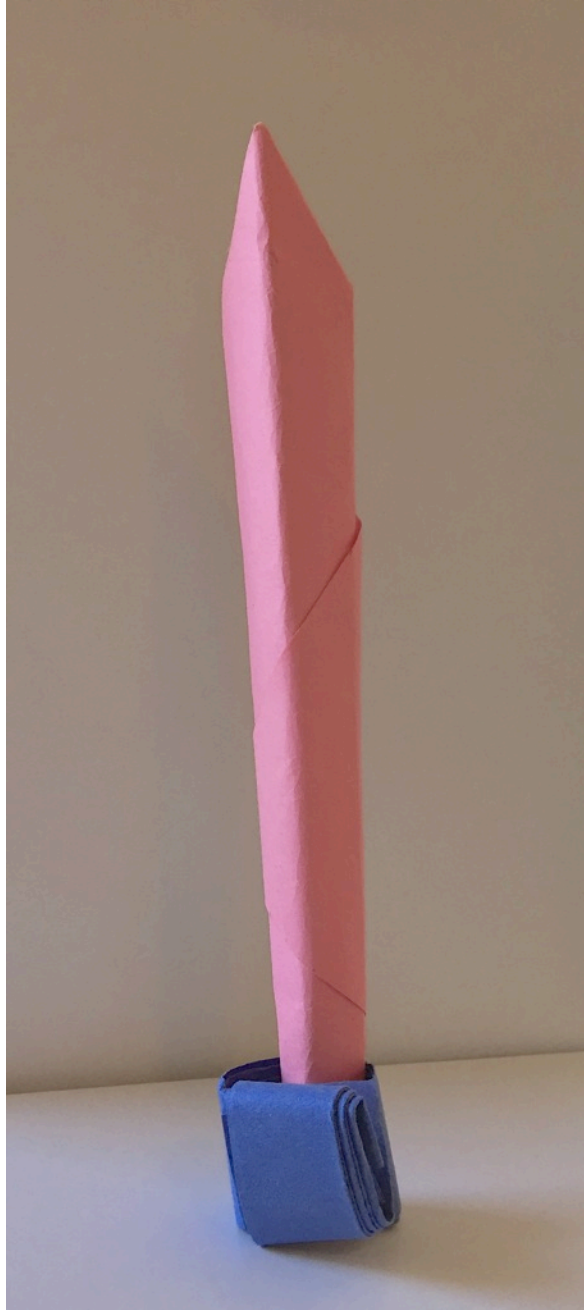
Figure 5. Paper sculpture by Tracy (Session 5)

Around this time Tracy came into session and disclosed that she was experiencing

great distress due to PTSD symptoms, particularly in the form of persistent nightmares in

which she found herself trapped in a re-experience of her rape and stabbing. I offered a

variety of art materials and provided psychoeducation on how they might be used as

grounding tools, anchoring her to the present moment by shifting her focus to the

sensations they were producing. Tracy naturally gravitated toward folding paper, and

occupied her hands with this process as she shared some of her trauma narrative. After

creating the pink blade-like shape, she used blue paper to create a stand for it (*Figure 5*).

The resulting sculpture is both strong and ominous, seeming to echo the shapes of the

weapons by which she was violated.
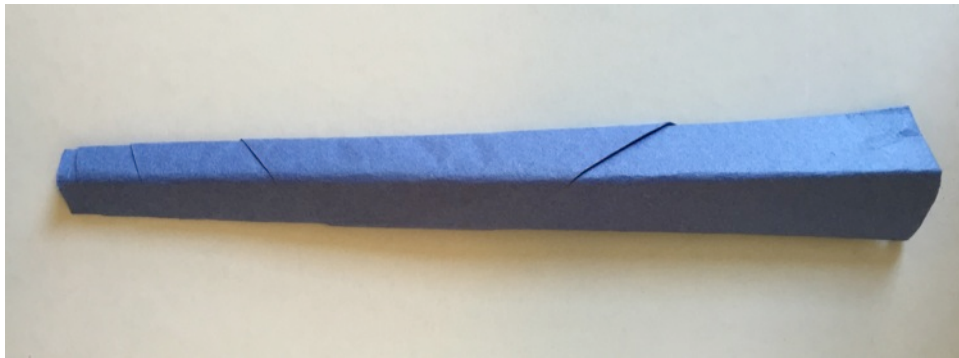
Figure 6. Paper sculpture by Tracy (Art brought to session 6)

Figure 7. Paper sculpture by Tracy (Art brought to session 6)

I checked in with Tracy in between our normally scheduled sessions to assess her

PTSD symptoms and provide her with an LED flashlight she could use when waking from

nightmares to confirm her safe surroundings. She brought two folded paper sculptures to

the session and gave them to me, informing me that she had been using this process when

triggered during groups and was finding it to be helpful for her (*Figures 6 and 7*), though

she did not perceive them as art. The striking similarity in the shapes of these paper

sculptures indicated to me that Tracy had discovered a meaningful self-soothing technique

in this grounding activity that was providing her with a sense of security.
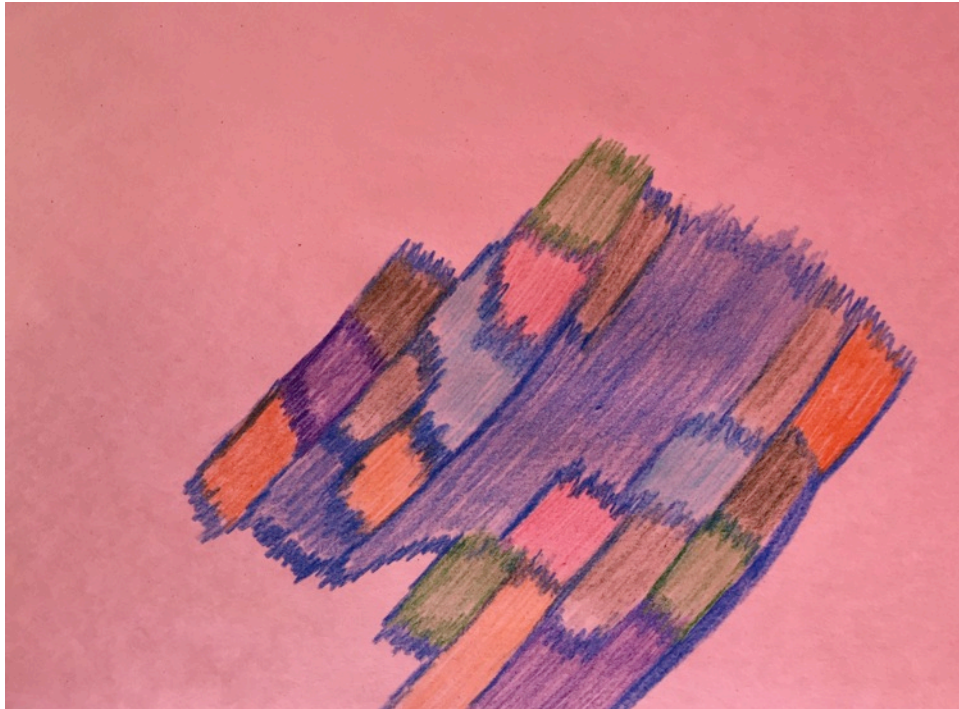
Figure 8. Colored pencil drawing by Tracy (Session 7)

Tracy told me at the start of our next session that she wanted to take a

break from trauma work, suggesting that we might each do a pencil drawing instead. I

consented in an effort to support Tracy's self-determined limits, believing that her

initiation of this alternate art process signified that, while wanting to back off of trauma

material, she was indeed invested in treatment. Tracy's colored pencil drawing (*Figure 8*)

has a map-like quality, the bordering of the tightly-shaded areas seeming to organize and

contain them. I noticed a parallel between these formal qualities and Tracy's self-

protective instinct in requesting a reprieve from working on her trauma. I also noticed that

this bordering and shading process appeared to provide emotional containment when

Tracy introduced the topic of being away from her children around the holiday season. In a way similar to her use of the paper-folding technique, the pencil drawing seemed to increase her capacity to tolerate a difficult emotional experience, allowing her to move through it without experiencing a panic attack.
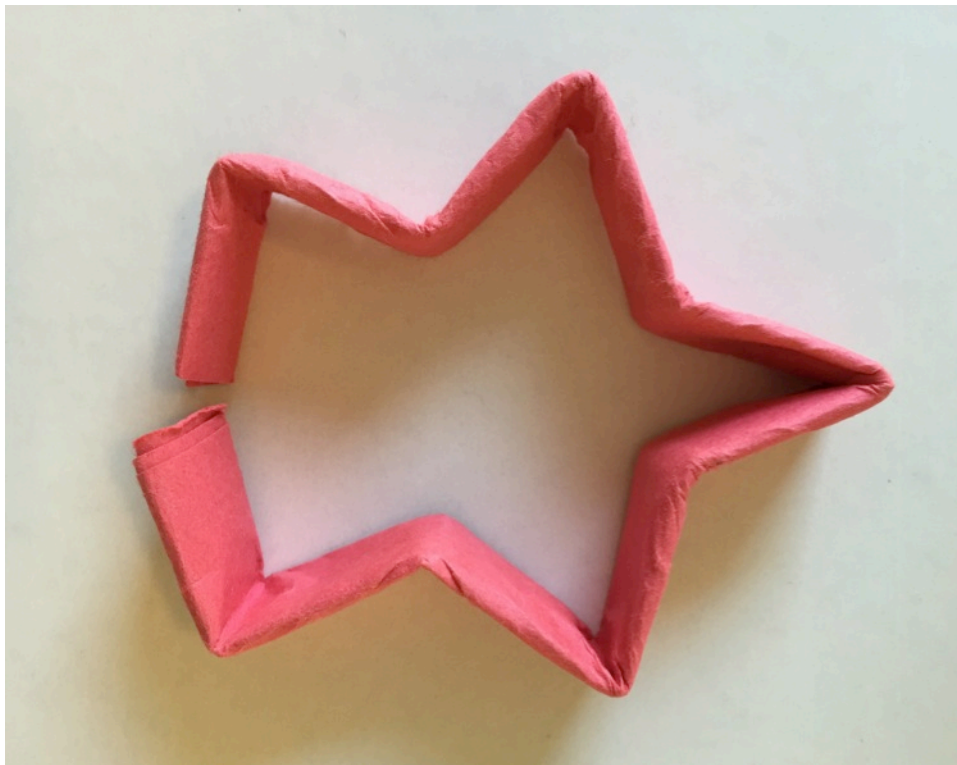
Figure 9. Paper sculpture by Tracy (Session 8)

The following session began with Tracy "venting" frustration surrounding an interaction with a staff member by whom she felt disrespected. Though she utilized paper-folding while recounting this experience, her process of manipulating the paper shifted, beginning with accordion folds rather than a rolling process. As I introduced the reframing of this incident as a positive instinct on Tracy's part to find power and assert her self-worth in the midst of working through trauma that has left her with a profound sense of disempowerment, she folded the paper into a star shape (*Figure 9*). Though the star closed into itself at first, its ends came apart from one another before the session ended,

and Tracy was unable to reattach them. Though her initiation of a product-oriented final step in her paper-folding technique seemed to me to indicate a shift in Tracy's sense of hope, her inability to close the shape effectively seemed to reflect the shakiness of this new ground.

Figure 10. Container for Tracy's paper sculptures (Session 9)

Tracy did not make new art in our next session, which functioned as something of a "mid-treatment review." I brought out the folded paper sculptures that had begun to amass in my cabinet, allowing Tracy to appreciate and voice their significance. She noted

that the folding process helped her to cope in the moment she was re-experiencing trauma or feeling intense anxiety, while the process of drawing onto the folded paper later allowed her to process and integrate her experiences in therapy and treatment at large. I offered Tracy a box to keep the sculptures in, hoping to convey to her to my own appreciation of their value and desire to protect them for her during our work together.
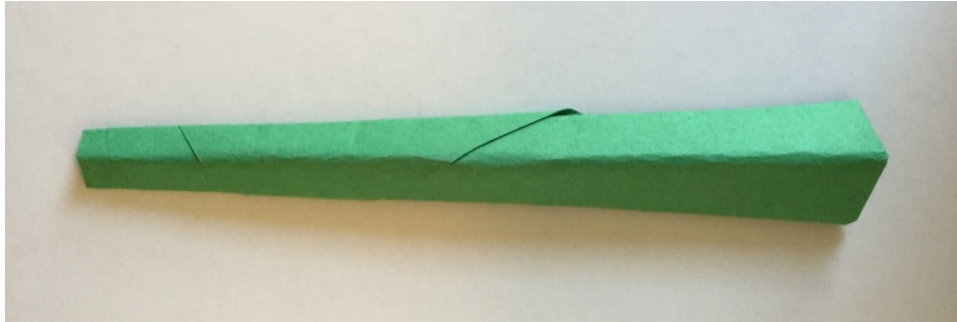
Figure 11. Paper sculpture by Tracy (Session 10)

At the start of our next session, Tracy again presented with intense emotion surrounding her interactions with a staff member. While discussing the situation and its parallels to her relationship with her mother, she selected a green sheet of paper and began folding it using her original rolling and folding method (*Figure 11*). Tracy's acknowledgment of the importance of her unresolved feelings toward her mother provided a powerful emotional trigger, as she for the first time expressed her own guilt about perhaps failing to keep her own children safe. I understood Tracy's return to her original folding method as a signal that she needed something familiar and grounding in order to tolerate voicing this feeling.
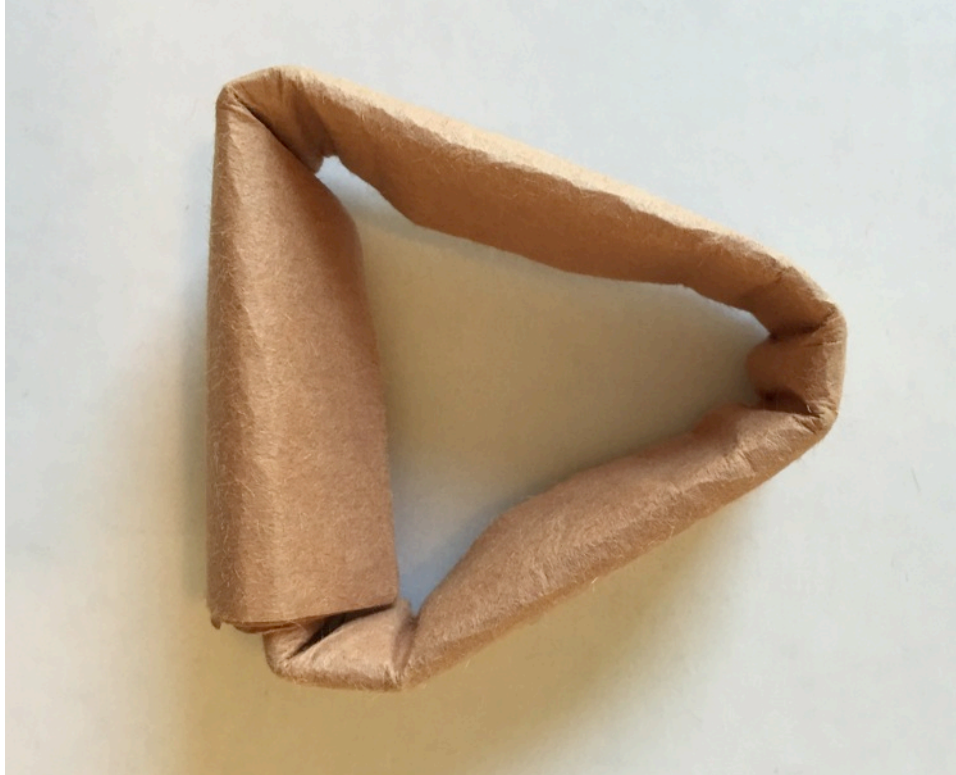
Figure 12. Paper sculpture by Tracy (Session 11)

The subsequent session began with a discussion of self-care, spurred by Tracy's decision to cut off her hair, which had previously been matted into a bun. Tracy then disclosed that she had had a trauma nightmare the previous night, but had been able to cope successfully by initiating a conversation with the night staff person about an incident in which she shot a would-be burglar in the leg. Tracy quite joyfully recounted this story to me, appearing to find a great sense of empowerment in it. She folded a sheet of paper during this time, again venturing out into a new folding process that resulted in a new shape (*Figure 12*). This time, however, Tracy persisted in her efforts to secure the shape, refusing my offer of tape or glue. She reflected that she didn't seem to need to crease and re-crease the paper so much anymore, suggesting her recognition of her progress in treatment. Both Tracy's shift in personal care and her response to her nightmare seem to

be reflected in her art process, in which she experimented with technique and found strength in her own ability to forge something solid.

Figure 13. Paper sculpture by Tracy (Session 12)

Again beginning with a "vent" of frustrations related to goings-on in the treatment community, our next session eventually shifted into a discussion of Tracy's lack of safety in childhood. Entering this emotional territory, she initiated a nervous process of rolling and re-rolling a sheet of paper, and was able to make another profound connection between her survival strategies in childhood and her actions in addiction. Following this emotionally intense moment, Tracy switched to a discussion of her developing spiritual

beliefs, beginning at this point to fold the paper accordion-style. Unlike all of her other

paper sculptures, this one was complete in an open and unsecured state, remaining flexible

(*Figure 13*). Though this session did not mark the end of Tracy's treatment, the shift in

her art process during this session provides a picture of the progress made up to this point.

Initially unable to effectively tolerate triggering emotions, Tracy had arrived at a space

where she felt capable and willing to utilize her art process as an aid in tolerating difficult

emotional material. Simultaneously, Tracy's demonstration of increasing confidence and

experimentation in her process during this stage of treatment paralleled her improvements

in self-care and boundary-setting, suggesting an improvement in self-esteem.

John, 29. John is a Caucasian male from a middle-class background referred to

treatment by the VA due to heroin addiction after receiving VA services for Posttraumatic

Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) following his service in the US

Army. John reports that his traumatic brain injury is the result of proximity to explosions

during his deployment, and PTSD is related to both witnessing and causing a multitude of

deaths.

John reports that he has "always been an addict," but notes that addiction became

particularly devastating when he began using heroin intravenously. He reports enrolling

in three prior treatment programs since 2010, after each of which he accomplished periods

of sobriety from 3 months to 1 year, but continued to relapse. He endorses current PTSD

symptoms, though he reports that they are greatly reduced since he entered treatment and

began taking prescribed trazodone and Seroquel. John reports experiencing an

exaggerated startle response when triggered by a loud noise, trauma-related nightmares,

and avoidance situations where he knows there will be loud or jarring noises, as these tend to trigger flashbacks.

John reports some notable features in his family life that seem to be relevant to his drug use. He describes his mother as his "guardian angel," detailing her heavy involvement in monitoring his using and countless efforts to get him into recovery. His father and grandmother died on the same day in 2010, the day after which he overdosed and technically died before being revived. John states that his father was an alcoholic and their relationship was poor during his childhood, but reports a good relationship with his father during the last few years of his life. John laments spending little time with his father during these years due to his military involvement and subsequent involvement with addiction.

John describes himself as a thrill-seeker, noting this as an important piece of his identity that relates to both his drug use and his passion for danger in his military career. My case formulation relates this piece of John's identity to his need for emotional regulation, noting this as a common theme in many areas of his life. John's description of his relationship with his mother suggests that he has come to rely on her as a self-regulating tool, lacking the ability to regulate his own behavior. His ability to thrive in the military suggests a similar affinity for regulatory structure, which perhaps provides him with an outer mechanism of control that he has been unable to create for himself since completing his service. His drug use can be viewed as yet another means of regulating his emotional experiences. Finally, John's discussion of his identity as a "killer" seems to reflect his deep fear of his own emotions and his inability to control them.

John and I established initial treatment goals of improving his ability to cope with flashbacks and intrusive thoughts and reducing the frequency and intensity of these experiences by creating an outlet for John's trauma narrative in the art.   Though John expressed the desire to do this trauma-focused work, he also expressed ambivalence about the process. Due to his shortened course of treatment (VA contract only allows three months instead of the usual six at the facility), we settled into a focus on John's thrill-seeker identity as it relates to emotional tolerance and emotional self-regulation rather than going into deep trauma work.

Figure 14. Clay sculpture by John (Session 2)

After my initial assessment I conducted my first art therapy session with John, in which I offered him air-dry clay and suggested he manipulate it freely. Compared to the highly structured initial intake session, the freedom offered in both session structure and in the art material seemed to function as an emotional opener for John, quickly leading to an emotive discussion of his traumatic experiences during deployment, particularly his experience of becoming afraid of his own capacity for violence. John's use of the clay

was particularly interesting to me, as he manipulated it impulsively and passionately, demonstrating no concern as it squished beneath and around the ring on one of his fingers. At the close of this emotionally intense session, John squeezed the clay aggressively into its final shape, naming it a "fist." The tension and aggression in this form (*Figure* 14) is a poignant representation of John's experiences, and seems to reflect his effort to control or contain his own emotions.
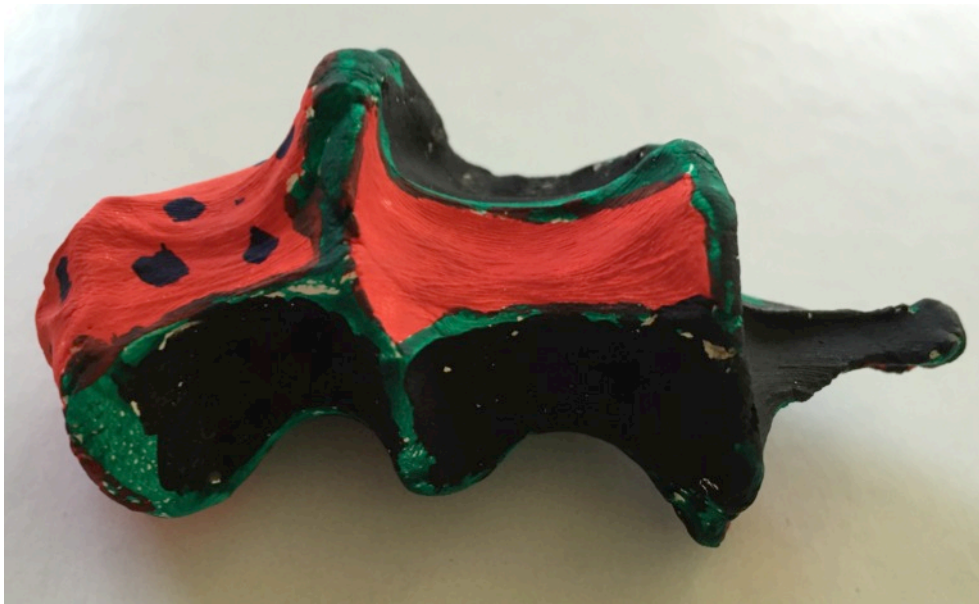
Figure 15. Painted clay sculpture by John (Sessions 3 and 4)

In the next two sessions, John worked in a careful and controlled manner on the painting of his "fist." This process of covering and containing seemed to me to indicate a discomfort on John's part with the emotional intensity of the session in which he created the fist. John initially descried this process as "painting the fist Christmas colors," but settled into a more complex explanation of his choice of color and shape by the end of his work with this piece (*Figure 15*).

Ultimately, John explained these choices as representations of different pieces of himself, identifying dualities of adrenaline junkie/hard-working soldier and dark side/light

side as key points of tension in his identity. Within this conversation I noticed John

shifting through these pieces, becoming passionate in one moment about the importance of

structuring his life around recovery and the desire to start a family, then jumping quickly

into an excitement-fueled and somewhat provocative explanation of his enjoyment of

physical pain. Though John's desire to paint the "fist" may have been spurred by a desire

to backtrack on his level of emotional exposure in therapy, his work with the painting

process led us to another key theme in his treatment, his struggle with integrating disparate

parts of himself.

Figure 16. Oil pastel drawing by John (Sessions 5 and 6)

In the next session, I introduced to John the idea I was having about emotional

regulation as a theme in his personality and experiences. We engaged in a dialogue about

this theme, discussing its various applications. Again I noticed the tension in John's dialogue, this time manifesting as conflicting narratives about his desires for his future. In one of these narratives John described a quiet and practical life structure, while in the other he envisioned himself as a nomadic adventurer. This verbal paradox seemed to me to signify John's deeper questions about what to do with the intense, excited and emotional pieces of himself that he had learned to keep inside, and how these might find outlets that would not threaten his life the way heroin use had.

John began his pastel drawing (*Figure 16*) with the explosion-like line structure in the center, identifying it as a "firework." His identification of this form linked his art piece to both his deployment experiences and his desire to seek out thrill as a means of excitement. In spite of the high energy of the subject matter, John's engagement with the materials was careful and slow-paced, again reflecting tension between wildness and control.

In the following session, John expanded on this image by adding sections of color and imagery in the firework's background. One of these images, the flames in the lower right corner, signified John's newly developed plan of pursuing a career as a firefighter. Another, the mountains in the top right corner, represented John's desire to continue to travel throughout his life. I understood this image as a step in the direction of a realistic integration of John's thrill-seeker identity into the structure of his desired sober life. This supposition was supported by John's presentation in session, as his hopefulness about the pursuit of these goals and his vision of a cohesive future for himself seemed to be both invigorating and comforting to him.

Figure 17. Painted mask by John (Session 7)

As John's short course of treatment began to approach its end, I began to notice

performative aspects of his behavior in group settings that differed from his presentation

in our individual sessions. While respectful and introspective in individual therapy, John

was often boisterous in art therapy group, often initiating discussions of glorified violence.

Though John's painted mask was a project initiated in my art therapy group, I heeded his

request to work on it additionally in individual therapy, as I felt that the mask-making

process provided an ideal metaphor for considering these different presentations and their

meaning.

John worked carefully on the bullet hole in the mask's cheek, telling me it was

important to him to get the bruising just right (*Figure 17*). John's work on this wound was

accompanied by discussion of his experience of causing the death of others. "When you

kill, that person's soul is attached to you forever as your responsibility." He described

feeling that once he had "broken the seal," he felt compelled to keep going to save others

from shouldering that same responsibility. The expressive eyebrows of the mask's

wounded face in contrast with the intimidating quality of the black beanie seemed to

parallel his verbal expression. Though he described feeling broken by the duties required

of him in his service, he also described a responsibility to these duties and a sense of

finding purpose in his ability to continue to carry them out. This disclosure added depth to

my understanding of John's exaggerated and performative military identity, as I was now

able to understand this as an area of John's life in which he was able to feel a deep sense

of altruistic accomplishment even as he suffered emotionally.

Figure 18. Painted mask by John (Session 8)

The final session in which John made art was dedicated to the completion of his

mask, which underwent a significant transformation. Once expressive and somewhat

vulnerable, I observed a more intimidating and hardened quality in the overall tone of the

mask's final state (*Figure 18*). Perhaps John's need to reengage his own "mask" grew

from a sense of fear of incompetency surrounding his ability to maintain his recovery

post-treatment. Though John had been a model client throughout his course of treatment,

often commended by facility staff as helpful, positive and capable, the final few weeks of

his time in treatment was fraught with disorder and decomposition surrounding his planning for post-treatment life. John's uncertainty about his ability to execute any new course of action in his life seems to be reflected in his retreat into the known territory of "hardened soldier."

Though John's mask constituted his final artwork within treatment, I dedicated our final two sessions to assisting John in the practical tasks required to enroll in fire science school and secure housing. John's ability to express his need for help in these areas constituted a new course of action for him, as he has previously exited treatment without plans in place due to his desire to maintain an image of competence and independence. Though John may have continued to need his mask in certain spaces within his life, his ability to let it fall within our last few sessions allowed him to complete treatment with a concrete plan that lead him in the direction of his goals.

Monique, 37. Monique is an African-American female of low SES who identifies as Christian. She entered treatment in compliance with a DCFS case in an attempt to reunify with her three youngest children. All of these children, ages 2, 1, and 3 months, were removed from her custody when they tested positive for cocaine at birth. Monique reported depressive symptoms upon initial assessment, stating that she felt inadequate, frequently isolated herself from others, and sometimes had feelings of hopelessness and worthlessness. She also reported continued cravings for crack cocaine while simultaneously accepting that using at this point will have negative consequences for her. Monique entered treatment with ongoing medical complications from her recent cesarean section operation in which her ureter was cut unintentionally. She was frustrated with this

situation due to both the constant pain it caused her and the shaming and perceived

discrimination she experienced from the medical professionals involved in her care.

Monique's family history is significant in her case formulation. She reports that

she "was a drug baby," and that every member of her family with the exception of her late

grandmother was addicted to crack cocaine. Monique reports being molested at age 10 by

her uncle, who lived in the home with her family growing up, and reports that this uncle

also molested younger siblings and cousins. When Monique was 10 years old, she and 9

other children (some siblings and some cousins) were all removed from the family home

in a traumatic incident in which the police raided the house, after which she was placed in

institutional foster care.

In her adult life Monique has incurred further trauma related to her lifestyle. Her

24 years of cocaine use have caused ongoing problems in many areas of her life. She has

spent time in prison, resorted to prostitution to fund her substance use, and had three

infants removed from her care by DCFS. Monique's romantic partnerships have been

unsatisfying and unstable, and the father of two of her children is currently serving time in

jail for kidnap, rape and robbery. My case formulation supposes that the 60 days of

sobriety Monique had achieved at the outset of therapy cleared her system of drugs but left

her with depressive symptoms and residual anger related to these traumas.   Monique

named her faith and her children early on as sources of strength and clarity for her, though

her feelings surrounding her children are also a gateway into multilayered feelings about

her identity as a mother and her relationship with her own mother.

Monique identified her goals in therapy as gaining understanding about why she

uses drugs and working on her "hotheadedness." As treatment progressed, it became clear

that she was also motivated to use therapy as a space to process her childhood trauma and explore her family legacy of addiction, themes that became the focus of our work together.

Monique made two drawings in our first session after I gathered basic intake assessment information. I offered the directive of depicting something important I should know about Monique, which she responded to by producing a list of the names of her four children written in script, each beside their age in brackets (I have excluded this image for confidentiality purposes). She explained this image by telling me the stories behind the names of each of her children, appearing proud and smiling during this discussion. Though her discussion of her children was in many ways typical of a new mother, a sobering moment arrived when Monique acknowledged her drug use during her pregnancies with her youngest three children and noted that she herself was born with cocaine in her system. My understanding of this initial art piece was that, in spite of her separation from her children and the emotional pain surrounding it, Monique also had a desire to cling to her identity as a mother and go through the motions of motherhood. I also gathered that there was a strong and complex connection between Monique's identity as a mother and her feelings about her own mother, a connection which was likely to be weighted with both resentment and guilt.
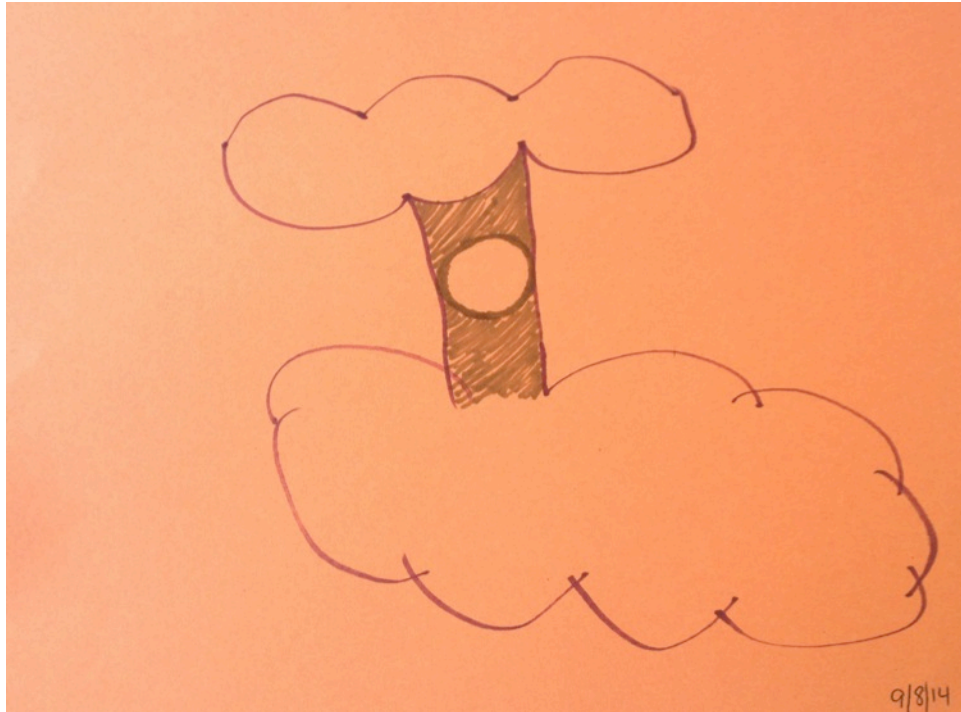
Figure 19. Marker drawing by Monique (Session 1)

The second drawing Monique made in our initial session (*Figure 19*), likely a response to the complex emotions brought out by the first, began as a tree-like shape. After completing a treetop shape, Monique inverted the paper, adding another treetop-like shape on the other side of the trunk. The resulting form appears to be a tree lacking orientation. The trunk, while thick and opaque, contains a hole so large that its stability appears at risk. Both of these formal qualities suggested to me that Monique was feeling similarly disoriented and unstable in that moment of her life, and perhaps within the therapy session.

Figure 20. Oil pastel drawing by Monique (Session 2)

Monique presented in our second session with defeated affect, reporting a sense of hopelessness and cravings to use. She became tearful during her description of these feelings, appearing overwhelmed by her own emotional state. In an effort to provide her with enough containment for her to remain in treatment, I suggested she create an image depicting her motivators for recovery and personal strengths. Monique described her oil pastel drawing (*Figure 20*) as an image of her faith, and also identified an accidental self-portrait in the image. Appearing rejuvenated and uplifted by this image, Monique also seemed to relish the art process itself, noting her enjoyment of the texture and vibrancy of the pastels. Both Monique's recognition of herself in the image and her joyful engagement with the materials indicated to me that art was a powerful method of mobilizing Monique's resiliency.

Figure 21. Folder by Monique (Sessions 3 and 4)

In our next two sessions, Monique utilized collage process to create a folder for her

artwork, an activity that provided her with an opportunity to express parts of herself not

addressed in the intake assessment process. In a manner similar to her engagement with

the sun drawing, Monique seemed to draw incredible strength from the process of creating

and reviewing the resulting art piece (*Figure 21*). Selecting images that expressed her

passions, strengths, spirituality, perseverance, and strong cultural identity, Monique

compiled an art piece that, when viewed by her retrospectively, seemed to affirm the

fullness and richness of her life and identity. Because this collage became another

strengthening symbol for Monique, I printed a miniature version of it that she could keep

with her outside of our sessions to reconnect her to her strength in difficult moments.
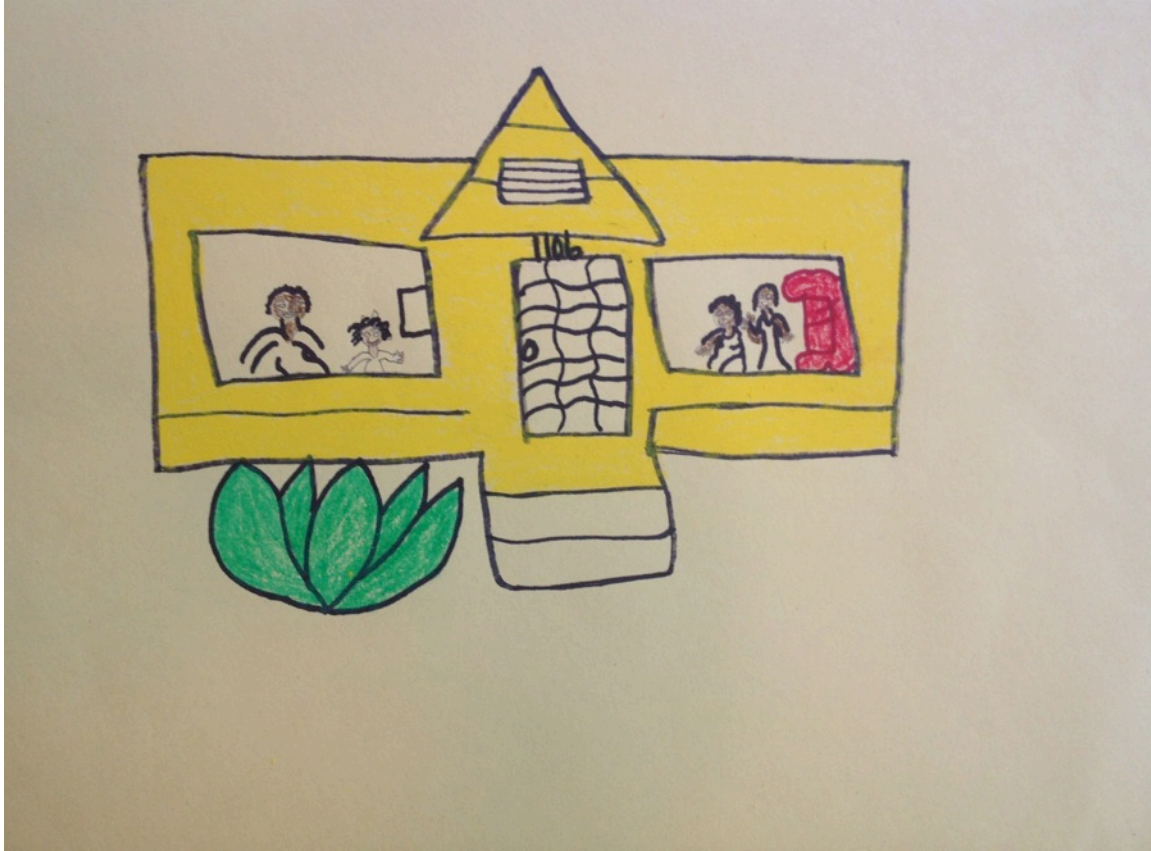
Figure 22. Drawing by Monique (Session 5)

Monique initiated our next session with a request that she might use our time together to work on a "family drawing" assignment she was required to complete as part of the workbook pages assigned by her counselor. Grateful that Monique had the instinct to utilize our space to undertake this potentially destabilizing process, I agreed. Because of Monique's childhood trauma and the multigenerational history of substance abuse in her family, this initial "family drawing," was the start of a long and elaborate process that grew into the main body of work in Monique's course of treatment.

In her first installment of the family drawing, Monique focused primarily on creating an architectural structure in the likeness of her family's home. Utilizing pencil first and then adding Sharpie for outlines and pastel for color, Monique's process reflected

her investment in setting the scene for the exploration of her childhood trauma she would

undertake in our ongoing work with this drawing. Her care in creating a strong structure

seemed to me to indicate her awareness that this process would require a strong

foundation, perhaps one she had begun to create in her earlier strengths-focused artworks.
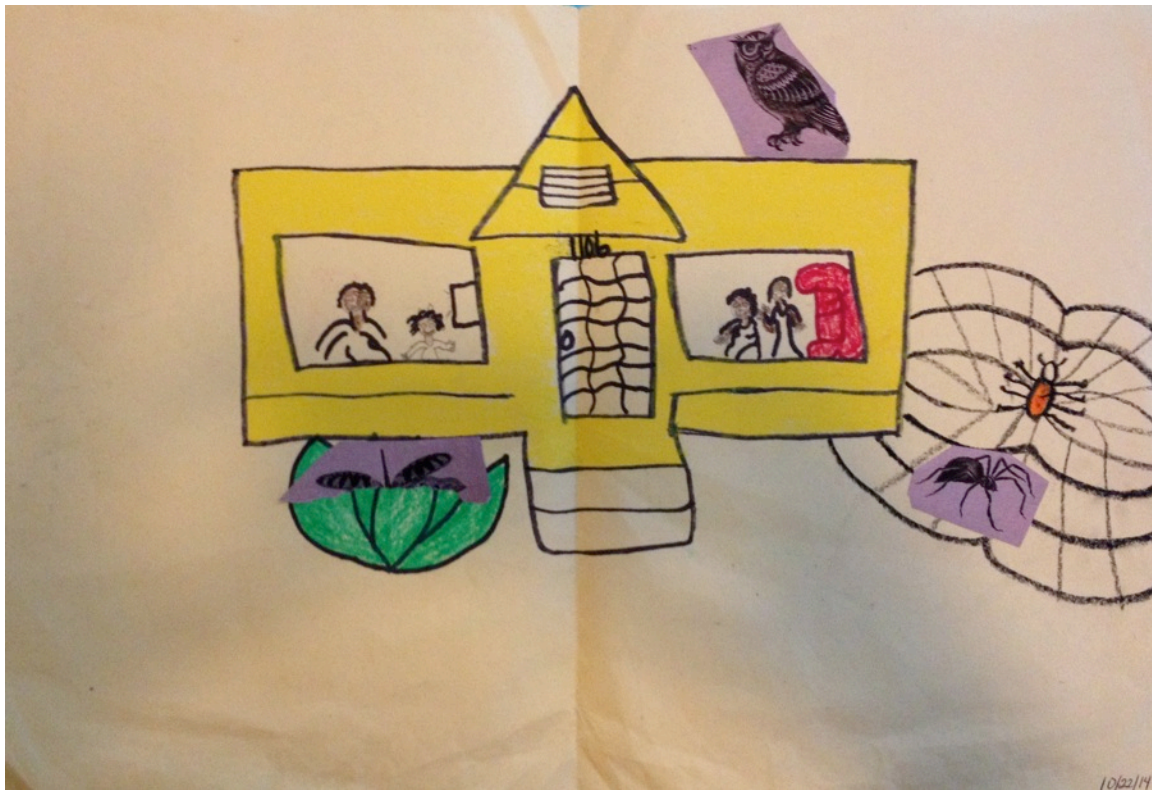
Figure 23. Drawing by Monique (Session 6)

The second installment of Monique's family drawing became an exploration of her

childhood trauma. Moving into a detailed description of the figures in the drawing,

Monique identified her grandfather, her childhood self, her grandmother, and her mother

(left to right), describing the roles of these different people in her family system. Monique

then disclosed a detailed account of her molestation by her uncle at age 10. She went on

to describe a consequent traumatic memory, the day when she, her siblings, and her

cousins were removed from the home by police and placed in institutional foster care.

The prominent spider web beside the home (*Figure 23*) was an important feature of this trauma narrative, as her confrontation with this web upon attempting to flee the home was the factor that caused her to decide she needed to stay with her younger siblings and protect them rather than evading the police. Monique's description of this moment of decision, as well as her artistic emphasis on the spider web, indicated to me that this piece of the memory held powerful significance for her, seeming to relate to ideas about predestination, fate, and purpose. At the close of this session Monique folded the drawing in half before placing it into her folder, reflecting her need for containment during this process.

Figure 24. Drawing by Monique (Session 7)

In Monique's third session with her family drawing she began to fill in the background of the image, adding realistic elements from the setting of the home that held significance for her (*Figure 24*). This effort to fill in the space had the formal effect of

cushioning the image of the house, suggesting Monique's desire to protect her trauma

narrative by enclosing the scene of its occurrence. While adding the natural elements,

Monique shared some positive memories of her grandmother's history in the home,

indicating her desire to integrate her fond memories of that space with her traumatic ones.

Monique also included the sun and a telephone pole, both of which she described as

sources of power from God. Though the telephone pole and power lines held spiritual

meaning, Monique also connected them to her family's inability to pay their electric bills,

resulting in challenges keeping the water and power on at the house. This session seemed

to provide Monique with the opportunity to thicken the narrative of her family home by

bringing in enriching memories, spiritual ideas, and issues related to socioeconomic status.
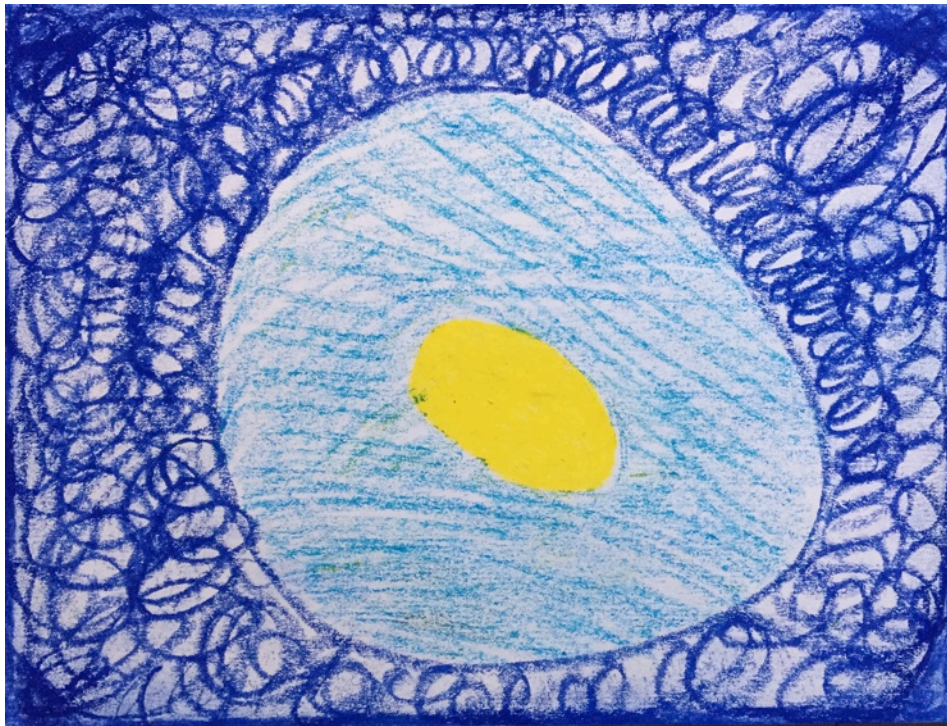
Figure 25. Pastel drawing by Monique (Session 8)

At the start of our next session together, Monique expressed feeling distressed

regarding the relapse and untimely discharge of two of her roommates. Expressing that

she "needed to see something blue," Monique proceeded to create an abstract image

(*Figure 25*). After creating this picture, Monique observed that it had the appearance of

an "egg" cushioned by water, which she linked to her renewed awareness in this situation

that her own recovery was vulnerable and required protection. Monique's self-directed

utilization of the art process to meet her own needs and explore current challenges

indicated both self-awareness and increased self-efficacy. Once she had processed the

meaning of this artwork, Monique announced that she wanted to return to her family

drawing, indicating that this art activity had provided her with the containment and

processing space she needed around the relapse event, readying her to resume working on

herself.

Figure 26. Drawing by Monique (Session 8)

Monique focused her fourth installment of her family drawing on the addition of a

chain-link fence (*Figure 26*). Unsure about how to depict the fence, Monique utilized

scratch paper to develop a system of rendering it before adding it to the image. Her

process with the addition of this fence reflected a growing sense of competency in

problem-solving through the art process, as well as a strong investment in the image. The

fence also seemed to serve as a containing structure, allowing Monique metaphorical

control over her engagement with the emotional material behind it. The bluebird Monique

added atop the fence, spreading its wings, seemed to represent her consideration of "taking

flight" from this space as she moved into a new era of her life.

Figure 27. Drawing by Monique (Session 9)

Monique's final engagement with her family drawing came alongside the news

that the family home was in the process of being repossessed due to nonpayment. Though

she considered adding a "for sale" sign to the drawing, Monique opted instead to add a

mailbox and a second rose bush as her final process with the drawing (*Figure 27*).

Monique's decision seems to reflect an understanding that, while the home will no longer

be a part of her family, she will retain the ability to communicate with the memories she

hold of her family's time in that space. The raised flag on the mailbox suggested to me

that there was more remaining to be said about this home and the family that occupied it

for decades.

Figure 28. Paper cut collage by Monique (Session 10)

As Monique's time in treatment neared its end, she came to a natural place of

reflection, finding great spiritual significance in that space of transition. Monique initiated

her final art piece, a visual representation of the state of gratitude and freedom she

described in our final sessions. With the plan of adding a butterfly to the picture, Monique

began the process of creating an environment using a paper-cut collage technique.

Featured in this background (*Figure 28*) was the sun, a powerful symbol of spiritual

connection that had been meaningful for Monique throughout her work in art therapy.

Though she had not done so in any of her other pieces, Monique urged me to help her with this picture by gluing down some of the rays she had cut out. I understood this gesture as Monique's way of acknowledging the end of our therapeutic relationship by inviting me to participate in the creation of her transition image.

Figure 29. Paper cut collage by Monique (Session 11)

The final additions to Monique's last artwork included not only the butterfly, a self-symbol Monique chose for it transformative symbolism, but also a cloud, a tree, and two apples (*Figure 29*). Monique's inclusion of the two apples, one beneath the tree and the other across the page, conjured images of the popular saying "the apple doesn't fall far from the tree," an observation I reflected to Monique. Our discussion of this saying and its relationship to her piece led her to the assertion that, in spite of her mother's addiction and the strong legacy of addiction in her family, she finally felt free to follow a different course. In this way, this final art piece became a visual representation of Monique's

determination to break free of the family cycle of addiction, a theme that appeared throughout our work together. Monique's boldly outlined butterfly, wings lifted from the page in preparation for flight, reflects her sense of ability to achieve this liberation.

Carmen, 25. Carmen is a Mexican-American female with a low SES background. Carmen was referred to treatment by her social worker after her son was removed from her care due to her methamphetamine use, an event resulting from a child abuse report made by her boyfriend, the father of her child. Prior to this intervention the couple lived with their 4-year-old son in a room they rented from his mother. Carmen reported that her siblings and father also have problems with alcohol and drugs, and that her boyfriend drinks but does not use illegal drugs. She acknowledged past gang involvement. Carmen reported that her prior treatment included a month in juvenile detention for grand theft auto when she was 16 and a partially completed treatment program for marijuana and alcohol at age 18 after which her drinking and using escalated.

Upon initiation of individual therapy Carmen reported depressive symptoms, stating that she isolated herself from peers and felt alienated and lonely. She reported sleeping during the day as a means of making time pass, difficulty concentrating, and difficulty remembering information imparted in groups. Additionally, she reported experiencing strong and frequent cravings.

Carmen reported complex feelings toward her father, who abandoned the family when she was thirteen. My case formulation at the outset of therapy was that Carmen's reckless behavior and substance abuse related in part to her father's abandonment. I suspected that her substance use served a self-medicating function that disconnected her

from the pain of his abandonment, and that perhaps her gang involvement had come to serve as a surrogate family experience for her. Considering her symptoms at the start of therapy, I guessed that the pain of this abandonment might be reemerging through her depressive symptoms now that she has discontinued her drug use. I also suspected that her strong mixed emotions toward her father might be tied into feelings of guilt and shame about her own performance as a parent.

Carmen's self-defined goals at the outset of treatment were to be able to mother her son again and to learn to love herself. She also shared early on in therapy that she felt she needed to process resentments toward her father. Though I did not realize this at the outset, we might have decided to focus first on reducing the strength and frequency of her cravings and reducing isolation and withdrawal behaviors, keeping in mind the long-term goal of reducing Carmen's feelings of inadequacy by building her self-esteem. In retrospect I see that this change in pace and organization of treatment might have better served Carmen.
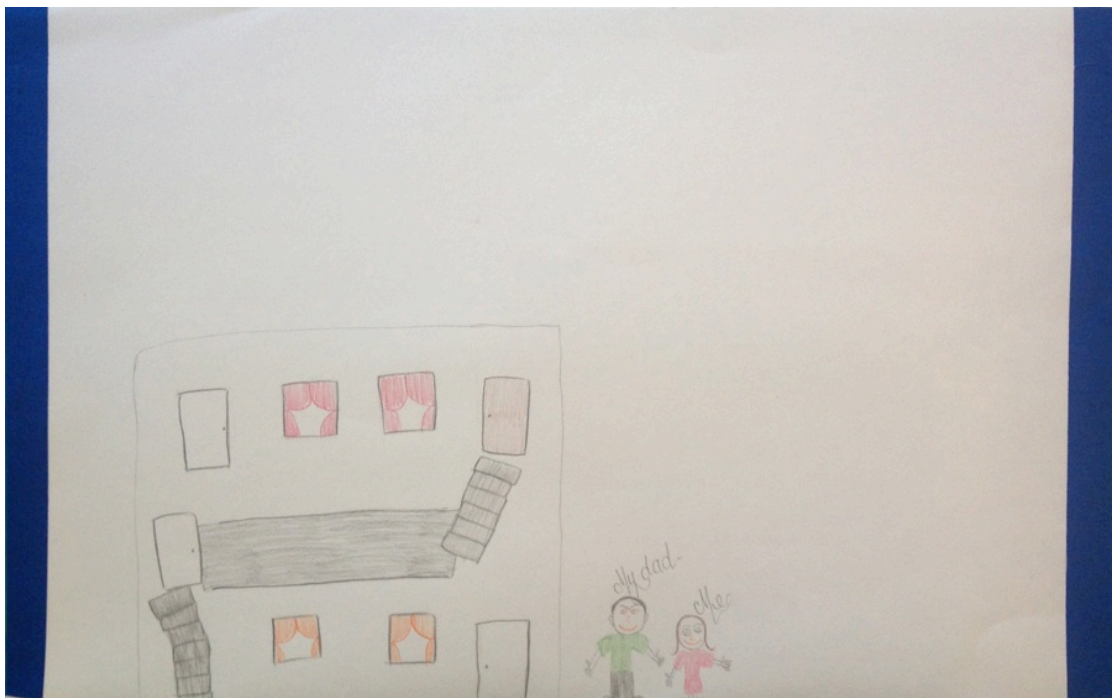
Figure 30. Folder by Carmen (Session 1)

I had already begun to know Carmen though her participation in art therapy group

at the point we initiated individual sessions. Perhaps because of this familiarity, my first

individual session with Carmen found us in highly charged emotional territory. I had

given her the directive to create an art folder decorated with something she would like me

to know about her, and Carmen made the decision to depict the last time she saw her

father before he abandoned her family during her youth (*Figures 30 & 31*).
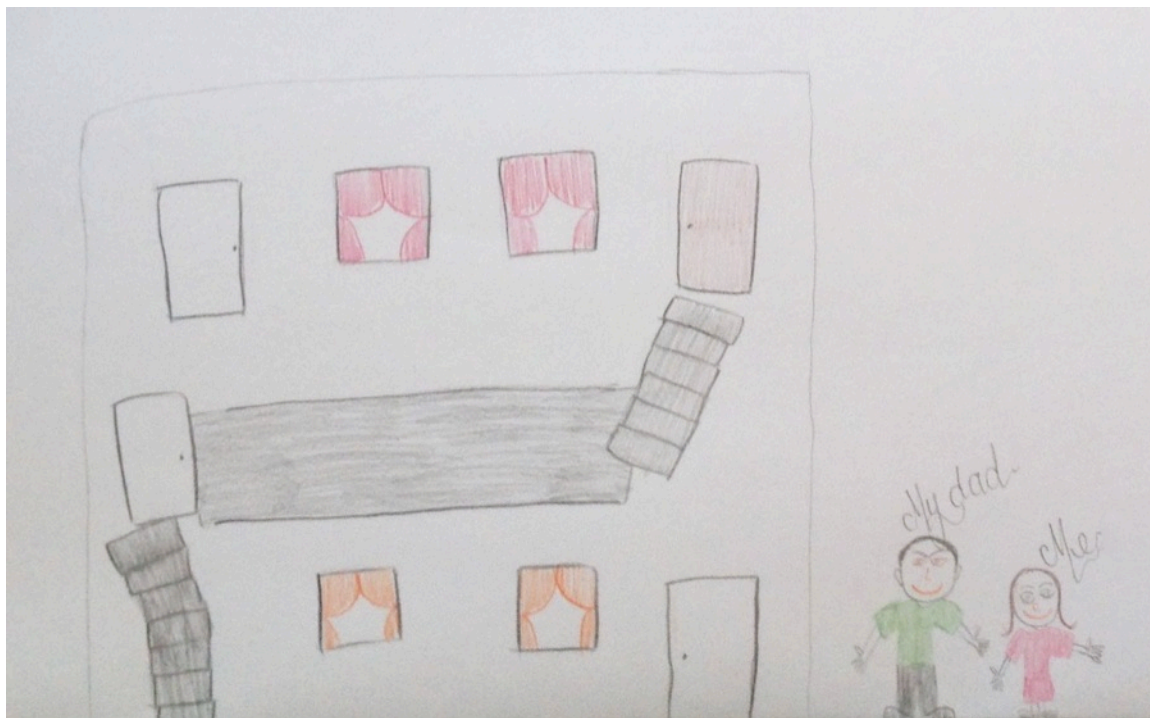
Figure 31.   Detail of folder by Carmen (Session 1)

Carmen's choice of pencil and her careful coloring of this image (*Figure 31*)

suggested a need for containment around this topic, even as she indicated readiness to

explore it by introducing it early in therapy. Both Carmen's childlike depictions of the

figures and the x-ray vision style of depicting their apartment building, suggest that

Carmen's engagement with this drawing came from the space of a younger version of

herself. Though she verbalized longing, anger, and pain surrounding this topic, Carmen's

affect did not indicate connection to these feelings during the session.
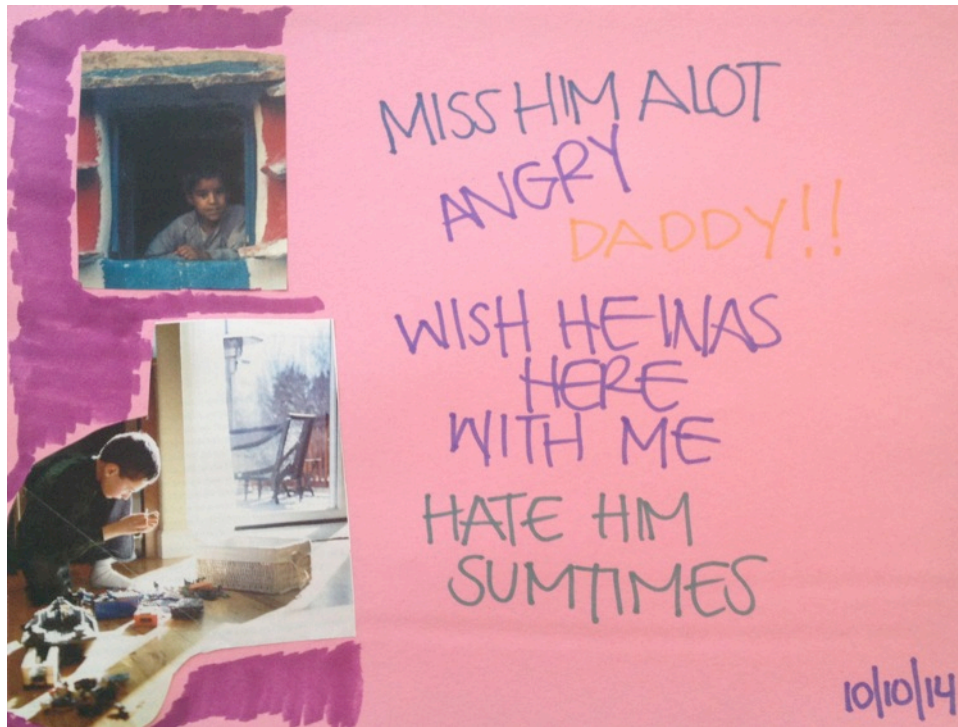
Figure 32. Drawing/collage by Carmen (Session 2)

In our second individual session, Carmen expanded on the theme introduced in our

first session. Having reviewed her folder, she began to describe the layers of feelings she

had toward her father, which she then translated into an image (*Figure 32*). The words

Carmen selected for this image illustrate the duality of anger and longing, while the

collage images she selected suggest a sense of loneliness. Interestingly, Carmen selected

collage images featuring boys, which suggested to me a fear of recreating her experience

of abandonment in her son's life. Carmen's use of marker to fill in the blank space around

the images seemed to indicate a desire to hold or cushion these lonely figures, perhaps

relating to her own desire to parent her son.

Figure 33. Mask by Carmen (Session 3)

Because she had missed the art therapy group in which her peers made masks, Carmen expressed a desire to make a mask in our third individual session. Utilizing collage, Carmen focused this art piece on the topic of addiction and recovery, departing from the territory of her feelings surrounding her father. The high concentration of demonic and substance-related images in the mask's brain region seemed to mimic Carmen's current experience of struggling with cravings to use (*Figure 33*). Though Carmen stated the intention of using the bottom half of the mask to depict her hopes for recovery, her focus on the upper region in this first session seemed to reflect her current state of mind. The image of clasped hands connecting the two regions perhaps indicated

hope of rescue from the overwhelming mental state of addiction. The mismatched eyes seemed to mirror Carmen's own struggle between two selves – one wanting to achieve sobriety for the sake of her son and the other wanting to return to using.

Figure 34. Mask by Carmen (Session 4)

Our next session provided space for Carmen to finish her mask, and found Carmen experiencing ongoing cravings and ambivalence about recovery. Carmen's completed mask (*Figure 34*), though more full spatially, seemed to reflect a challenge filling the "recovery" half of the mask. Blank space remained in this region, and it also housed some unwelcoming imagery, namely the word "scare" and the lock bar atop the mask's mouth.

These departures from Carmen's stated plan of focusing on her hopes and goals for

recovery on the bottom half of the mask further highlighted Carmen's ambivalence about

pursuing long-term sobriety.

Figure 35. Clay sculpture by Carmen (Session 4, originally created in art therapy group)

As Carmen's verbalizations in our sessions began to lean more heavily on

discussion of her relationship with her boyfriend, I decided to re-introduce the self-symbol

she had created in art therapy group prior to initiation of our individual sessions. I made

this decision because Carmen's description of this figure as weak, scared, and desperate

for affection from anyone who would give it had seemed to me at the time to relate to the

dynamics of her romantic relationship. As I reintroduced this figure, I pointed out to

Carmen that its tail had broken off. Our initial integration of this cat self-symbol into our

individual work focused on Carmen's repair of the figure's tail, a symbolic act of self-

care. Simultaneously, her perspective on this figure began to shift, leading to her assertion

at the close of the session that "It's actually pretty cute."

Figure 36. Clay sculpture by Carmen (Sessions 5, 6 and 7)

Our next several sessions focused on providing a context and companionship for

Carmen's cat self-symbol (*Figure 36*). In the first of these sessions, I asked Carmen to

think about what the cat needed, which spurred her construction of a bed, a pillow, and

two balls of yarn. In another symbolic act of self-care, Carmen placed her cat inside the

bed with these items, reflecting that it now had the things it needed. The symbol of the

yarn balls spurred Carmen's acknowledgment of her own desire to improve her parenting,

as she recognized that she had used toys to placate her son while using but not had the

intention of playing with him actively.

In the following session, Carmen decided that the cat needed her family with her.

Carmen constructed a kitten first, placing him beside her self-symbol in the cat bed. Next

she began constructing a tiger, which she stated would be the symbol for her partner. Her

choice of this wilder and more aggressive cat as his symbol indicated a possible

intimidating quality in his character. Though her construction had been quick and purposeful with the cat and kitten, her process in constructing the tiger was less straightforward, as she encountered problems with the attachment of legs and stability. I suspected that perhaps her struggle with the building of this form reflected struggles within her relationship with her partner.

Interestingly, though the tiger remained incomplete, Carmen chose to proceed with her family sculpture by painting her own cat in our next session. She carefully coated her self-symbol in bright pink, reflecting that she needed to take care of herself first before attempting to improve her relationship. Carmen's decision to leave the tiger unfinished, as well as his placement outside of the bed seemed to reflect a desire to disempower this figure within the scene.

In her painting process Carmen encountered a challenge while painting around the details of the cat's whiskers and facial features. Though she did so tentatively, Carmen discovered a process through experimentation by which she could remove excess paint from the features using a water-dipped brush. This experimentation and problem-solving in the art process mirrored Carmen's choice of hot pink – both seemed to reflect increased self-confidence since the initiation of treatment.
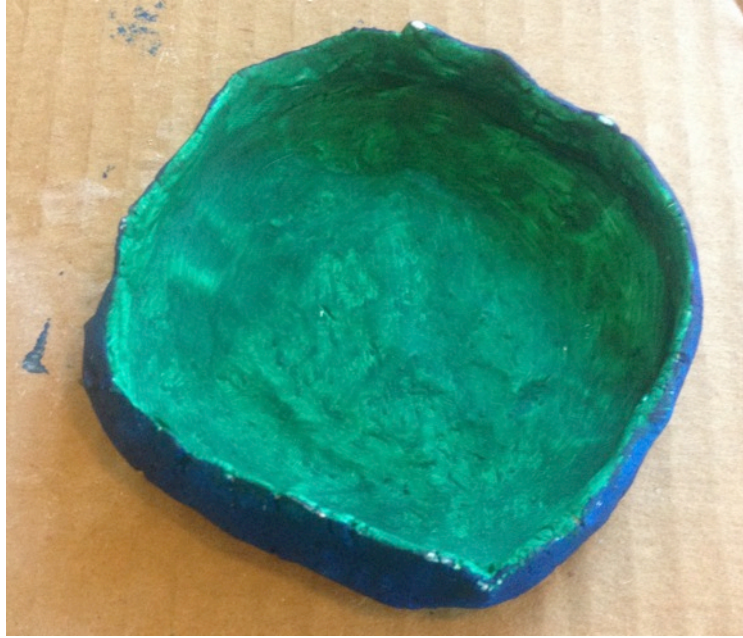
Figure 37. Painted clay sculpture by Carmen (Session 8)

Figure 38. Painted clay sculpture by Carmen (Session 8)

Though Carmen reported a reduction of her cravings in the following session, she

began to open up about her partner's controlling and suspicious behavior in their

relationship. Carmen's work on her family sculpture during this session consisted of

painting the bed (*Figure 37*), then moving on to paint the tiger orange (*Figure 38*). I

found it interesting that Carmen chose to proceed with so many other processes in the

piece before completing the construction of the tiger. Her prioritizing of these other tasks

seemed significant to me, perhaps a symbolic strategy of avoiding the problems in her

relationship. Though Carmen voiced a decided intention of remaining in with her partner

in order to preserve their family unit, her handling of the tiger in her art process continued

to reflect ambivalence about certain qualities in their relationship.

Figure 39. Painted clay sculpture by Carmen (Sessions 9 and 10)

In her penultimate session working on the cat family, Carmen dedicated herself to

making repairs to broken whiskers and detached tails and ears. This repair process

seemed satisfying to her, perhaps as a metaphor for the repair process she was hoping to

undertake in her family system. The sculpture's need for continuous repairs seemed to

serve as a process-based metaphor for the work in store for Carmen's family after her

treatment completion.

Carmen's last engagement with the piece brought stripes to the tiger, as well as his

long-awaited ears and tail. Painting the kitten grey was Carmen's last process with the

sculpture. Even as she marveled at her completed artwork and expressed satisfaction, I

noticed that the arrangement of the figures retained the tiger's distance from the rest of the

family (*Figure 39*).

In Carmen's review of her entire body of artwork, she noted insightfully that her

cat's propensity to "love whoever pets it" was likely related to a desperation for attention

from men, stemming from her father's abandonment. Though Carmen was unwilling to

engage in open critical discussion of her relationship with her partner, her process with the

cat family and her ability to make this connection indicate a level of awareness about the

problematic pieces of her relationship.

Carmen reported being uncertain about long-term sobriety even at termination,

acknowledging that she might use once her DCFS case closed. In many ways, Carmen's

ambivalence about her recovery paralleled her ambivalence about looking into the

problems in her relationship. Both commitments seemed to require from her a level of

responsibility she feared and prescribe a course of action she was unsure about taking.

Carmen's art process and product, coupled with her verbal expressions, provide an

illustration of these themes.

Analysis of Data

Development of coding system. I developed a coding system (see Appendix I)

for analyzing client artwork based on my review of the literature. I selected key points

from each of the theoretical models of addiction and recovery I reviewed that I anticipated

might be noticeable in the artwork. I based my selections on themes in process, product,

and therapeutic dynamics that I had already begun to observe in my work with substance

abuse clients. I include footnoted citations for the concepts identified in the coding system

so that the specific ideas can be easily traced to the literature.

I made revisions to the initial draft of the coding system after piloting it with my

research mentor, based on our mutual observation that the level of detail in the coding

system was distracting and cumbersome. In an effort to streamline this coding tool I

revised the categories listed, paring them down by combining similar or related concepts

within each theoretical model. I also made an alteration to the categories I was using to

situate these theoretical ideas within the art therapy process and product, reducing them

into three more general clusters. I utilized the first of these categories, "therapeutic

process," to code incidences of each concept that I observed in the clients' interactions

with the therapist and engagement with therapy itself. I used the second category, "art

content and verbalization," to code incidences of each concept that I noted in the artworks

themselves or in clients' verbal descriptions of the artwork. The third category, "art

process," I reserved for incidences in which I observed the concept at work in the clients'

engagement with the art materials.

Application of coding system. I utilized the coding system to analyze the artwork

and therapeutic process of each session I held with my four participating clients. For

artwork that continued across multiple sessions, I coded sessions separately, as these

sessions often had quite different foci in spite of the common art project. I limited my

selection of relevant coding categories for each session to those I felt were clearly

emphasized in the therapeutic process, art process, art content, or verbal content of the

session. When I understood the concept as relevant in more than one category (e.g. I

observed it in both the therapeutic process and the art process), I counted it in multiple

times. I consulted with my art therapy supervisor throughout the course of therapy in order to maximize my understanding of the artwork as it relates to these theoretical ideas.

Process of data analysis. In an effort to interpret the data gathered through the application of the coding system, my first step was to count the number of times I identified each concept across all of the coding sheets I utilized. I totaled these numbers, then input them into an excel spreadsheet, where I chose to highlight the five themes I had identified as most prevalent through the application of the coding tool (Table 1). I then utilized the chart creation feature within Excel to reformat the data into a bar graph to create an alternative visual representation of the data (Table 2).

Concepts from Literature Noted in Cases

	Therapeutic Process	Art Process	Art Content and Verbalization	Totals
Personal responsibility (moral)				0
Powelessness/HP (12-Step)			3	3
Principles/routines (12-Step)			3	3
Existential concepts (spiritual)	1	1	13	15
Meditation/mindfulness (spiritual)				0
Reinforcement systems (CBT)				0
Schemas/Cog. Restructuring (CBT)	10	5	2	17
Trait impulsivity (personality)		1	5	6
Neuroticism (personality)				0
Intolerance of negative emotion (personality)	31	12	4	47
Lack of control/responsibility (disease)	4		4	8
Splitting (psychodynamic)	1	1	9	11
Projective process (psychodynamic)		1	5	6
Defense mechanisms/denial (psychodynamic)	5	1	8	14
Traumatic experiences (psychodynamic)	2	4	22	28
Narcissism (psychodynamic)				0
Attachment/OR issues (psychodynamic)		1	5	6
Family substance use patterns (family)			14	14
Problematic family dynamics (family)		4	30	34
Abuse in the family (family)			7	7
Cultural issues (macro)	2		15	17

Table 1

Concepts from Literature Noted in Cases

Legend: ■ Art Content/Verbalization   ■ Art Process   ■ Therapeutic Process

Concept	Art Content/Verbalization	Art Process	Therapeutic Process
Cultural issues (macro)	15		2
Abuse in the family (family)	7		
Problematic family dynamics (family)	30	4	
Family substance use patterns (family)	14		
Attachment/OR issues (psychodynamic)	5	1	
Narcissism (psychodynamic)			
Traumatic experiences (psychodynamic)	22	4	2
Defense mechanisms/denial (psychodynamic)	8	1	5
Projective process (psychodynamic)	5	1	
Splitting (psychodynamic)	9	1	1
Lack of control/responsibility (disease)	4		4
Intolerance of negative emotion (personality)	4	12	31
Neuroticism (personality)			
Trait impulsivity (personality)	5	1	
Schemas/Cog. Restructuring (CBT)	2	5	10
Reinforcement systems (CBT)			
Meditation/mindfulness (spiritual)			
Existential concepts (spiritual)	13	1	1
Principles/routines (12-step)	3		
Powelessness/HP (12-step)	3		
Personal responsibility (moral)			

Table 2

Discussion of emergent themes. I chose to focus on the five most frequently identified themes in my expanded discussion of their application to my case studies. I selected this number of themes to expand on in order to keep my data analysis manageable, recognizing that this number is essentially arbitrary. For each of these themes I present two examples that illustrate their relevance to my cases, referring to related art pieces.

Intolerance of negative emotion. The concept from the literature coded with the highest incidence in my cases was intolerance of negative emotion, which I noted 47 times. I noted 31 of these incidences in the therapeutic process, 12 in the art process, and four in the art content and client verbalization during session.
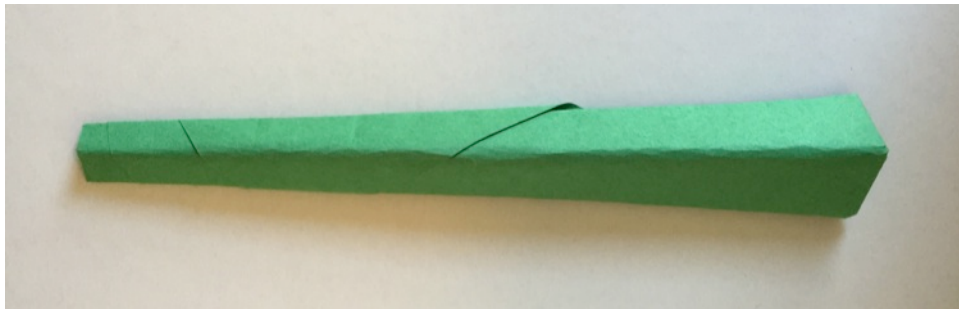
Figure 11. Paper sculpture by Tracy (example of intolerance of negative emotion)

The folded paper sculptures that constitute a large portion of Tracy's body of artwork provide a useful illustration of this concept. Much of my work with Tracy consisted of increasing her ability to tolerate the distressing emotions that arose upon contemplating either her own traumatic experiences from childhood or her current estrangement from her own children due to her DCFS case. Upon initiating treatment, Tracy's level of emotional distress when engaging with these topics was so great that she often experienced panic attacks, prohibiting her from functioning effectively.

During our course of therapy, Tracy was able to acknowledge that her methamphetamine use prior to entering treatment allowed her to keep these distressing feelings at bay, making its draw powerful for her. Much of Tracy's strategy for existing in the world seemed to me to involve a perpetual flight from distressing emotions, whether via substance use or simply remaining compulsively busy. Thus, the moments within our sessions in which she was able to utilize the paper folding technique to anchor her while simultaneously sitting with her emotions were monumental.

Tracy's own authorship of this process as important for her, as well as her ability to alter and experiment within the process she authored, constituted an important piece of its meaning. By creating a basic folding technique and pattern during the early phase of treatment, she was then able to explore deviations from this secure base, returning to the basic process for stability in later moments of deep distress (*Figure ?*). What Tracy accomplished through the creation and use of her paper-folding process was a method by which she could learn to tolerate emotional distress without the use of substances or other escapist means, which enabled her to explore and process her childhood trauma within therapy.

Figure 15. Painted clay sculpture by John (example of intolerance of negative emotion)

John's first art piece, a process he completed over the span of three sessions, provides an alternative example of the relevance of the concept of intolerance of negative emotion. In our first session, John's intense engagement with the clay coincided with a powerfully emotional outpouring of dialogue about his combat experience in Iraq during his service, opening up memories of his most traumatic experiences. The "fist" shape John settled on as the sculpture's final form seems to reflect his history of converting difficult emotions into aggressive energy in order to discharge them.

John's subsequent painting of the fist in our second session reflects his discomfort with the emotional content represented in this physical form. In keeping with the holiday season, John declared he would paint the fist with "Christmas colors," which I understood as an effort to cover up the hard-to-tolerate emotional material contained in the fist sculpture. Ultimately, John also added large areas of black to the fist, which he described as his "dark parts." This integration in the piece's final stage (*Figure ?*) suggested to me that, in spite of John's challenges with tolerating his own emotional experiences, he was interested in finding a way to integrate these effectively into his life.

Problematic family dynamics. The concept I coded with the second-highest incidence was problematic family dynamics, which I noted 34 times in my data analysis. I observed four of these incidents in the art process, while I noticed the other 30 in the art content and verbalization.

Figure 39. Family sculpture by Carmen (example of problematic family dynamics)

The many sessions Carmen dedicated to the sculpting and painting of her family

sculpture reflect the importance of the theme of family dynamics in her case. Though

Carmen verbally expressed dedication to maintaining the unity of her family unit, the

process and content of this art piece indicated an awareness of the problematic aspects of

her family dynamic.

The father of her child, depicted as a tiger, stands apart from Carmen's self-symbol

and the symbol for her son, both domestic cats. The history of intimate partner violence in

Carmen's relationship and her ambivalence about their partnership took shape as conflicts

in her process of creating their two symbols. The order of her tasks in the art process, her

arrangements of the sculpture's pieces, and her choices of color and symbol acted as the

primary means for processing these issues, as Carmen's steadfast commitment to

preserving the relationship for the sake of her son closed these issues off for verbal

discussion. Carmen's conflict between desire to be a mother and desire to focus on herself

also manifested in her art process, as she struggled to navigate a balance between

prioritizing work on her own self-symbol and the construction and repair of her son's.

Carmen's open discussion of her ambivalence about maintaining sobriety mirrored her ambivalence about the method of constructing her family sculpture she demonstrated in her art process. The overwhelming and time-consuming nature of this art activity seemed to act as a manifestation of the overwhelm Carmen felt about the task of repairing and maintaining her family awaiting her in sobriety.

Figure 22. Family drawing by Monique (example of problematic family dynamics)

The strong history of addiction and abuse in Monique's family made her family drawing another powerful illustration of the theme of problematic family dynamics. Though Monique worked on this drawing diligently across multiple sessions, its earliest manifestation (*Figure ?*) provides a useful window into the importance and complexity of family dynamics in her case.

The central symbol of the family home became a metaphor for her family's generational legacy of addiction and abuse, even as it simultaneously provided a backdrop for all of Monique's memories of her grandmother, her only positive parental figure.

Initially, Monique identified the figures depicted in the drawing as her grandfather, herself as a child, her grandmother, and her mother (left to right). As Monique's work with this image progressed, she demonstrated insight by noting that these figures might hold multiple identities, locating her uncle (her abuser) beside her childhood self, and identifying her adult self in the figure originally designated as her mother.

For Monique, the fluidity and complexity of the symbol of her family's home was a key theme in treatment, as it provided a holding space for her exploration of childhood trauma, her family's multigenerational legacy of substance use, and her own engagement with these histories as a mother of four during her own addiction.

Traumatic experiences. Another concept I coded with high incidence was the relevance of traumatic experiences in my cases. I coded this concept 28 times, two of these appearing in the therapeutic process, four in the art process, and 22 in the art content and clients' verbalizations.

Figure 18. Painted mask by John (example of traumatic experiences)

John's engagement with the painting of his mask offers an illustration of the importance of his traumatic experiences in his case. The violent and intimidating qualities in John's finished mask (*Figure ?*) are consistent with his post-deployment PTSD diagnosis, but a fuller picture of his art process expands the clinical understanding of how John's trauma interacts with his substance use.

John identifies as "always [being] an addict," meaning that his heroin use predated his enlistment in the US Army. In John's case, the relationship between trauma and substance use was not causal or uni-directional, rather an ongoing interplay. John's identity as a thrill-seeker is likely to have influenced his original decision to enlist, as well as his voluntary heavy interaction with explosives during his deployment. In this manner,

the same qualities that atracted John to drug use may have attracted him to the military.

Once he had experienced trauma during his service, John's drug use became a refuge from

his PTSD and TBI symptoms, though this coping mechanism soon began to threaten his

life. For John, processing his trauma and developing a functional strategy for integrating

his thrill-seeker identity into his life structure were equally important treatment issues.

In its earlier state, John's mask featured a camouflage-inspired background with

expressive brushstrokes, a bullet hole instead of the wide gash displayed on the final

product, and eyebrows that added a human quality to the overall impression of the piece.

John's decision to darken the base color, cover the eyebrows, and dramatize the facial

wound seems to reflect his need to cling to his military identity as he approached

treatment completion. John's use of this piece of his identity as a protective character,

perfectly symbolized in the mask, seemed to me to relate to his fears surrounding his

history of chronic post-treatment relapse.
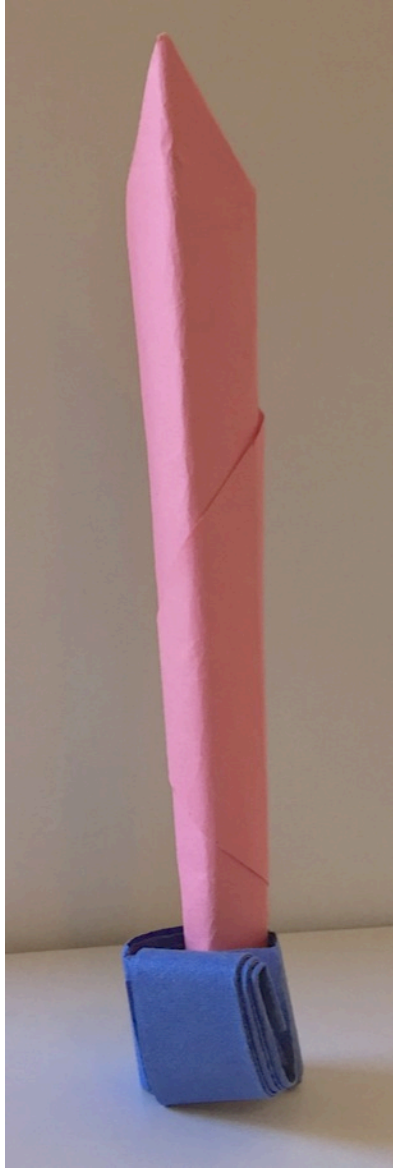
Figure 5. Paper sculpture by Tracy (example of traumatic experiences)

Tracy's first use of the paper-folding technique that came to form the basis of her

art engagement grew out of a grounding exercise I suggested in the hopes of anchoring her

to the secure present in moments of traumatic re-experience. Tracy found that the tactile

quality of rolling and folding the paper was indeed grounding for her, and provided her

with a coping skill that enabled her to tolerate emotional distress during treatment.

Tracy's initial paper sculpture (*Figure ?*) grounded her during her first detailed account in therapy of her rape and stabbing at age 12. Tracy's decision to create a stand for this piece and its vertical arrangement served to give the piece a feeling of strength. This strength seemed to me to function as a duality, symbolizing both her own strength and the violent and imposing quality of the weapons that violated her. Throughout her treatment, Tracy utilized this paper-folding process both to ground herself and to experiment with finding her own strength through modifications of her folding technique. Thus, what began as an in-the-moment tool for coping with trauma re-experiencing came to function as the overarching process theme of Tracy's entire course of treatment, underscoring the significance of trauma in her case.

Schemas and restructured cognitions. Also prevalent in my cases was the theme of schemas and restructured cognitions, which I coded 17 times. 10 of these I identified in the therapeutic process, five in the art process, and 2 in the art content and verbalization.

Figure 35. Clay sculpture by Carmen (example of schemas and restructured cognitions)

Carmen's cat self-symbol (*Figure ?*), originally created during a group art therapy activity, went through a transformation in ascribed meaning that illustrates the relevance of schemas and restructured cognitions in Carmen's case. Carmen's initial description of this self-symbol sculpture was striking and emotionally complex. She explained that she "hates cats because they're weak and afraid. They love whoever pets them." Because of the strong emotional content that seemed to exist in this piece, Carmen and I ended up utilizing it as a springboard for exploration within our individual sessions.

As Carmen wrestled with her ambivalence about sobriety, her recommitment to her partnership, and her responsibilities as a mother, she also underwent changes in her perspective on the cat as a symbol. In a poignant moment, Carmen came into one session and reported that she had actually begun to like cats because her son loved them, and

decided to reinvest in her self-symbol sculpture by beginning to paint it. This shift in Carmen's attitude toward the cat as an abstract symbol and her sculpture as a personal representation seemed to signal a deeper internal shift in her self-concept and investment in her own recovery.
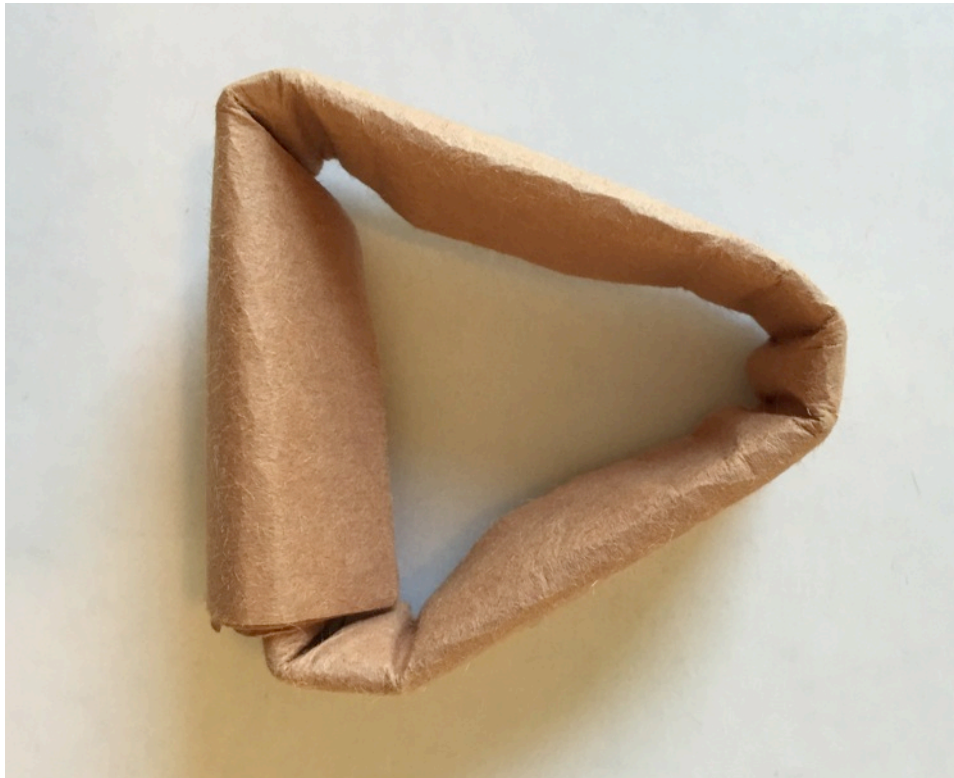
Figure 12. Paper sculpture by Tracy (example of schemas and restructured cognitions)

Tracy's experimentation with literal restructuring in her paper sculptures presents a visual demonstration of the restructuring of schemas about herself that became important later in her treatment after her PTSD symptoms began to subside. Tracy's neglect of her physical self-care seemed to be a manifestation of core beliefs about her femininity, beauty and self-worth. One particular session constituted a clear turning point in the restructuring of these schemas, when Tracy arrived to session showing a dramatic change

in her physical presentation. Though we had previously discussed her evasion of self and desire to focus only on her children, this moment marked the moment when Tracy became ready to experiment with how increased attention to and value of herself might look on a day-to-day basis. In Tracy's art process, her bold experimentation with a new method of paper-folding and her determined process of securing the resulting triangular shape without assistance (*Figure ?*) provided another physical manifestation of this shift.

  Cultural issues. The final theme I will elaborate on that featured prominently in my cases according to my coding process was that of cultural issues, a broad category I used to capture themes dealing with race, ethnicity, socioeconomic status, religion, age group, and membership in other discreet groups that seemed to be playing a role in art therapy sessions. I coded 17 incidences of this concept in my cases, two of which I identified in the therapeutic process and 15 of which I noted in the art content and verbalization.

Figure 27. Family drawing by Monique (example of cultural issues)

The final product of Monique's lengthy process with her family drawing holds visual representations of important cultural pieces of Monique's case, which manifested in many of the sessions spent on this art piece.

The telephone poll and power lines that frame the house served two purposes for Monique, both of which are culturally significant. First, they illustrate the family's socioeconomic struggles, as Monique described the family's method of obtaining electricity illegally by hooking their wiring up to this poll, in spite of the family's inability to pay electric bills for many years. In fact, the family's financial situation was so dire that the family home was repossessed during Monique's course of treatment, adding a grief-processing element to her engagement with this drawing.

The second function of the power lines Monique described was as a visual symbol for connection to a source of spiritual power. Combined with the symbol of the sun, Monique identified the power coming into the image through these lines as the power she is able to access through her relationship with God. Monique's strong Christian faith came into many of our sessions, generally providing her with a source of strength and comfort in otherwise discouraging circumstances. As a person with a strong connection to her cultural identity, Monique brought cultural issues to the forefront in many spaces within therapy, underscoring the importance of these themes in her own understanding of her life and her addiction.

Figure 1. Collage by Tracy (example of cultural issues)

Tracy's later disclosures about her socioeconomic status informed my clinical understanding of her initial collage as a culturally significant art piece. Tracy's associations with the outdoors, while positive, held a strong relationship to the many

outdoor adventures she had with her children in her dedicated efforts to provide them with a fun childhood in spite of their poverty. One such effort involved holding Christmas evening outside of a relative's trailer by utilizing a tree found on the property. Tracy's accounts of these adventures indicated to me that her socioeconomic status was indeed a key treatment issue for her, as it appears to be intertwined with many of her survival strategies, including her engagement with methamphetamine sales. The images of a sleeping figure and food cooking in the collage (*Figure ?*) perhaps hint at this survival effort, as they encapsulate the basic needs of food and shelter.

Emergent themes not coded from literature. Several themes emerged as prominent in my data analysis that did not fit neatly into any category in the coding system I derived from the literature on theories of substance abuse and recovery. The global themes I noted as common were integration of identity, and issues surrounding self-care and self-acceptance. It is possible that my own theoretical orientation and therapeutic style relate to the prominence of these themes in my clinical work. Other popular themes related to specific aspects of the treatment setting. Challenges with peers and staff members within the treatment facility were often brought into sessions, and transition planning often became a prominent issue in the late phase of treatment. Though each of these emergent themes merits discussion in its own right, I have chosen for the purposes of this paper to limit in-depth discussion to those concepts which illustrate ideas from the literature I reviewed on addiction theory.

Concepts from the literature not identified in case studies. Though I located points of connection between most of the key theoretical concepts from the substance abuse literature and my cases, there were several concepts I did not identify as significant

elements in any of my cases. In this section I will name these concepts and offer speculations about the reasons for their absence from my data.

The first theme present in the coding system that I did not identify in my cases was the notion of personal responsibility for addiction, the keystone concept of the moral model. Because this concept opposes the disease model, from which most treatment centers operate, I was not surprised at the apparent absence of this concept in my cases. All of the clients on my caseload are educated about addiction from the basis of the disease model, making the natural emergence of this moralistic concept unlikely.

The second theme I did not code in my data, located within the category of personality models of addiction, was the trait of neuroticism. Although parts of Tracy's process in art therapy might have qualified for coding in this category, I opted not to code them in this way because I held that her neurotic features were linked to PTSD rather than personality-derived.

The concept of narcissism, located within the psychodynamic model, also went un-coded in my data analysis. It is likely that the dominant theme of motherhood and the accompanying nurturing instinct in my cases eclipsed this feature. It is also possible that my own humanistic lens may have prevented me from conceptualizing my clients in this manner.

Though I did code concepts related to spirituality with high incidence, I did not locate the specific theme of meditation or mindfulness practice in my cases, a concept located within the "other spiritual and existential models" section of the coding system. It is likely that I did not locate this practice in any of my cases because I did not introduce these techniques into my sessions, though I recognize that the art-based grounding

techniques I utilized in my work with Tracy might arguably be categorized as mindfulness practice.

The final concept I did not code as significant in any of my cases was that of reinforcement systems, located in the category of cognitive and behavioral models. Again, I suspect that my failure to note this theme in my cases relates to my own orientation. The treatment facility in which I gathered the data utilized behavioral reinforcement systems, and in part because of this, I strived to create a space within individual therapy that operated outside of these systems.

Findings

My exploration of the relevance of prominent themes in the literature on addiction theory to four of my individual art therapy clients with substance use disorders yielded mixed findings. The coding system I created based on key theoretical concepts from the substance abuse literature provided me with a framework for analysis, lending clarity to my exploration. Through the application of this coding system to each specific art process within these four cases I was able to form grounded observations about the areas of agreement and disagreement between the literature and my clinical work.

Some of the themes from the literature that I included in my coding system proved to be quite significant in my understanding of the art therapy process with these individuals. Those most prevalent have been detailed above with examples illustrating their manifestation through art therapy. Most notable in their prominence were themes of intolerance of negative emotion, problematic family dynamics, traumatic experiences, schemas and restructured cognitions, and cultural issues.

In other ways the coding system highlighted differences between the concepts I derived from the literature and those I observed in my cases. Certain concepts emerged as prominent themes in my clinical work with these clients that did not find a fitting location within the coding system, and several of the literature-based concepts I included in my coding system did not appear significant in my own analysis of art therapy in these four cases.

Meanings

My research process and findings gave me a new lens through which I could view the literature on addiction theory in both the substance abuse and art therapy fields. In this section I will tie my research findings back to the literature, offering observations about how my findings inform my understanding of the literature.

Meanings related to substance abuse literature. My use of the coding system to organize and locate concepts from the literature on theories of addiction and recovery within my clinical work provided me with enhanced insight about this body of literature. I became aware during my review of the literature that most of the theoretical ideas discussed were not contradictory, rather they examined different features and mechanisms of the overall experiences of addiction and recovery. My use of the coding system to analyze the art therapy process with my own clients provided me with a grounded experience of this multiplicity. As I utilized the coding system, I experienced the challenge of categorizing the human experiences of my clients in terms of these concepts, often finding that multiple concepts might be viewed as relevant to the same clinical moment within art therapy, depending on my perspective.

Meanings related to the art therapy literature. The findings yielded by my data analysis also enhanced my understanding of the art therapy literature I reviewed on substance abuse. In general, I found that my cases illustrated the utility of art therapy as an alternative mode of expression in addiction treatment, a central focus of much of the art therapy literature. My ability to connect a wide variety of theoretical concepts about addiction and recovery to moments in the art therapy process with my clients demonstrated the usefulness of the art therapy process as an experiential space within which many of the mechanisms central to addiction emerge and can potentially be resolved.

The preponderance of certain themes in my data analysis reflected some of the unique qualities of the art process noted in the literature. The concept I coded with the highest incidence, intolerance of negative emotion, was demonstrated heavily through both the therapeutic process and in interactions with the art process itself. Some of the art therapy literature references the ability of this modality to foster increased connection to and comfort with emotional material, and my findings confirm this as an area ripe for work in the art therapy process (Devine, 1970; Foulke & Keller, 1976; Kaplan, 1978).

The emphasis in the art therapy literature on psychodynamic concepts as central mechanisms of addiction was not clearly supported by my findings, but the high incidence in my cases of problematic family dynamics and traumatic experiences did suggest connections to some of the ideas featured in the psychodynamic art therapy literature (Cooper & Milton, 2003; Glover, 1999; Luzzatto, 1989; Siporin, 2010). My decision to favor "problematic family dynamics" in my coding process over "impaired object relations and attachment issues" reflects the inherent subjectivity of the coding process. In

many such instances, both categories might have been applicable. Regardless of categorization, the popularity of this subject matter in the art therapy process suggests that engagement with the art process is an effective means of accessing and exploring the relationship of family relationships to the features of addiction.

My findings underscored the overall paucity of art therapy literature, specifically the dearth of art therapy literature that clearly connects the use of art therapy in substance abuse treatment to theoretical understandings of addiction and recovery. The challenges I had in organizing the art therapy literature according to the categories I devised in my review of the substance abuse literature were, in fact, not mirrored by my findings. Where some of the concepts from the substance abuse literature found no reference within the art therapy literature, I was indeed able to locate these ideas in my case studies through the use of the coding system. Specifically, I identified the concepts of cultural issues and the restructuring of schemas as prominent in my cases, while these concepts found little space in the art therapy literature I reviewed. This may be due, in part, to the frequency with which the art theory literature leans on theoretical assumptions about addiction and recovery without clearly naming these concepts.

My findings informed my consideration of art therapy as a potential holding space for multiple theoretical concepts relating to addiction. In agreement with Horay (2006), who pointed out the limiting quality of powerlessness-inducing art directives as a 12-Step complement in art therapy, I interpreted my findings as an indicator that the art therapy process is best utilized as an open space within which the client is free to express any aspect of the experience of addiction or recovery. Through the use of theory-mindfulness in case conceptualization, the clinician may then integrate the theoretical concepts that

appear most relevant to the client's authentic experience as evidenced by the art process and product.

   Limitations of the study. While the findings and meanings resulting from this study offer beneficial information regarding the use of art therapy with the substance abuse population, the subjectivity of each of the processes involved in the study are inherently limiting. My efforts to understand and critically evaluate the results of my coding process left me with the awareness that my own clinical and personal perspectives are inextricable from my handling of the research process. The construction and execution of the research process by the same clinician conducting the art therapy considered in the study presents a challenge related to bias and personal investment. Even the process of selecting and organizing the literature that I reviewed as the basis of this investigation was subjective in nature, and my interaction with the literature was invariably informed by my own preexisting ideas about both substance abuse and art therapy.

   Additionally, certain features of the structure of this investigation merit discussion as limiting factors. Ideally, more individuals would have been involved in the analysis of the art therapy process. Also, due to the timing of this study, the design and detailed structure of the research process was not determined until after I had already initiated treatment with the four participating clients. If the study were to be replicated, much could be gained by cementing this process prior to beginning data collection, particularly in the area of consistent note-taking and coding practices.

Conclusion

   My experience of relating theoretical understandings of addiction and recovery to my own art therapy cases in this research process gave me a useful window into directions

for the art therapy field in its work with this population. My utilization of the coding

system as the organizing principle in my data analysis provided me with a framework

within which I was able to more effectively locate and categorize moments of relevance to

addiction theory. Without this guiding tool, I imagine that my presentation of these cases

might have taken the narrative or testimonial shape I noticed in many of case studies

presented in the art therapy literature. Because the art therapy process in itself becomes

such a tangible narrative, the desire to present case information in this manner seems both

natural and logical. However, this art therapy narrative style of data presentation runs the

risk of perpetuating the insular identity of the field, missing opportunities to connect with

current information from adjacent topics in mental health.

My own method of describing prominent themes in my art therapy case studies did

not differ significantly from many of the detailed case studies presented in the art therapy

literature. I believe the point of departure lay in my mindfulness about stepping out of the

narrative and looking for points of connection to addiction theory, a process necessitated

by my use of the coding system. In this way the structure of my research process was

itself the guiding force in my theory-conscious case conceptualization. I discovered

through my application of the coding system that I was utilizing theoretical concepts about

addiction as the underpinnings to my clinical work before clearly identifying them, and

making these connections in hindsight afforded me an enhanced understanding of my

clients that I was then able to access in our later sessions.

This two-layered clinical process wherein I dedicated myself fully to being present

with my clients in the moment, utilizing time outside of session to code the key issues and

themes I had observed, became a model for my developing identity as a theory-informed

clinician. I noticed the utility of this practice in my work with Tracy, whose treatment continued after I completed my data analysis. The research process I underwent in my exploration of art therapy in the treatment of substance abuse will inevitably inform my continued work with this population, as I now hold the coding system I created as an organizing tool within my mind. As I continue to work with substance abuse clients, I intend to continue to expand my internalized coding system through sustained engagement with substance abuse literature, allowing me to notice the connections between current ideas in this field and my work as a clinical art therapist.

In a mutual process, my engagement with the literature offered a tangible benefit in my clinical work while my clinical art therapy practice informed my understanding of the literature. My initial engagement with this body of literature was overwhelming, and my conceptualization of ideas from the literature was cumbersome. Locating these ideas within my own clinical experience increased my working knowledge of the concepts themselves, their varied relevance to this population, and my personal clinical style of working with them.

My experience with this research process leads me to consider critically the role of case study methodology, predominant within art therapy research, as a factor in the field's literary shortcomings. While ideal in its ability to capture rich and emotionally potent material, pure case study methodology itself may be limiting, whereas mixed research methods might provide more opportunities to build connections between art therapy research and corresponding topics in general mental health research.

Future research connecting the rich stories of the art therapy process with addicted individuals to theoretical concepts in the substance abuse field stands to benefit each of

these sectors greatly. Art therapy as a field may gain enhanced legitimacy, its research gain funding, and its practice earn improved credibility as a core psychotherapeutic process. The substance abuse field may gain access to art therapy services from clinicians who possess an improved understanding of addiction and recovery and utilize art directives fluidly to allow space for their many features. Individuals with substance use disorders may gain more compassionate, humanistic and informed treatment, and may have increased access to art therapy as a means by which they can enhance their process of recovery. Though the literature and the findings of this research agree on the utility and power of art therapy in the treatment of substance abuse, future studies hold the potential to magnify this power by providing a framework for understanding it.

The findings of this research support the potential of art therapy as a modality within which the multitude of theoretical concepts about addiction and recovery might comfortably coexist. My experience with the application of the coding system suggests that art therapy might be used with great success to determine which theoretical concepts are applicable to an individual's experience of addiction and recovery, and which of these concepts the individual is naturally motivated to explore. The field of substance abuse treatment, though divided in its own accepted understandings, might find useful points of connection through the use of this modality with addicted persons. In this way, art therapy practice may expand the theoretical lenses of addiction treatment.

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Appendix A: Coding system for data analysis

Client _____

Art piece_____

Session Date_____

	(i) Therapeutic Process	(ii) Art Process	(iii) Art Content and Verbalization
1) Moral model			
a) Personal responsibility[1]			
2) 12-Step model			
a) Powerlessness/Higher Power[2]			
b) 12 step principles, routines[3]			
3) Other spiritual models			
a) Spiritual/Existential concepts[4]			
b) Meditation/mindfulness practice[5]			
4) Cognitive-Behavioral			
a) Reinforcement system[6]			
b) Automatic thoughts/Schemas and Restructured cognitions[7]			
5) Personality models			
a) Trait impulsivity[8]			
b) Neuroticism[9]			
c) Intolerance/avoidance of negative emotion[10]			
6) Disease model			

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[1] Morse, 2004, p. 443

[2] Bristow-Braitman, 1995, p. 415

[3] Bristow-Braitman, 1995, p. 416; Chen, 2010, 371

[4] Chen, 2010, p. 370

[5] Brewer, 2014, p. 77

[6] Brewer, 2014, p. 71; Quirk, 2001, p. 97

[7] Bristow-Braitman, 1995, p. 416

[8] Kovac, 2013, p. 24; Quirk, 2001, p. 99

[9] Quirk, 2001, p. 99

[10] Measelle, Stice & Springer, 2006, p. 225; Quirk, 2001, p. 98

a) Lack of control/responsibility [11]			
7) Psychodynamic			
a) Splitting [12]			
b) Projective process [13]			
c) Defense mechanisms/denial [14]			
d) Traumatic experiences [15]			
e) Narcissism [16]			
f) Impaired object relations and Attachment issues [17]			
8) Family Models			
a) Family substance use patterns [18]			
b) Problematic family dynamics [19]			
c) Abuse in the family system [20]			
9) Macro-level systems			
a) Cultural issues [21]			

[11] Morse, 2004, p. 442; Reinarman, 2005, p. 309

[12] Matusow & Rosenblum, 2013, p. 243

[13] Matusow & Rosenblum, 2013, p. 243

[14] Morgenstern & Leeds, 1993, p. 202

[15] Morgenstern & Leeds, 1993, p. 197

[16] Morgenstern & Leeds, 1993, p. 196; Quirk, 2001, p. 100

[17] Margolis & Zweben, 2011, p. 43; Morgenstern & Leeds, 1993, p. 202

[18] Rowe, 2012, p. 60, Tuten et al., 2012, p. 156

[19] Margolis & Zweben, 2011, pp. 46-52; Rowe, 2012, p. 60; Saatcioglu et al., 2006, pp. 125-130

[20] Tuten et al., 2012, p. 156

[21] Kovac, 2013, p.21

Appendix B: Letter of Agreement from Agency

CORPORATE OFFICERS

Albert M. Senella
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Chief Excutive Officer

Bobbi Sloan, Ph.D
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November 10, 2014

RE: Review of Research Proposal by Lily Frances Braverman

Dear IRB:

Tarzana Treatment Centers' Research Committee has approved Lily Frances Braverman's proposed study titled *Expanding the Lens of Substance Abuse Theory Through Art Therapy Practice.*

We are going to request that she have the participant sign Tarzana Treatment Centers' *Informed Consent to Participate in Human Research*, as well as the LMU Informed Consent, since TTC's informed consent has information on it that is not in the LMU consent. Otherwise, you can incorporate both informed consents into one document. Should she choose to do the latter, we would need to review the new informed consent.

If you have any questions, please feel free to contact me at 818-654-3806 or at kbachrach@tarzanatc.org.

Sincerely,

Ken Bachrach, Ph.D.
Clinical Director

Appendix C: IRB Letter of Approval and Application

Paterson, Julie <Julianne.Paterson@lmu.edu>   11/18/14 ☆ ⟨ ▾
to me, Debra, David, John ▾

Dear Ms. Braverman,

Thank you for submitting your IRB application for your study titled *Expanding the Lens of Addiction Theory Through Art Therapy Practice*. All documents have been received and reviewed, and I am pleased to inform you that your study has been approved.

The effective date of your approval is **November 18, 2014 – November 17, 2015.** If you wish to continue your project beyond the effective period, you must submit a renewal application to the IRB prior to **October 1, 2015.** In addition, if there are any changes to your protocol, you are required to submit an addendum application.

For any further communication regarding your approved study, please reference your new protocol number: **LMU IRB 2014 FA 41.**

Best wishes for a successful research project.

Sincerely,

Julie Paterson

Julie Paterson | Sr. IRB Coordinator | Loyola Marymount University | 1 LMU Drive | U-Hall #1718 | Los Angeles, CA 90045 | (310) 258-5465 | jpaterso@lmu.edu

LOYOLA MARYMOUNT UNIVERSITY

IRB Application Questionnaire

All materials must be typed.

1.   RESEARCH BACKGROUND

   The objective of this research is to explore how art therapy has been and is currently being used to treat substance abuse, highlighting the substance abuse theories that form the bases of these applications. There are many differing theories and models that describe the nature of substance abuse, and many related approaches to treating it. The moral model, the disease model, spiritual models, behavioral models, psychoanalytic theory, family models, and integrative theories all describe the condition of addiction differently, each with its own implications for treatment and recovery.

   Published accounts of art therapy with substance abusers have most often situated the problem in one of two ways. The first, likely related to the psychoanalytic roots of many of art therapy's pioneers, relies heavily on psychodynamic concepts to understand and treat addiction. The second is the shaping of art therapy treatment as a deliberate complement to the 12-Step approach. Still, other accounts of art therapy with addicted persons have different theoretical underpinnings, mixed theoretical influences, or lack reference to a model of addiction altogether. Though these accounts as a whole suggest that art therapy can be a meaningful process that contributes to recovery, they also as a body illustrate the lack of cohesion in the field with regards to theoretical understanding of addiction itself as well as framework for using art therapy in treatment.

    This work's relevance to clinical practice lies in its potential to guide clinicians into a more fluid understanding of theories of addiction and recovery within which they can allow the artwork to shape their conceptions of the client's experience. Considering the widespread relevance of substance abuse in the mental health field, an expanded understanding of models of addiction and their relationship to art therapy practice is valuable to any art therapist.

2.   SUBJECT RECRUITMENT

   Subject(s) will be selected from researcher's current caseload at an inpatient substance abuse treatment program. Subject(s) will be selected based on the relative absence of confounding case features compared to other cases, with the goal of choosing participants whose primary focus in treatment is substance abuse. Once subject(s) are selected and agree to participate, they will not be screened further.

Subject(s) may be any sex, and will be between the ages of 18 and 65. Research may utilize anywhere between 1 and 10 subjects. Subject(s) will be informed about the study by the researcher during a weekly individual art therapy session, and given information about the study's purpose and the details of their potential involvement.

3. PROCEDURES

Data will be gathered during weekly art therapy sessions. Art-making will take place in each session, and directives will be constructed in alignment with treatment goals. Researcher will attempt to structure directives in a client-directed manner. The data will consist primarily of the images created by clients, as well as brief descriptions of contextual case material.

4. RISKS / BENEFITS

Potential benefits to subject(s) include a possible sense of pride or achievement at being selected and contributing artwork to the study, possible pride and/or altruistic gratification for participating in a project that advocates for addicted persons, and potential improvement of art therapy services received during future treatment by art therapists exposed to the study.

Reasonably foreseeable risks are limited, but include possible discomfort with having artwork viewed by strangers, possible embarrassment about being "studied" as a recipient of treatment, and possible impact on the natural flow of treatment given participants' understanding that artwork will be included in study. Participants will be reminded of their opportunity to discontinue participation.

5. CONFIDENTIALITY

Participants' identifying information will be excluded from case study data, and any artwork depicting identifying information will be re-rendered with pseudonyms to protect participant identity. Researcher, faculty sponsor, and supervisors will have access to data. After artwork is reviewed with supervisors, it will be stored in a locked cabinet during the study, and researcher will delete electronic images of participant artwork upon completion of the project.

6. INFORMED CONSENT
Attached.

7. STUDENT RESEARCH

Because student is principal investigator, application is signed by faculty sponsor.

8. RENEWAL APPLICATIONS
Not applicable

9. PAYMENTS
Not applicable

10. **PSYCHOLOGY SUBJECT POOL**

Not applicable

11. QUALIFICATIONS AND TRAINING

Researcher has past clinical experience conducting individual art therapy as a trainee in practicum. Researcher will meet weekly with faculty sponsor for one-on-one discussion of research progress. Researcher has completed Human Subjects Protections Training through NIH.

12. RANDOMIZATION

Describe criteria for assigning subjects to sub-groups such as "control" and "experimental."
Not applicable

13. USE OF DECEPTION

If the project involves deception, describe the debriefing procedures that will be used.
Include, verbatim, the following statement in the consent form: "Some of the information with which I will be provided may be ambiguous or inaccurate. The investigator will, however, inform me of any inaccuracies following my participation in this study."

Not applicable

14. QUESTIONNAIRES AND SURVEYS

Include copies of questionnaires or survey instruments with the application (draft form is acceptable).
If not yet developed, please so indicate and provide the Committee with an outline of the general topics that will be covered. Also, when the questionnaire or interview schedule has been compiled, it must be submitted to the Committee for separate review and approval. These instruments must be submitted for approval prior to their use.

Consider your population. If they are foreign speakers, please include copies in the foreign language.

Not applicable

15. PHYSICIAN INTERACTIONS

To ensure that all patients receive coordinated care, the principal investigator is obligated to inform the primary physician (when not the principal investigator) of all studies on his/her patients.

Not applicable

16. SUBJECT SAFETY

Describe provisions, if appropriate, to monitor the research data collected, to ensure continued safety to subjects.

Researcher will monitor data as a part of regular therapy and continually assess for participant safety.

17. REDUNDANCY

To minimize risks to subjects, whenever appropriate, use procedures already being performed on the subjects for diagnostic or treatment purposes. Describe provisions.

   All procedures performed on research participants are already being performed in standard treatment process.

18. COUNSELING

In projects dealing with sensitive topics (e.g., depression, abortion, intimate relationships, etc.) appropriate follow-up counseling services must be made available to which subjects might be referred.
The IRB should be notified of these services and how they will be made available to subjects.

Not applicable

19. SAFEGUARDING IDENTITY

When a research project involves the study of behaviors that are considered criminal or socially deviant (i.e., alcohol or drug use) special care should be taken to protect the identities of participating subjects.
In certain instances, principal investigators may apply for "Confidentiality Certificates" from the Department of Health and Human Services or for "Grants of Confidentiality" from the Department of Justice.

Confidentiality will be ensured according to procedures outlined in #5.

20. ADVERTISEMENTS

If advertisements for subjects are to be used, attach a copy and identify the medium of display.

Not applicable

21. FOREIGN RESEARCH

When research takes place in a foreign culture, the investigator must consider the ethical principles of that culture in addition to the principles listed above.

Not applicable

22. EXEMPTION CATEGORIES (45 CFR 46.101(b) 1-6)

If you believe your study falls into any of the Exemption Categories listed below, please explain which category(ies) you believe it falls into and why.

1) Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (i) research on regular and special instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), if information taken from these sources is recorded in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

3) Research involving survey or interview procedures, except where all of the following conditions exist: (i) responses are recorded in such a manner that the human subjects can be identified, directly or through identifiers linked to the subjects, (ii) the subject's responses, if they became known outside the research, could reasonably place the subject at risk of criminal or civil liability, or be damaging to the subject's financial standing, employability, or reputation, and (iii) the research deals with sensitive aspects of the subject's own behavior, such as illegal conduct, drug use, sexual behavior, or use of alcohol.

All research involving survey or interview procedures is exempt, without exception, when the respondents are elected or appointed public officials, or candidates for public office.

4) Research involving the observation (including observation by participants) of public behavior, except where all of the following conditions exist: (i) observations are recorded in such a manner that the human subjects can be identified, directly or through the identifiers linked to the subjects, (ii) the observations recorded about the individual, if they became known outside the research, could reasonably place the subject at risk of criminal or civil liability, or be damaging to the subject's financial standing, employability, or reputation, and (iii) the research deals with sensitive aspects of the subject's own behavior such as illegal conduct, drug use, sexual behavior, or use of alcohol.

5) Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

6) Unless specifically required by statute (and except to the extent specified in paragraph (1)), research and demonstration projects which are conducted by or subject to the approval of the Department of Health and Human Services, and which are designed to study, evaluate, or otherwise examine: (i) programs under the Social Security Act or other public benefit or service programs, (ii) procedures for obtaining benefits or services under those programs, (iii) possible changes in or alternatives to those programs or procedures, or (iv) possible changes in methods or levels of payment for benefits or services under those programs.

Not applicable

Please deliver to: Julie Paterson, IRB Coordinator, University Hall, Suite 1718 or jpaterso@lmu.edu.

Appendix D: Experimenal Subjects Bill of Rights

LOYOLA MARYMOUNT UNIVERSITY

Experimental Subjects Bill of Rights

Pursuant to California Health and Safety Code §24172, I understand that I have the following rights as a participant in a research study:

1. I will be informed of the nature and purpose of the experiment.

2. I will be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized.

3. I will be given a description of any attendant discomforts and risks to be reasonably expected from the study.

4. I will be given an explanation of any benefits to be expected from the study, if applicable.

5. I will be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous and their relative risks and benefits.

6. I will be informed of the avenues of medical treatment, if any, available after the study is completed if complications should arise.

7. I will be given an opportunity to ask any questions concerning the study or the procedures involved.

8. I will be instructed that consent to participate in the research study may be withdrawn at any time and that I may discontinue participation in the study without prejudice to me.

9. I will be given a copy of the signed and dated written consent form.

10. I will be given the opportunity to decide to consent or not to consent to the study without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on my decision.

Appendix E: Informed Consent Document
LOYOLA MARYMOUNT UNIVERSITY
Graduate Department of Marital and Family Therapy
Consent for participation in research based on practicum treatment case material.

Expanding the Theoretical Lenses of Substance Abuse Treatment Through Art Therapy Practice

1) I authorize Lily Braverman, MFT Trainee, to include me in this case study research project.

2) I have been asked to participate in this research project that is designed to explore themes in art therapy productions of substance abusers as they relate to theories of addiction and recovery models.

3) It has been explained to me that the reason for my inclusion in this project is that, as a current client in residential substance abuse treatment, my artwork and brief descriptions of my situation are ideally suited to use in this project.

4) I understand that as a participant, nothing in my treatment experience will be different as a result. The therapist will utilize case material and artwork from treatment as part of her data although all identifying information will be carefully removed. This process has been fully explained to me.

5) It has also been explained to me that this information will be used for research purposes only and that my identity will not be disclosed. I understand that I have the right to review the research project before April 2015.

6) I understand that the research project which may include case material and artwork from my experiences in art therapy, will be available in a scholarly way on the internet.

7) I understand that Lily Braverman, who can be reached at lily.braverman@gmail.com, will answer any questions I may have concerning this study.

8) If the study design or the use of the information is to be changed, I will be so informed and my consent reobtained.

9) I understand that I have the right to decline to participate in this research without prejudice to my future art therapy treatment.

10) I understand that I have the right to withdraw from this research before April 2015.

11) I understand that if I have any further questions, comments, or concerns about the study or the informed consent process, I may contact David Hardy, Ph.D. Chair, Institutional Review Board, 1 LMU Drive, Suite 3000, Loyola Marymount University, Los Angeles CA 90045-2659 (310) 258-5465, david.hardy@lmu.edu, OR   The research mentor, Debra Linesch, PhD, MFT, ATR-BC, Marital and Family Therapy Therapy Department Chair and Program Director, at (310) 338-4562, debra.linesch@lmu.edu.

12) In signing this consent form, I acknowledge receipt of a copy of the form, and a copy of the "Subject's Bill of Rights".

Client's/Research Participant's Signature _____   Date _____

Appendix F: "Protecting Human Research Participants" Certificate of Completion

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Lily Braverman** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 08/27/2014

Certification Number: 1524732