

Shedding Internalized Shame and Guilt: The Use of Art Therapy in Substance Use  
and Mental Health Treatment Programs

By

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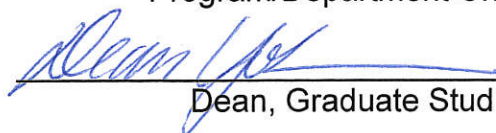
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## Abstract

Drug and alcohol abuse has become a costly epidemic in society. Helping those who suffer from addiction requires proper treatment and care. Addiction is defined as compulsive alcohol and drug seeking despite negative consequences. It is a biopsychosocial disease that is wide-ranging on a complex scale. Often people who suffer from addiction internalize the stigma that comes along with the disease so much that they consider it a part of their identity. The “addict” part of an individual’s identity is often negative and feelings of guilt shame and low self-esteem become internalized. Through the review of art therapy sample studies, cognitive behavioral therapy treatments for addiction and neuroscience and biological research, it becomes apparent that other methods of treatment need to be explored to improve success rates of recovery and positive view of self. Art therapy could be a beneficial tool in the improvement of addiction treatments and in shedding the negative internalized stigmas of the illness.

*Keywords:* substance use disorders, stigma, art therapy

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## **Introduction**

Drug and alcohol dependency disorders are considered some of the most frequent and severe mental disorders in society. These disorders not only have a negative impact on physical health but on the individual's personal relationships, social interactions and emotional well-being. In the past, chemical dependency was considered a moral issue. Research by medical professionals show that dependence on alcohol and drugs has been considered an illness by the American Medical Association since 1956 and is currently in the DSM V under substance use disorder. Although addiction has been considered a disease/disorder for some time, the stigmas attached to it are still engrained into society and have severe implications on the treatment and recovery of the individual. In this paper, I will explore these issues in an effort to outline how these therapeutic practices are valuable in helping those suffering from chemical dependency disorders to cope with their disease and heal from the pain caused by stigmas.

## **Literature Review**

The national institute of drug abuse continues to use the term “addiction” to describe compulsive drug seeking despite negative consequences. However, “addiction” is not considered a specific diagnosis in the fifth edition of *The Diagnostic and Statistical Manual of Mental Disorders* (2013)—a diagnostic manual used by clinicians that contains descriptions and symptoms of all mental disorders classified by the American Psychiatric Association (APA). I will be also be using the term addiction throughout this paper.

In 2013, the APA updated the DSM which replaced the categories of substance abuse and substance dependence with a single category: substance use disorder. The symptoms

connected to a substance use disorder were placed into four major categories. These categories are impaired control, social impairment, risky use, and pharmacological criteria (such as tolerance and withdrawal). Addiction is considered a brain disease because of how drugs alter the brain structure and how it operates. The disease can be long lasting and can lead to many harmful, often self-destructive, behaviors.

Nearly all addictive drugs directly or indirectly target the brain's reward system by flooding the circuit with dopamine. Dopamine is a neurotransmitter present in regions of the brain that regulate movement, emotion, cognition, motivation, and feelings of pleasure. The overstimulation of this system, which rewards our natural behaviors, produces the euphoric effects sought by people who use drugs and teaches them to repeat the behavior.(NIDA, 2012, p.3)

There are both biological and environmental factors that contribute to the disorder. Some of the biological factors include genetic makeup; whether or not a biological relative has a disorder, high risk personality traits, one's gender or ethnicity all play biological roles in how susceptible an individual is to addiction. Environmental factors include life-altering events, relationship issues, or physical and mental health. The biological and environmental factors vary in different combinations for each individual which also results in varying degrees of risk of developing the disorder as well as level difficulty in resolving issues and achieving successful recovery treatment.

The Substance abuse and Mental Health Services Administration (SAMHSA) estimated that 22.2 million people in the United States have substance abuse or dependence diagnoses and of these 22.2 million, only 2.3 million have obtained treatment. That leaves an

estimated 20 million individuals who have not received treatment. Substance abuse treatment costs are averaged around 21 billion dollars a year. (Laurer, 2015)

Worldwide, mental and substance use disorders are leading causes of morbidity and mortality. The social and disease burden of these disorders increased by 37 percent between 1990 and 2010, primarily due to demographic trends in population growth and aging... In another survey regarding substance use, 24 million Americans aged 12 and older (9.4% of the population) said they had used illicit drugs in the past month, and 17 million (6.6%) reported alcohol dependence or misuse.<sup>3</sup> Of the nearly 23 million Americans who needed treatment (met standard criteria) for a drug or alcohol problem, less than one in ten received any treatment. Untreated substance use disorders reflect an estimated \$417 billion in annual costs related to crime, health care services, and lost work productivity.<sup>4</sup> This estimate does not capture the many social costs of drug overdose and suicide. (National Academies of Sciences, Engineering, and Medicine, 2016, p.17)

There is dire need for more effective substance abuse treatment programs. So often those who fall victim to addiction are thrown in jail, leaving them untreated and once released, left to their own devices. Creating more programs that treat the physical, mental and emotional symptoms of substance abuse disorders would be advantageous for those diagnosed as well as society as a whole.

Research has repeatedly shown that investment in treatment is valuable and, furthermore, produces better outcomes with more cost-effectiveness than incarceration. The Justice Policy Institute reported that if an individual receives treatment while incarcerated, there is, on average, an estimated benefit of \$1.91 to \$2.69 for every \$1 invested in prison

programs. “Benefit” is measured for taxpayers by program costs and for crime victims by lower crime rates and less recidivism. There is also an estimated \$8.87 benefit for every \$1 invested in therapeutic community programs outside of prison. They found that other community-based substance abuse treatment programs generate \$3.30, drug courts generate \$2.83 and intensive supervision.” (Drug Policy Alliancing Guiding Drug Law Reform and Advocacy, n.d.)

Generating more services will reduce incarceration rates and costs as well as aid in an individual’s ability to contribute to society. Environmental and biological factors create a variance of degrees in which one might develop a substance abuse disorder, which also contribute to the high comorbidity rate of substance abuse with other mental health issues. One common co-occurring disorder is depression. Using drugs or alcohol can cause a person to become depressed during use or withdrawal from substance. On the other hand, those who suffer from depression may turn to substance use in order to temporarily alleviate their negative feelings and eventually come to rely heavily on substances for comfort. It is because of these co-occurring disorders that it is important to offer different methods of addiction treatment (NIDA,2012).

### **Cognitive Behavioral Theory**

“One criticism of addiction treatment is that it is primarily concerned with the acute care aimed at stabilization rather than the longer-term changes required to sustain recovery.” (Mitcheson, 2010, p. 2) Despite the advances in knowledge and treatment of addiction, there are still limitations in the effectiveness of these treatments. For example, individuals who suffer



from addiction often have co-occurring illnesses and treatment does not always address other issues, which often results in relapses. “This outcome has led to a call for reorientation of treatment away from an acute-care model to a recovery management model” (Mitcheson, 2010, p. 2) While short term treatments are effective with those who are not in chronic conditions, others who are in specialist treatment programs may need what White refers to as the “chronic care model”. A chronic care model focuses more on empowering service users to self-manage their condition and locates resources to managing well-being and sustaining recovery within social networks and the broader community. Mitcheson describes this as a recovery management model which focuses on addressing the range of issues associated with substance use problems, such as educational underachievement and vocational, legal and housing difficulties, as well as co-occurring mental health problems (e.g. trauma and depression) (Mitcheson, 2010) . The goal of the chronic care model is to aid individuals in long term management and recovery of their substance abuse.

The cognitive behavioral approach bridges the gap between acute-care model and the chronic care model. One core belief of the cognitive behavioral approach recognizes the importance of environmental factors outside treatment and focuses on skill building for clients in managing those outside factors in order to achieve successful recovery maintenance. Mitcheson describes addressing the acute and chronic aspects of substance use problems as a two-phase process, which is recovery from, and recovery for. Recovery from the substance could refer to abstaining from the substances altogether, harm minimization, or substance stabilization. Recovery for, refers to the next phase where clients search for the positive things that lie ahead for the individual’s reintegration into society. These two components are not always clear cut

and often do not transpire in a consecutive order. Although the desire for a life beyond alcohol or drugs is often the initial reason for change, ambition alone is not enough in many circumstances. “Often clients report pessimism about their ability to change, underestimate their own abilities, feel they have very few social connections outside their using behavior and feel trapped, as if real choice has been taken away from them” (Mitcheson, 2010, p. 3). CBT focuses on skill building in order to successfully maintain recovery outside of treatment. Mitcheson identifies four core principles that clinicians in cognitive behavioral treatment believe to be particularly important with substance abuse disorders. These are increased client optimism, resilience, integration, and choice (ORIC). The belief is that the application of the ORIC principles will lead to increased optimism and resilience in clients, aid in becoming acclimated into healthy roles in society and decision making that will enhance their sense of identity and connection with those around them. It is important to pay attention to the development in these areas, as it is considered just as important as the treatment intervention itself because of the high prevalence of those battling feelings of pessimism and low self-esteem (Mitcheson, 2010).

As mentioned previously, abstinence from drugs or alcohol is not the only step to recovery. Some individuals may become addicted due to unfortunate circumstances, such as gang influence or forced upon by outside parties. Others may turn to drug or alcohol use to fulfill a significant need.

Drugs may be an escape from loneliness, low-self-esteem, or some other painful condition of one’s life. Therefore, it is not surprising that a dual diagnosis of substance abuse and mental illness characterizes a large proportion of those admitted for psychiatric hospitalization (Wadson, 2010, p. 203).

Investigations by Lori Hanngaan Blocher have indicated that 20-50 percent of any psychiatric population has a coexisting substance abuse problem. In the past co-occurring disorders were treated separately, which overlooked many of the interconnected issues of the two conditions (Wadeson, 1999). More modern approaches acknowledge patients with dual diagnoses but it is often complicated and difficult to determine. Treatment of multiple conditions poses many challenges and can be very difficult to address (Wadeson, 2010).

Although art therapists work primarily in rigorous chemical dependence programs, they should also be alert to the possibility of substance abuse in patients in treatment for other conditions, due to the denial that often accompanies drug use. Despite the difficulties in working with patients with severe mental illness, substance abuse problems, and dual diagnoses, and in spite of the short time treatment in inpatient settings, art therapists have developed some innovative ways of working with this population (Wadeson, 1999, p. 215).

Art therapy provides an outlet that addresses the internal emotional issues associated with addiction and co-occurring disorders which can be especially beneficial in after care treatment in dealing with internalized guilt and shame.

### **Stigmas**

Guilt and shame are feelings that are prevalent among those with substance use disorders. Many of these negative feelings are fueled by stigmas about substance abuse. “Stigma can be defined as relationship between an attribute and a stereotype that assigns undesirable labels, qualities, and behaviors to a person. Labeled individuals are devalued socially, leading to inequality and discrimination” (National Academies of Sciences, Engineering, and Medicine,

2016, p. 21). There are different types of stigmas such as public stigma and self-stigma. Public stigmas are negative beliefs and attitudes held within communities or larger cultural framework. These negative social norms lead to preconceived notions causing them to fear and reject individuals with substance use disorders. Discrimination towards those with substance use disorders obstructs their chances for fair opportunities in areas such as housing, gainful employment and health services. Self stigma is when the public stigma is internalized by the individual which can lead to denial of symptoms, isolations and feelings of guilt, shame and anger (National Academies of Sciences, Engineering, and Medicine, 2016).

Stigmas associated with substance abuse disorders are a very real problem. The stigmas tied to those who suffer from substance abuse are different from other mental illnesses and often result in the maltreatment of those with the disorder. Substance abuse disorders are often seen as a lifestyle choice made by the individual rather than an involuntary symptom from mental disorder. Those who suffer from addiction are often viewed as responsible for their condition and would be able to abstain from substances if they really wanted to. A research study showed that 85% of the general population believed that someone with alcoholism is responsible for his or her condition. (Corrigan, Schomerus, 2014) The general public views substance abusers as lazy, selfish, weak willed, violent and unreliable. The negative stigmas associated with substance abuse disorders are so prevalent that the route to treatment without judgment seems inescapable. The shame and guilt associated with these disorders results in decreased numbers of individuals who seek help as well as the effectiveness of treatment.

The drug and alcohol culture is one that is exclusive and feared, and this adds to a general prejudice against people with these problems. In my experience, few types of patients are

so unpopular with general psychiatric care staff as these. They are described by some staff as being deviant, abusive towards others, demanding and unable to self-accuse. The distinction is such that it usually is deemed necessary to separate them from the general psychiatric milieu and create specialist drug and alcohol services for them (Wadeson, 1999, p. 145).

It is stereotypes like the ones shown above that pushes those with addiction to fall back on the comfort of substance use rather than building meaningful social relationships with others. It can also lead an individual to the belief that the stereotypes tied to their illness are true and may, in turn, view themselves in a negative way.

“Stigma experiences are not restricted to experienced, perceived, or anticipated discrimination by others. Self stigmatization is a cognitive and emotional process within the stigmatized individual that adds significantly to the impact of stigma on the well-being.” (Corrigan, Schomerus, 2014, p. 63) Corrigan’s model of self-stigma describes how people are aware of the negative stereotypes associated with their disorder and on some level, agree with them. There is a large body of research that suggests self-stigma in those with mental illness is linked to negative outcomes like depressive symptoms, loss of motivation and an increase for the need of inpatient care. (Corrigan, Schomerus, 2014) This internalization can also lead to denial of symptoms and rejection of treatment. The rejection of treatment could isolate people with mental and substance use disorders from valuable social supports. Self-stigma does not stem from lack of awareness or intentional reassertion of negative social norms, but from previous life encounters of discrimination and rejection. Self-stigma can lead to major obstructions in the

road to recovery for those with mental and substance use disorders. (National Academies of Sciences, Engineering, and Medicine, 2016)

The link between the internalized stigmas of guilt and shame and decrease of effectiveness in treatment is an obvious indicator that promoting emotional well-being should be considered a priority in recovery programs. This could be especially important in substance abuse treatment if one is relying on substance use to escape negative feelings. The use of substances to avoid internal conflict could turn into a vicious cycle of seeking treatment, getting sober, feeling guilt and shame because of substance abuse and then returning to substance abuse to numb the negative emotions.

### **Art Therapy Research**

According to Malchiodi, among the many emotional factors implicated in addictive disorders, shame is viewed as central to the addictive process and core of all addiction and that those suffering from addictive illness are believed to have more shame than individuals with mental illness or the general public (Malchiodi, 2012). “Shame is characterized as a particularly intense, painful, and often incapacitating experience that involves critical self-judgment and feelings of inferiority” (Malchiodi, 2012, p. 303). Shame can cause critical damage to the self by internalizing negative self-talk and image. The shame that one feels may be amplified by the stigmas associated with addictive illnesses. Internalized shame can influence one’s interpersonal relationships, self-esteem, aspirations and how they view the world. “...shame has been characterized as both the cause of addictive behaviors and the reason they continue” (Malchiodi, 2012, p. 303). The more a person is burdened by shame, the more likely the individual is to seek relief from the pain that comes from within. Substances are used as temporary relief. Although

cognitive behavioral therapies have been shown to reduce depression and anxiety, there is little evidence that it reduces shame with addicts (Malchiodi, 2012).

Expressive approaches such as art therapy could offer a method of reducing shame since shameful feelings may flow more easily and be more directly accessed via nonverbal, creative approaches since they bypass rather than active confront well-practiced defenses. Art therapy is thought to tap into unconscious processes and provides a safe method for accessing and containing painful feelings through the process of sublimation and projection, and by remaining within the relative safety of metaphor, symbol, or image (Malchiodi, 2012, p. 305).

Treatments for addiction have much more of a chance of success if feelings of shame are reduced.

Substance use over a long period of time will alter the body's natural production of neurotransmitters that are essential to maintain and regulate mood. This may result in biochemical imbalances which will alter emotional states and behaviors. These biochemical changes, those due to such battling with substance use may experience severe emotional stress and struggle managing negative emotional states. The withdrawal process releases stress-related neurotransmitters whereas the body's natural neurotransmitters that contribute to positive well-being are depleted. This process can generate unpleasant emotions and drug-seeking thoughts (Matto, 2002). Individuals that go through the initial physical withdrawal process often experience severe psychological, emotional and spiritual stress. The intense stress levels may be extremely difficult to cope with, which may increase drug seeking behavior in order to cope with stress triggers. Lack of proper treatment and services to help manage stress levels often results in

the recurring challenge with incessant stressors from multiple compounding sources. These include increased sensitivity to natural, psychological, and socio-environmental stressors of daily living, biologically based stress related to substance induced neurochemical changes and stressors related to negative outcomes resulting from continued addictive behavior (Matto, 2002).

Neuroscience shows how the sensory pathways are activated and can aid in the healing of physical, mental, and emotional ailments as well as promote positive self-esteem and view of self. Art therapy focuses primarily on how expressive depictions reveal emotional experiences and how the emotional experiences influence thoughts and behavior. Lusebrink states that the formation of internal images activates sensory pathways. There is research which illustrates how art therapy interventions benefit in multiple areas. The capacities that benefit from art therapy include, but are not limited to, the reconstitution and rehabilitation of physical impairments, promotion of mental, emotional, and physical healing and enhancement of cognitive and emotional growth (Lusebrink, 2004). Like the cognitive behavioral approach, art therapy could be a useful tool in bridging the gap between “recovery for” and “recovery from” phases. The recovery from phase as stated earlier, is the stage beyond substance use in which clients are searching for positives in their lives, such as social reintegration.

An example of how art therapy can be used in substance abuse treatment programs is shown in this case example done by Matt Laurer and Rene van der Vennet. Laurer and van der Vennet conducted a study to investigate whether producing art and art viewing would be effective in reducing negative mood and anxiety in 28 adults with substance abuse disorders. They had 28 participants, eleven women and seventeen men, who were diagnosed with AXIS I



substance abuse or dependence disorder who were receiving outpatient treatment. These individuals had no prior experience or training in art. The treatment center's groups were gender specific so each gender group was split into two groups by random selection of a coin toss. They had two control groups and two experimental groups (one male and one female for each) The control group viewed art and the experimental group produced art.

The study was conducted in two sessions with both groups. In the initial meeting, consent forms were filled out and completed. The following week the participants had to write a ten-item list of their most pressing concerns or worries as well as two standardized mood assessments. The standardized mood assessments would be used for data collection and the to-do lists would be kept by the participants for their private use. The to-do lists were used to produce a baseline level of mild negative mood and anxiety in order for the study manipulations to be assessed. The art making group was given twenty minutes to complete an artwork of their choosing. They were given paper, colored pencils, watercolor, chalk, oil pastels and charcoal pencils. They could draw and use as many sheets of paper as they liked.

The control group viewed and sorted 60 classical art prints. They were asked to categorize them into groups based on the content of the images. They were able to go at their own pace and make their own judgments as to how the artworks fit together. The idea was to give the group the same freedom as the experimental group but without art making. All groups had to complete the standardized assessments once the directives were completed as well as make a to-do list of their ten happiest memories. A verbal and written debriefing followed and the group members received a list of resources in the event that the participants experienced any adverse effects. The assessments taken before and after the directives were then analyzed. The

experimental group that produced art showed a significant decrease in negative mood and anxiety and the control group that viewed the art had little change in reduction of negative mood and anxiety. The results suggest that engaging in artmaking shows potential for reducing negative mood states and anxiety for clients struggling with substance abuse (Laurer, 2015).

### **Methods**

As mentioned previously, cognitive behavioral therapy is one of the growing methods of treatment in substance abuse groups. The cognitive behavioral approach uses talk therapy which initiates a top-down method that activates the cortex and limbic system. The top-down method stimulates the most developed parts of common brain. Art therapy uses the bottom-up method which activates the cortex and stimulates sensory parts of the brain as well as the promotion of healing in emotional, physical and mental capacities.

Because individuals with substance abuse disorders often involve such a complex variety of co-occurring disorders and personalities, art therapy could be a beneficial tool in improving emotional well-being by addressing internalized negative beliefs. Art therapy can provide beneficial coping skills and gain a positive outlook. Improving emotional health and shedding feelings of guilt, shame and anger will enable persons to move on to the “recovery for” stage of recovery. By shedding internalized stigmas, individuals will be able to look forward to the positive things that lie ahead, which will help in maintaining lasting recovery and increase success rates.

### **Case Studies**

To demonstrate how art therapy can activate the basic building blocks in processing information and dealing with emotions I will explore the benefits of art therapy in substance

abuse groups and how it can be beneficial in shedding internalized negative feelings of anger, shame and guilt. I will provide two case examples and two directives that took place in an art therapy group setting with adults in a substance abuse and mental health services center for out-patient care. I met with this group for approximately three and a half months for the group sessions. I will refer to the individuals that participated as Client X and Client Y to protect their privacy.

Client X is a 59-year-old male, who has struggled with alcohol throughout his life. Although he was a heavy drinker he could maintain his occupation as a business owner and maintained relationships with his three sons and wife. Around the age of fifty, when all but one of his children were entering their college years, he retired. His alcohol use became more severe and his relationships became strained. He and his wife divorced and he lost custody of his youngest child. By the time I had met him he had been divorced for years and he had scheduled visits with his youngest child. He lives with a roommate and keeps himself busy with miscellaneous jobs and hobbies.

In my first meeting with the group I was met with a lot of resistance from Client X. He was the first to claim that he “was no artist”. He would engage in discussion in the group but put forth a minimal amount of effort in art making. Throughout the following weeks I observed that he used very little color in his work. His drawings were all done on a very small scale and only used black and white. During group discussion, he often expressed his need to stay busy and did not like sitting still. I observed that he had difficulty during our mindfulness practices. He would leave the room often during meetings.

Client Y is a female in her early forties. She has struggled with substance use, but said her main substance of choice was alcohol. Her former boyfriend also abused substances. She has a restraining order against her boyfriend. Her drinking had become so severe that she was hospitalized due to an alcohol induced coma. She lost custody of her ten-year-old son and was only allowed supervised visits.

She expressed her feelings of intimidation with the initial creative process and claimed she had no artistic talent but “would give it a shot”. Once she became more comfortable with the idea that it was not about the product but the process she appeared to immerse herself in the practice. Her creative flow appeared to blossom more and more with each session. Upon observation, Client Y took a great deal of thought and care in completing each directive. She seemed committed to treatment and healing for not only herself, but for her son as well.

Several weeks into our sessions, I asked the group to create a list of events/behaviors from self or others that contributed to their feelings of guilt and/or shame. They also listed ways their alcohol use affected their sense of shame/guilt. After the list was completed, they had to transform the list (e.g. ripping, shredding, cutting, folding, painting, etc.) to represent the release of the negative feelings they were holding on to and then create an artwork that represents a more positive image of self.

Client X ripped his white sheet of paper into small pieces and glued it onto another sheet of white paper. The ripped pieces seemed to be placed methodically but could only be seen when viewed up close. He spoke briefly but did express how his alcohol use significantly altered his life and that he felt ashamed of how he let a substance take control of his life. He did not divulge

into how the piece represented something positive but did speak of how he is continuing to work towards recovery.

Client Y created a box that was brightly decorated on the outside representing the person she wants to be. She expressed that she wants to rid herself of the self-doubt and shame she feels every day from her past decisions and actions while she was using. She spoke of her deep seeded negative opinions of herself due to the situation she put herself and son in. She had extreme guilt about her parenting and neglect for her son while she was drinking. She spoke of building a new life with her son and taking care of herself so that she can feel a sense of pride and accomplishment. She expressed how she was working toward her goals of getting her job back and regaining custody of her son. When she opened her box, she had her list ripped into individual slips of paper. She explained that she will always feel regret about her past but that she wanted to keep the list as a reminder and motivation to move forward and not make the same mistakes again.

Another intervention took place where the group was asked to represent how they react towards others on the outside of a mask and what triggers their anger on the inside of the mask. Client X expressed how he had always been very cool, calm and collected. He hardly ever felt angry in the past and did not let things bother him. He explained that even when his ex-wife was nagging him or trying to change his ways he never lost his cool. His mask was white with a very bright red forehead. He explained that recently he feels angry more often. He expressed how he even “snapped” at his neighbor and his roommate last week. He said he had never spoken to them like that before. He did not know where the anger was coming from. He wrote down recent situations where he lost his temper on the inside of his mask. As he was describing his recent

outbursts it became clear to him that he in each case he had felt pressured to perform tasks/favors that he was hesitant or unwilling to do. He explained that he did not like others telling him what he should do and like to be in control. He half-jokingly expressed that this was why he should never marry again. He again referred to how his life was with his ex-wife and admitted that he may have some lingering resentment towards her. Through the art therapy process he discovered his repressed feelings of anger. He discussed that now that these repressed feelings were coming out he could now begin to figure out how to cope with his feelings in a healthy manner.

Client X used color for the first time since we had begun our sessions. He also worked on his mask until it was finished without taking any breaks which was a significant improvement in his concentration. He was also much more expressive in his movements and even worked on the floor in order to get the detail he desired on the forehead of the mask. Through his creative processing, Client X was able to identify some of his triggers which is a step in the right direction in finding healthy outlets to deal with his anger.

Client Y created a mask with large black and red feathers on the outside and labeled where her anger came from on the inside. While she was using, she would lash out and have outbursts of rage and do things like punch walls. She voiced that alcohol was her escape when she was angry but after a while it made her anger worsen and actions more aggressive. She is currently fighting for unsupervised visits with her son. She discussed how her central trigger at this time was her ex-boyfriend. He also struggles with addiction and is still using. She now has a restraining order against him but he keeps trying to contact her. Since being in treatment she has started to go to the gym as a healthier outlet for dealing with her anger towards him and herself, but voiced that she still has intense feelings of anger.

When those with substance use disorders get through the first phase of recovery from the substance, they are left with overwhelming emotions. Because they had relied on substances to cope with inner feelings, they often need to rediscover and identify what they are feeling.

### **Limitations of Therapy**

While art therapy could be beneficial to substance abuse disorder treatment plans and in shedding internalized negative views of self, there are limitations of the therapy. Though there is much evidence that art therapy is very effective in promoting emotional well-being and reducing stress and anxiety, there is little recent evidence of research specifically done on the benefits of art therapy as treatment for those suffering from substance abuse.

Another limitation could involve the guarantee of an adequate work space for clients. The implementation of art therapy treatment programs may face obstacles in providing an ideal environment for artmaking. Dilemmas may arise in supplying a suitable art room depending on the facility's space and budget for supplies.

There are also financial and societal obstacles faced with implementing art therapy into treatment programs. Funding is always an issue when it comes to any sort of mental or behavioral health treatment. Most behavioral health services are financed through public sources and mental health services are largely funded by Medicaid and alcohol and drug treatments are largely funded by state and local non-Medicaid sources. Communities will also often reject treatment facilities (National Academies of Sciences, Engineering, and Medicine, 2016).

People with mental illnesses and substance use disorders require more treatment than the general population but treatment and services vary in quality and timeliness due to the disjointed funding for care.

Among adults who reported an unmet need for mental health care in the past year, the most common reasons were inability to afford the cost of care (48%), believing that the problem could be handled without treatment (26.5%), not knowing where to go for services (25%), and not having the time to go for care (16%). Smaller proportions reported that they did not seek care because it might cause neighbors or the community to have a negative opinion (10%), they did not feel a need for treatment at the time (10%), they thought that treatment would not help (9%), they had fear of being committed to an institution or having to take medicine (9%), they had concerns about confidentiality and the potential negative effect on employment (8%), they did not want others to find out (6%), and they had no insurance coverage or inadequate coverage of mental health treatment (6% to 9%) (National Academies of Sciences, Engineering, and Medicine, 2016).

Since there is limited funding, individuals may not be able to afford alternative treatment options. Public and self-stigmas may also influence the decision to seek treatment as well as the number of available care facilities if the communities reject treatment programs in the area.

### **Conclusion**

Substance abuse in the United States causes high economic costs due to incarceration and medical expenditures. Treatment for substance use disorders have been proven to be beneficial to society in lowering economic costs. Though treatments are helpful, current treatment options are



limited and have much room for improvement. Those suffering from these disorders do not fit into a neat category where one form of care treats all. Substance use disorders are complex and vary amongst individuals, also often comorbid with other disorders. Research on substance use disorders show the critical need for alternative treatment options in response to the varied needs of individuals. Stigmas play a role in the limited treatment options available as well as the internalized negative view of self that many endure. Cognitive behavioral therapies are common in substance abuse treatment and use a top down method aimed to encourage lasting recovery through the “recovery for”, which aims at fostering emotional health and positive outlook on life. Art therapy has the potential to increase the success rates of recovery and promote physical and emotional healing by using a bottom up method which has been found to directly address feelings of shame and guilt.

## References

- American Art Therapy Association*. (2013, September 19). Retrieved September 19, 2016, from What is Art Therapy?: <http://www.arttherapy.org/upload/whatisarttherapy.pdf>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Bell, C. J. (2007). Effect of art production on negative mood: A randomized, controlled trial. pp. 71-75.
- Drug Policy Alliancing Guiding Drug Law Reform and Advocacy*. (n.d.). Retrieved from Drug Policy.org: <http://www.drugpolicy.org/docuploads/ndny-costeff.pdf>
- Ending Discrimination Against People with Mental and Substance Use Disorders. (2016, August 3). *Committee on the Science of Changing Behavioral Health Social Norms; Board on Behavioral, Cognitive, and Sensory Sciences; Division of Behavioral and Social Sciences and Education; National Academies of Sciences, Engineering, and Medicine*. Washington D.C. Retrieved from Committee on the Science of Changing Behavioral Health Social Norms; Board on Behavioral, Cognitive, and Sensory Sciences; Division of Behavioral and Social Sciences and Education; National Academies of Sciences, Engineering, and Medicine.: <https://link.uwsuper.edu:3921/books/NBK384915/> doi: 10.17226/23442
- Gussak, D. (1997). *Drawing time: Art therapy in prisons and other correctional settings* (Vol. 1). (E. V. David Gussak, Ed.) Chicago, IL: Magnolia Street Pub.
- Hanes, M. J. (2007). "Face to face" with addiction: The spontaneous production of self portraits in art therapy. *Art Therapy: Journal of American Art Therapy*, 33-36.
- Laurer, M. v. (2015). Effect of art production on negative mood and anxiety for adults in treatment for substance abuse. *Art Therapy: Journal of the American Art Therapy Association*, 32(4), 177-183. doi:10.1080/07421656.2015.1092731
- Lusebrink, V. B. (2004). Art therapy and the brain: An attempt to understand the underlying processes of art expression in therapy. *Art Therapy Journal Of The American Art Therapy Association*, 125-135. doi:10.1080/07421656.2004.10129496
- Malchiodi, C. (2012). *Handbook of art therapy* (2nd ed.). New York, New York: Guilford Press.

- Matto, H. (2002). Integrating art therapy methodology in brief inpatient substance abuse treatment for adults. *Journal Of Social Work Practice In The Addictions*, 2(2), 69-83. Retrieved 11 10, 2016
- Mitcheson, L. M. (2010). *Introduction to CBT for substance use problems, in applied cognitive and behavioural approaches to the treatment of addiction: A practical treatment guide*. Chichester: John Wiley & Sons, Ltd. doi:10.1002/9780470661420
- National Academies of Sciences, Engineering, and Medicine. (2016). *Ending discrimination against people with mental and substance use disorders: The evidence for stigma change*. Washington, DC: The National Academies Press. doi: 10.17226/23442.
- NIDA (2012). *Principles of drug addiction treatment: A research-based guide* (3rd Ed.). Retrieved December 9, 2016, from <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition>
- Rubin, J. (2001). *Approaches to art therapy: Theory and technique* (2nd ed.). New York: Taylor and Francis Group.
- Schomerus, G. (2014). The stigma of alcohol and other abuse. (In Corrigan, P., Editor, *The Stigma of Disease and other Disability: Understanding Causes and Overcoming Injustices*, pg. 57-69) Washington, D.C., U.S.A>: American Psychological Association. Retrieved 10 4, 2016, from <http://dx.doi.org/10.1037/14297-004>
- Wadson, H. (1999). *Art therapy practice: Innovative approaches with diverse populations* (1st ed.). Hoboken, N.J.: John Wiley&Sons.
- Wadson, H. (2010). *Art psychotherapy*. Hoboken, N.J.: John Wiley&Sons.