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An Art Therapy Program Designed for Women Recovering from Alcoholism in an Extended Care Treatment Center

Mary Jo Chapman

AN ART THERAPY PROGRAM DESIGNED FOR WOMEN RECOVERING FROM ALCOHOLISM IN AN EXTENDED CARE TREATMENT CENTER

Mary Jo Chapman, B.A.

A Digest Presented to the Faculty of the Graduate School of the Lindenwood Colleges in Partial Fulfillment of the Requirements for the Degree of Master of Art in Art Therapy

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The problem of alcoholism is a major health concern in our society. It is considered to be a disease that is treatable, but not curable. The number of women entering treatment for alcoholism has increased steadily in the past few years. Since statistics indicate that there is a high rate of relapse and recedivism within this group, treatment methods that can aid in the recovery process are important.

Art Therapy is a non-verbal approach to traditional treatment methods. It aids the therapeutic process by transforming unconscious and conscious material into symbols rather than words. The individual can use the artistic media to explore and work through personal conflicts, and can project her thoughts and feelings into concrete, visual form. Through this process, she can gain insights that encourage unity and growth.

This project explains how Art Therapy was incorporated into an extended care treatment program for

women recovering from alcoholism. Art Therapy was used over a four-year period for diagnostic evaluation, group and individual therapy.

The Art Therapy, as a treatment component, was found to be helpful in encouraging a greater self-awareness in the individual, as well as in confronting the high denial system that was usually present in the alcoholic. It was also beneficial in promoting a more positive self-esteem in the recovering woman.

AN ART THERAPY PROGRAM DESIGNED FOR WOMEN RECOVERING FROM ALCOHOLISM IN AN EXTENDED CARE TREATMENT CENTER

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A Culminating Project Presented to the Faculty of the Graduate School of the Lindenwood Colleges in Partial Fulfillment of the Requirements for the Degree of Master of Art in Art Therapy

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Table of Contents

Introduction

Art Therapy is becoming more widely recognized for its therapeutic qualities. It is a non-verbal medium that is adaptable for many populations and clinical settings. In this presentation, I will describe how it was adapted for use in an extended-care treatment center to aid in the recovery process for alcoholic women who were making necessary life style changes. Art Therapy provided a useful tool to facilitate the release of feelings and the integration of denied attitudes. It also helped to make past behaviors that were related to drinking patterns more visible.

The De Novo Program is a unique treatment idea in the alcoholism field, and Art Therapy made a meaningful component to the program. The art contributed to the diagnostic material, treatment planning, and treatment monitoring of each resident.

Chapter One: Review of the Literature

Art Therapy

At the very dawn of man's journey into civilization, art was used as a tool for non-verbal expression. On the surfaces of caves, rocks, and trees, as well as on his own body, early man drew his symbolic messages. We may not understand these ancient symbols, but in its way the message spells out the artist's attempt to bring together his/her inner world of self with his/her outer world of experience. Civilization has marched on, but the necessity to bring meaning and purpose from our two worlds remains intact. In more recent times, art therapy has evolved in reaction to this on-going and intriguing challenge. Art therapy has combined mankind's ancient approach to synthesis with some modern theories on human dynamics. Simply put, art therapy is the process of using art and the creative process for therapeutic purposes. It strives to combine both art and therapy in a compatible marriage and to explain why it is an appropriate match.

One theory was set forth by Margaret Naumburg (1966). She focused on the idea that the art released the unconscious into symbolic speech that could be shared between therapist and client as a result of transference and the encouragement of free association. She felt that art therapy speeds up the therapeutic process because it tends to release deeply unconscious material into pictures rather than words.

Even young children have the ability to use images as symbolic language. Kellogg (1967), Gardner (1980), Di Leo (1970), and Lindstrom (1970) have done studies to show that normal children all seem to go through very similar patterns of expression in their art. These patterns correspond to their physical, mental and emotional development.

This ability to project our inner experiences into symbolic speech emerges early in the development of the individual. Richmond (1971) states:

> Symbolic representation emerges from sensori-motor representation at about the two-year mark. Sensori-motor thinking continues in parallel with this symbolic activity. The symbolic function arises because internal-ized imitation--the end product of sensori-motor thought--can be evoked in the absence of the actions which originally created the imitation. Deferred imitations give rise to images, which are the symbols that a child uses for preconceptual thinking. His image-symbols are a collection of actions, objects, and events which are related to one another in a unique and private way. (p. 29)

It is within the human brain that this symbolic representation occurs. Even though there is still much that is not known about the human brain, there is some evidence that gives us insight into the way the brain operates. Our senses begin almost at birth to receive a myriad of messages and information. The ear, the eye, the nose, and our sense of touch and feel--all are constantly reporting input from our environment. We may unconsciously, as well as consciously, send information to the brain for storage. Kepes (1966) feels that much of the routine input of our senses occurs below the threshold of our awareness. We do not consciously remember much of what we have experienced during our day's activities, even though our brain has duly received and stored the information.

Recently, Roger Sperry of the California Institute of Technology has conducted experiments to investigate how the human brain functions. He postulates that there are two distinct hemispheres in the human brain and each of these processes information in a different cognitive style: "The left hemisphere for an analytical, logical mode in which words are an excellent tool and the right hemisphere for a holistic, Gestalt mode, which happens to be particularly suitable for spatial relations" (Restak, 1979, p. 179).

Sperry's experiments also have shown that the right hemisphere seems to be the one for "memory storage of emotionally charged material" (Restak, p. 179).

Dr. David Galin, of the Langley Porter Neuropsychiatric Institute in San Francisco, feels the right hemisphere is the repository for the unconscious. He

> thinks the right hemisphere's performance is strikingly similar to the operation of the unconscious process. For one thing, both the right hemisphere and the unconscious deal with images which cannot ordinarily be verbalized. Secondly, their functioning depends less on logical analysis than on the perception of the total pictures, which psychologists refer to as Gestalt. (Restak, p. 176)

The unconscious part of the mind represents a large portion of the individual. Jung (1964) believes that at one point in the development of mankind, the unconscious was more accessible to peoples' thinking and on more familiar terms with their conscious expression. As mankind became more "civilized," they lost touch with their natural instincts and their guiding intuitions. A "dissociation" began to develop and continued to widen between the conscious and the unconscious side of man.

In his book, Man and His Symbols (1964), Jung states:

> For the sake of mental stability and even physiological health, the conscious and the unconscious must be integrally connected

> and thus move on parallel lines. If they are split apart or "dissociated," psychological disturbances follow.

In dreams, Jung feels symbols emerge that:

> are the essential message carriers from the instinctive to the rational parts of the human mind, and their interpretation enriches the poverty of consciousness so that it learns to understand again the forgotten language of the instincts. (p. 37)

The unconscious (right hemisphere) can only speak its message through the language of symbols because it has no other voice. All the input that has gone into the unconscious from the individual's experiences, feelings, subliminal awareness, sensory perceptions, and conscious thought is used as the ingredients for making symbols particularly relevant to the individual and for making its message known to the consciousness.

Maslow believes that

> . . . those portions of ourselves which are rejected and relegated to unconscious existence can and inevitably do break through into open effects upon our communication. . . . this is easily demonstrated by . . . art expression. . . . We express what we are. To the extent that we are split, our expressions and communications are split, partial, onesided. To the extent that we are integrated, whole, unified, spontaneous, and fully functioning, to that extent are our expressions and communications complete, unique, and idiosyncratic, alive and creative rather than inhibited, conventionalized, and artificial, honest rather than phoney. Clinical experience shows this for pictorial . . . art expressions. (Kepes, 1966, p. 135)

Since art uses symbols to depict thoughts, feelings, and experiences, it can be an important vehicle for expressing the unconscious and for unifying the unconscious and the conscious sides of human beings. This synthesis is therapeutic in nature. As ancient man drew on caves and rocks, he did not understand the therapeutic process that he was engaged in, but no doubt he experienced the healing quality of his symbolic messages. The field of art therapy has developed the use of symbols, expressed especially on paper and in clay, to continue this synthesis. Ulman (1961), a pioneer in the field of using art for therapeutic purposes, suggests that:

> art is a way of bringing order out of chaos--chaotic feelings and impulses within, the bewildering mass of impressions from without. It is a means to discover both the self and the world, and to establish a relationship between the two. (p. 13)

Not only does art therapy use symbols as its basic language, but it also uses the creative process that is inherent in each individual to produce the symbolic form. Edith Wallace (1976), states that:

> the creative process is that part of the individual that transcends the personal, bringing him closer to the non-personal potential within himself and this is the prerequisite to being truly creative. (p. 87)

Zinker (1978) feels that the "creative process is

therapeutic in itself because it allows us to express and examine the content and dimensions of our internal lives" (p. 8).

Wolf describes how the creative process works:

> . . . the creative person is highly attuned to both inner unconscious processes and outer environmental stimuli. He allows this energy to build up within him; he flows with it and lets it lead him to a point where he seeks discharge through a process which transforms and binds the energy in a creative art form. If the creative product is then shared with others, the artist experiences a further sense of synthesis. (p. 91)

Kramer (1971) has placed great emphasis in her work with children on the healing property of the creative process. She contends that this healing occurs even without a verbal reflection or exchange. The participant experiences healing through using the art materials in a "complex ego function that engages his manual, intellectual and emotional faculties in a supreme effort" (p. 13).

The participant in the art therapy process uses the symbolic language of his/her right brain and the creative process stimulated by his/her unner and outer worlds. Art is the meeting point and self-awareness can be the result. Such self-awareness is the basis of change and therefore must be the goal of therapy. Branden (1982) suggests that:

> when a person acts without knowledge of what he thinks, feels, needs, or wants, he does not yet have the option of choosing to act differently. That option comes into existence with self-awareness. When a person becomes self-aware, he is in a position to acknowledge responsibility for that which he does, including that which he does to himself, to acknowledge that he is the cause of his actions--thus take ownership of his own life. Self-responsibility grows out of self-awareness.
>
> When a person becomes aware of what he is and takes responsibility for what he does, he experiences the freedom to express his authentic thoughts and feelings, to express his authentic self. Self-assertiveness becomes possible with the achievement of self-awareness and the acknowledgement of self-responsibility. (p. 137)

Art therapy provides an important opportunity for self-awareness as the art makes more accessible to the individual the unconscious, as well as the conscious elements in his life.

For example, Jane Rhyne (1973) states that:

> I find that most people in my groups, in the act of creating forms, recognize and realize for themselves some thoughts and feelings that they were not consciously aware of previously. In other words, the experience of creating concrete forms makes real and brings into cognition some feeling/thinking states that the person was only vaguely aware of before. Many people can then see that the patterns of their art forms symbolize how they pattern their attitudes and behavior in living: thus, seeing a clear gestalt in their art work can lead to perceiving a clear gestalt of themselves as personalities. This holistic recognition of themselves can lead to an increased acceptance of individual autonomy and responsibility.

> My experience is that this kind of self-discovery art can and often does lead not only to self-realization, but also to an increased capacity for communication, understanding, relatedness, and commitment with others. (p. 157)

This internal process of the person is a vital part of the art therapy experience, but the concrete, visible form that is produced is also valuable. This product is composed of an image or symbol which allows us to express simultaneously many complex relationships, feelings, and needs at one time.

Rubin (1978) suggests that

> in a nonlinguistic fashion, it is the peculiar power of art to be able to symbolize not only intrapsychic events, but interpersonal ones as well, and to collapse multi-leveled or sequential happenings into a single visual statement. The artistic symbol is a condensation, carrier of many meanings, and by its very nature able to integrate apparent polarities--like reality and fantasy, conscious and unconscious, order and chaos, ideation and effect. (p. 255)

The product cannot be neglected. This permanent and concrete expression of the inner process provides an opportunity for persons to view themselves in a way that they cannot achieve verbally. A more holistic picture of the person emerges. Often denied material slips by the defense system through the art medium and may be more easily owned because it emerges from within the self.

Since the art encourages self-awareness and growth, it can occur best in an environment that is non-threatening and accepting. The atmosphere must be conducive to lowering the defenses of people or they will be unable to gain maximum benefit from the art therapy process. Our defense mechanisms are in place to protect us. As Rogers (1970) notes, we are only able to release our defenses when we feel safe, affirmed, and accepted for what we are. It is in this environment that a person will be able to investigate his past patterns of behavior and to risk some new ones. Therefore, it is very important for therapists not to overlook their part in the therapy process.

Art therapists will be most effective if they are constantly evaluating the impact of the environment they create, as well as continually addressing self-awareness and growth in their own lives. The role of art therapists is to combine in a beneficial working dynamic the physical environment in which they work, their understanding of the creative process, and their own philosophy of art therapy, with the needs of the individual or group with which they work. This is the on-going challenge and the intriguing, complex nature of art therapy. It may have

begun with early man, but the symbols have moved from the walls of the ancient cave to the modern therapist's office to take their rightful place as agents of healing and change in today's society.

Alcoholism

Alcoholism is a growing problem and a major concern in the United States. It strikes across all barriers of age, culture, economics, and religion. Langone (1976) states that it is difficult to know just how severe our alcoholism problem is because

> estimating the number of alcoholics and problem drinkers is hard in view of the fact that many of those who have a difficult time with drink either lie about their habit or fail to realize they have a problem. "The number of Americans whose lives alcohol has adversely affected depends on definition," says the NIAA report. "Those under active treatment for alcoholism by public or private agencies are probably in the upper hundreds of thousands, but there may be as many as ten million people whose drinking has created some problems for themselves or their families or friends or employers, or with the police within the past year." (p. 38)

A 1980 Alcohol Problem Cost list from the Monday Morning Report, dated September, 1981, shows these figures:

Lost Production	$31,523,959,000
Health and Medical	20,448,841,000
Motor Vehicle Accidents	8,250,160,000
Violent Crime	4,590,556,000
Social Responses	3,113,874,000
Fire Losses	690,189,000
Total	$68,617,579,000

However, the major cost and concern cannot be computed in dollars and cents categories. It needs to be evaluated in terms of human life, pain, and sorrow.

> . . . all alcohol abuse can shorten life from ten to fifteen years, harm the infants of alcoholic mothers, has been implicated in the development of certain cancers and is a factor in half the murders and a fourth of the suicides in the United States.
> (Langone, 1976, p. 39)

Alcohol is a prominent factor in many divorced or separated families. The literature suggests that nine out of ten husbands leave alcoholic wives, while one out of ten wives leave alcoholic husbands. It is also the direct or indirect cause of approximately 95,000 deaths a year. Alcoholism is related to the reason many young people do not work at their highest capacity in school or college and eventually drop out of the educational system. The National Council on Alcoholism (NCA) estimates that 3.3 million teenagers between the ages of 14 and 17 are developing serious alcoholism problems.

Alcohol effects not only the one who abuses it, but it also brings pain to the alcoholic's family, friends, co-workers, and other concerned people. The NCA estimates that for every alcoholic, another four persons are directly affected. This ripple effect is felt by a large number of people within our society

today. Hardly a life has not been touched in some way by someone who struggles with alcoholism.

The World Health Organization has defined alcoholism as a

> chronic, behavioral disorder, marked by repeated drinking of alcohol in excess of the dietary and social customs of the community and to an extent that it interferes with the drinker's health or how he functions socially or economically. (Langone, 1976, p. 27)

Another broad definition given by the American Medical Association (AMA) runs as follows:

> Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption, such as to lead usually to intoxication if drinking; chronicity by progression; and by a tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational and/or social adjustments as a direct consequence of persistent excessive use. (Langone, p. 27)

The AMA adds:

> In short, alcoholism is regarded as a type of drug dependence of pathological extent and pattern, which ordinarily interferes seriously with the patient's total health and his adaptation to his environment.

Put another way, alcoholism may be defined simply as "a disease in which alcohol interferes with the physical, emotional and social well-being of an individual (Langone, p. 28)

The Rutgers Center of Alcohol Studies offers this: "An alcoholic is one who is unable to consistently

choose whether he shall drink or not and who, if he drinks, is usually unable to consistently choose whether he shall stop or not" (Langone, p. 28).

The alcoholic person becomes physically dependent upon his consumption of alcohol. He finds that as the disease progresses, he must consume more and more alcohol in order to get the desired effect and feeling.

In the system of the average drinker, alcohol acts rapidly. It is in the blood stream in about 15 minutes and peaks in an hour. Alcohol, which is a sedative, depresses the brain's activity. Nerve impulses are no longer transmitted in the same manner; consequently, anxiety and fear are initially diminished or relieved. However, this initial calming action soon changes into agitation and the alcoholic feels more stress and anxiety than he did prior to drinking. This increased agitation causes him to continue drinking in the hopes that he can recapture the initial calm state. Instead, the alcoholic may progress into a blackout or an alcoholic stupor and experience severe withdrawal symptoms upon awakening. In order to relieve these physical withdrawal symptoms, the alcoholic may begin the drinking cycle again.

Along with the physical dependency of this disease, there occurs a psychological dependency. This can be so compelling that when the alcoholic person has dried

out and is aware of the problems of the disease, he/she will still return to drinking alcohol.

Coleman (1964) suggests:

> contrary to popular beliefs, alcohol is not a stimulant but a depressant which attacks and numbs the higher brain centers, thus lessening their inhibiting control. As behavior restraints decline, more primitive emotional responses appear; the drinker may indulge in the satisfaction of impulses he ordinarily holds in check. Some degree of motor incoordination soon becomes apparent, and the drinker's sense of discrimination and perception of cold, pain, and other discomforts are dulled. Typically, he experiences a sense of warmth, expansiveness, and well-being. In such a mood, unpleasant realities are screened out and the drinker's feelings of self esteem and adequacy rise. Casual acquaintances become the best and most understanding friends in the world, and the drinker enters a generally pleasant world of unreality in which his worries are temporarily left behind. (Langone, p. 313)

Since alcohol has this psychological effect on the drinker in that it can lead him to such a pleasant world of unrealistic adequacy, lack of worry, and warm sociability, combined with the approval society gives to alcohol, it is not surprising that it has become such a common pattern and such a far reaching problem in our culture.

However, even with the obvious evidence of the extent of the growing problem of alcoholism and alcohol abuse, there is no single factor which has been found to explain or predict its development. Some

people seem to begin their painful journey into alcohol abuse with the first drink; others seem to be able to drink for a length of time before reaching an addicted state. Alcoholism can develop in the young or old, rich or poor, religious or non-religious.

Zimberg (1978) notes that according to the psychoanalytical concepts,

> oral fixation is thought to be the arrested stage of development in the alcoholic. This fixation accounts for infantile and dependent characteristics such as narcissism, demanding behavior, passivity, and dependence. The fixation occurs after a significant degree of deprivation during early childhood development. Much evidence supports the view that alcoholics were exposed to rejection by one or both parents and that dependency needs are among the major psychological factors that contribute to the development of alcoholism. Other developmental factors that have been noted to contribute to a conflict with dependency have been the over-protection and the forcing of premature responsibility on a child. (p. 4)

Since this oral fixation is accompanied by a need or a desire to be emotionally childlike, the emotionally immature alcoholic person may use alcohol to substitute for more mature behavior in the situations that require adult reasoning and actions.

The social learning theory of behavior addresses alcoholism by saying that all behavior is learned. The individual learns by observing how others behave and by assessing the results of various kinds of be-

havior. There are many circumstances in which alcoholics might learn to use alcohol. They may observe it being used by their parents to cope with stress and tension. They may note that it is almost always offered in restaurants as a first choice of the diner, to relax before a meal. The often advertised "Happy Hour" by many bars may influence their use of alcohol as a deterrent to loneliness. Television and magazine advertisements show alcohol being consumed by the most sophisticated or the most macho of individuals. The person may learn through these media ads that alcohol is associated with the feeling of adequacy and acceptance.

Because of their observation of parents and environment, alcoholics can learn to use alcohol to cope and to escape. As they investigate the use of it, they learn a stimulus-response pattern that says when anxiety or stress comes into life, alcohol will relieve it. The more they depend on alcohol to satisfy these needs, the less initiative they have to try other alternatives to life's stress and tension.

The concept that there is a particular personality type that predisposes an individual to be an alcoholic has been investigated and tested in recent years. Most authorities feel that while there does

not seem to be any personality type that leads to alcoholism, there do seem to be traits that the alcoholic person has in common with others suffering from the same disease. According to Langone (1976), some of these traits are: sexually and emotionally immature or deprived, strongly dependent on someone or something, troubled by feelings of inadequacy, unable to tolerate tension, guilt-ridden, easily frustrated, extremely sensitive, impulsive, hostile, and convinced that they are more capable than they are.

Roebuck, Julian, and Kessler (1972) cite studies done by Zwerling and Rosenbaum in which 46 alcoholics were given psychological tests. The alcoholics were found to have similar underlying personality features.

1. They were basically schizoid, that is they showed a sense of isolation from other people. Sometimes this isolation was concealed by a facade that made them appear to be outgoing individuals, when in reality they were just the opposite.
2. They were depressed, with feelings of futility, hopelessness, and sadness. This depression was seen in both sporadic expressions of worthlessness and suicide attempts.
3. They were dependent in an irrational way upon

external forces for security and care.

4. They were hostile and at times would exhibit an overpowering amount of anger.
5. They were sexually immature and displayed serious problems of masculine (or feminine) identification.

Roebuck, Julian, and Kessler (1972) also cited a study by Buhler and Lefener that attempted to discover the psychological characteristics held in common by alcoholics. They used a mixed group of 100 alcohol dependent men and women. They found that the alcoholics had less ability to withstand strain and tension or to endure and persist under the presence of difficulties. They seem to suffer more from anxieties and guilt feelings in regard to themselves. The alcoholics were also more introspective and rational, but were found to be conflictive in their interests. They were ambitious, but at the same time found they were unable to withstand the strain and pressure to follow through on their ambitions. Since they seemed to lack the ability to set up realistic goals and the persistence to obtain them, they fell short of meeting their own expectations and resorted to unrealistic wishful thinking or frustration. This awareness in alcoholics combined with their inability to overcome their slug-

gishness of mind caused alcoholics to have anxieties which lead them to indulge in escape-drinking.

Zimberg (1978) adds to the personality traits commonly held by alcoholic persons by including the tendency to be obsessive-compulsive and perfectionistic, as well as having a strong need to maintain control over their lives. Zimberg goes on to explain that there seems to be a conflict in the alcoholic that

> consists of a lack of self-esteem, along with feelings of worthlessness and inadequacy. These feelings are denied and repressed and lead to unconscious needs to be taken care of and accepted (dependent needs). Since these dependent needs cannot be met in reality, they lead to anxiety and compensatory needs for control, power, and achievement. Alcohol tranquilizes the anxiety and, more important, creates pharmacologically induced feelings of power, omnipotence, and invulnerability. When the alcoholic wakes up after a drinking episode, he experiences guilt and despair because he had not achieved anything more than before he drank and his problems remain. Thus, his feelings of worthlessness are intensified and the conflict continues in a vicious circle, often with a progressive downward spiral. However, the alcohol provides an artificial feeling state of power and control that cannot be achieved in reality. The very act of producing this feeling of power at will feeds the alcoholic's grandiose self-image. (p. 5)

Even though there is information on the psychological traits that are held in common by most alco-

holics and an understanding of the physical reaction of the individual to alcohol, there is still much that is not known to explain why some persons become addicted and others do not. The origins of the disease remain obscure. It seems evident that no single psychological or physical factor can account for the etiology of alcoholism. This disease is a complex behavior disorder that has many inter-related factors involved. The diversity of the psychological, social, and physical experiences of individuals who develop alcoholism suggests that it may be more helpful to focus on how the person experiences the disease in order to mobilize intervention methods and treatment facilities effectively.

Alcoholics experience their disease as a progressive one. It seems to go through three basic stages in its development. Miller, Gorske, and Miller (1982) describe these stages as follows:

1. Early stage: Drinkers experience some definite personality changes as a result of ingesting alcohol. At this point the body is able to adjust to the alcohol in the blood. Since they tolerate the alcohol, they are able to increase the quantity of intake. At this stage, alcoholics experience a positive

reaction to the drinking and begin to drink more often and to drink larger amounts.

2. Middle stage: A loss of control over drinking emerges. The liver cells change in order to tolerate the increased intake of alcohol. This leads alcoholics to be dependent on their drinking. There is a progressive loss of control over when they chose to drink, over the way they behave during drinking episodes, and over the result of their drinking experiences. At this point, alcoholics begin to feel that they cannot function without alcohol. It is seen as the solution to their problems. Feelings of discomfort, anxiety and stress are all triggers to drinking.

3. Chronic stage: There is no more pleasure in drinking. Alcoholics now drink to get drunk and to relieve the physical and emotional discomfort that arises when their alcohol blood level drops. It is at this stage that the alcoholics' lives become unmanageable for them. Alcohol and drinking based activities control their lives. They deteriorate in all areas--physically, emotionally, behaviorally, and socially.

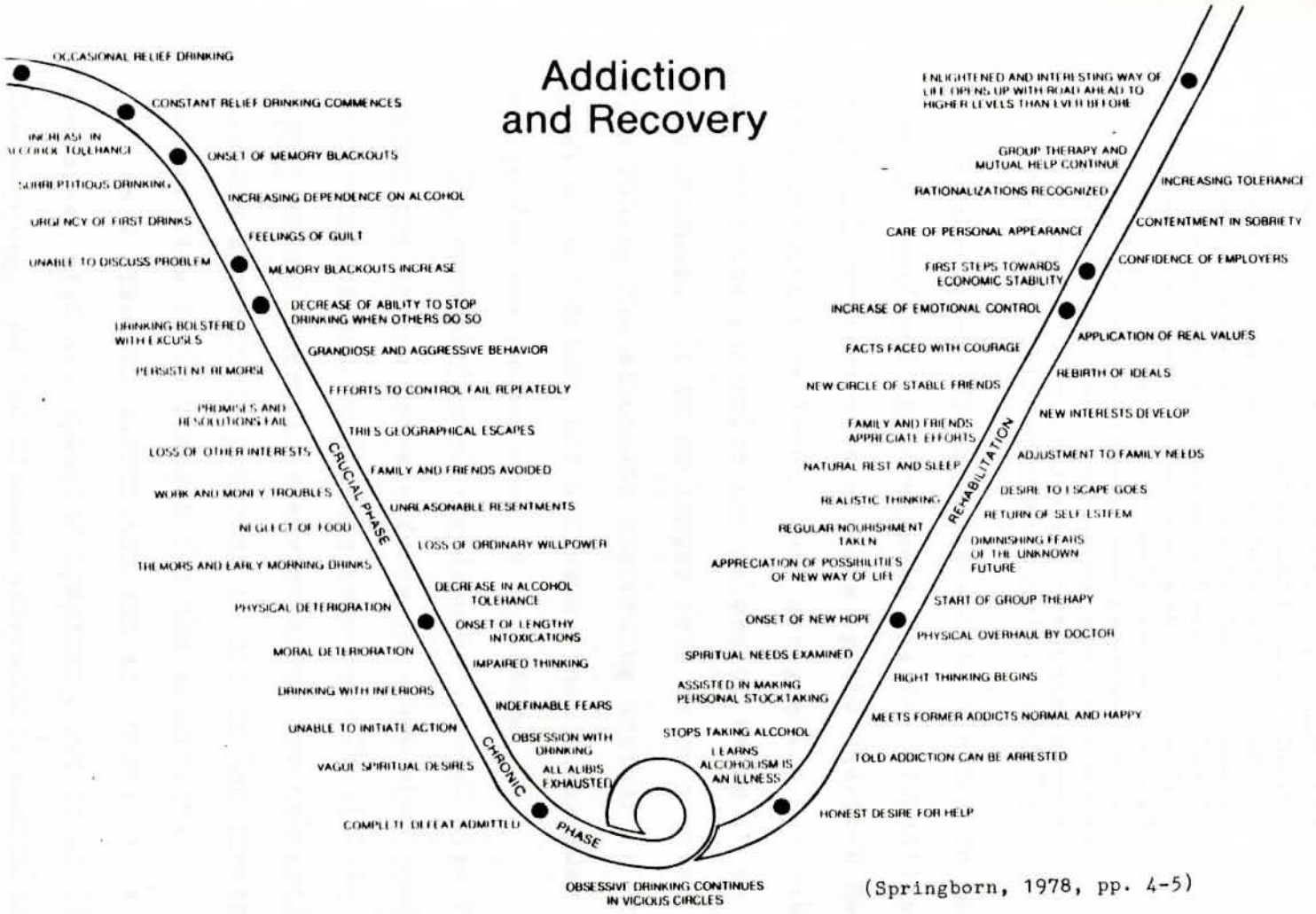
Figure 1 (page 25), based on the Jellinck addiction and recovery chart (Springborn, 1978, pp. 4-5), shows the basic steps in the progression of the disease of alcoholism. This figure outlines how the progression occurs in peoples' lives as they "hit the bottom" of their addiction. Even though their emotional, physical, and social losses are enormous at this point in their lives, there is hope for alcoholics. Recovery is the other side and is a possibility for them if they are willing to begin the journey back. The first step of this journey for alcoholics is usually treatment.

Treatment and the Recovery Process

For treatment purposes, alcoholism is considered to be a disease that is treatable, but not curable. One can be a recovering alcoholic but never a cured one. As Coleman (1964) points out:

> The objective of a traditional treatment program is recovery of the alcoholic: physical rehabilitation, control over the craving for liquor, abstinence from drinking, and realization on the part of the individual that he or she can cope with the problems of living and lead a much more rewarding life without alcohol. (p. 328)

According to Coleman, the statistics available on the long-range outcome for recovering alcoholics are not consistent. They



(Springborn, 1978, pp. 4-5)

Figure 1: Steps in the Progression of Alcoholism

> vary considerably depending both on the population studied and the treatment facilities and procedures employed. They range from a very low rate of success for hardcore alcoholics to recoveries of 70 to 90 percent where modern treatment and aftercare procedures are utilized. The outcome is most likely to be favorable when the drinking problem is discovered early, when the individual realizes he or she needs help, and when adequate treatment facilities are available. (p. 334)

Applying the disease concept to alcoholism has greatly benefited the treatment field. Alcoholism was officially designated a disease by the American Medical Association in 1956. This designation has taken away from the alcoholic the stigma of being in an ethical dilemma. It is no longer felt to be a moral decision facing the alcoholic concerning whether he should drink or not drink, but a disease that takes away that choice for the person once it is active.

The recognition of the disease concept also released public and private funds to study the problem of alcoholism and to finance treatment facilities to supply needed supportive environments for detoxification and appropriate programs to aid in the incorporation of life style changes for the alcoholic.

As a disease, alcoholism has an onset; it is progressive, with accompanying symptoms; and it is life threatening. As the disease progresses, alcoholics'

lives become unmanageable and are controlled by their need to drink. The addiction is the primary problem and must be treated first. Other physical and emotional problems usually stem from the drinking but cannot be addressed until alcoholics cease ingesting alcohol. Alcoholics may struggle to portray themselves as victims of life's circumstances and to see their drinking as a necessary solution to their problems. They may cite that their boss does not like them, their children are giving them problems, their health is poor, they have financial difficulties, their spouse nags them, and therefore their drinking is necessary for them to have some tranquility in their days. However, it is the alcohol and its control over their lives that is the real problem. The drinking is the villain in all these areas of the alcoholic's life: physically, emotionally, socially. Although alcoholics will want to see their problems in these areas as isolated events in their lives, they are all alcohol-related. Alcoholics cannot address their problems and make their lives more functional until they stop drinking. Since alcoholism is a progressive disease, it does not get better or even stay the same. It only gets worse without treatment.

Alcohol effects the central nervous system of the

drinker; therefore, the thinking ability of alcoholics is severely impaired so that they are unable to see reality and to realistically clarify issues in their lives. They are unable to use their problem-solving abilities and their life-planning skills. As drinking becomes more severe, their

> behavior becomes self-defeating. Behavioral problems result in social problems. The alcoholic, because of fear and anxiety and guilt, begins to isolate from family and friends. (Miller, et al., 1982, p. 24)

Alcoholics may experience the onset of periods of black-outs that occur as a result of the way their bodies respond to alcohol. During these periods, alcoholics will be active and conscious, but may have little or no recollection of their behavior later. Their inability to remember drinking behavior blocks the painful reality of their lives and supports the denial system alcoholics have built around their disease. This denial system in the alcoholic is one of the main blocks in the treatment of the disease of alcoholism. Alcoholism is one of the few diseases that denies its own existence and strengthens that denial as the disease progressively worsens.

Denial is unconscious lying to oneself and to others. It is used by alcoholics to protect their drinking and their drinking behavior so they do not

have to face the painful reality of their problem. If alcoholics faced the actuality of their situation and experienced the guilt and remorse of their behavior, they might be forced to change their lives. Since they believe they cannot cope with change, they must deny what is real. As the disease progresses, alcoholics change their beliefs and values to accommodate a different life style built around alcohol. In order to do this, they must distort the reality of their drinking amount, their drinking actions, and the unmanageability of their lives. Some of the ways the wall of denial is constructed is for the alcoholic to use the act of blaming others for their problems, minimizing their problems or their drinking, avoiding problems in the hope they will go away, rationalizing or excusing what they do in regard to their behavior or their drinking, manipulating others (family and friends) to do things for them that they can no longer accomplish themselves. Often, family members, friends, and employers negatively enable alcoholics to continue in the denial of their debilitating disease by protecting them from the consequences of their drinking and their drinking behavior (Miller & Gorske, 1982). Thus, the spouse or children may take over responsibilities that alcoholics can no longer manage at home. Employers

may alter job requirements at work and friends may make allowances for the alcoholic's embarrassing behaviors in social situations. This protection serves to strengthen alcoholics' own distorted views of their behavior and their ability, therefore preventing them from addressing their disease.

Hopefully, when alcoholics enter treatment for their disease, they have accepted the fact that they must stop drinking because their lives are unmanageable and out of control. However, this acceptance does not restore instant reality to their thinking and feeling. Since alcoholics built their wall of denial slowly as their drinking progressed, they will tear down the wall slowly as sobriety emerges. The dissolvement of the alcoholic's denial system is a gradual process, but a vitally important one. If the denial of past behaviors and the reality of their addiction is not addressed, it will most certainly sabotage their recovery process and entice them back to drinking.

According to Miller, Gorski, and Miller (1982), at any given time in the progress of their disease, alcoholics will be in one of seven basic stages of surrender in their attempts to control their drinking and in their willingness to consider treatment (p. 54). These are:

1. No attempt to control drinking. (Unregulated drinking.)

2. Attempt to control the quantity of intake. (They set limits on how much they will drink. This may work for a while.)

3. Attempt to change the type of beverage he consumes. (They feel that it is the type of alcohol and not the alcohol content that is the problem with their drinking.)

4. Attempt to pursue short periods of abstinence. (They feel that if they stop for a while, they can return to the earlier stage of their drinking, when alcohol did not have the power to control their lives.)

5. Attempt to control their disease by making a decision to stop drinking. (However, at this stage, alcoholics refuse to change the life style that is a part of the drinking pattern and the symptoms persist even with abstinence. The alcoholic usually returns to drinking in a short time.)

6. Attempt to use mood altering drugs to assist in controlling their drinking. (Mood altering drugs affect the body in basically the same way that alcohol does. At this point, the person may become addicted to drugs as well as alcohol.)

7. Attempt to control drinking by deciding to stop drinking permanently and to pursue a program to change their life styles. (It is at this stage of surrender that alcoholics are ready to consider treatment as the realistic approach to recovery.)

Without this last stage of surrender, alcoholics will not be able to accept treatment for their disease. Abstinence from drinking represents only 20% of the work of attaining sobriety, while the other 80% represents the need for a change of attitude, change of feelings, and change of life style. Without trans-

forming their thinking, feeling, and behavior, alcoholics will soon relapse into their previous drinking state. Therefore, abstinence is not recovery. It is only the first step to sobriety. Although alcoholics cannot begin to recover until they abstain from alcohol, recovery is a long process. It is experienced one day at a time and continues for the rest of the alcoholic's life. They can never drink again without activating the disease at the level it was when they stopped, or even at a more pronounced level.

When alcoholics decide to stop their drinking and to make drastic life style changes, they must be ready to go to any lengths to address their addiction. They are usually aware on some level of the power of their disease, the chaos in their lives, and their own inability to make the necessary changes alone. Professional treatment is an important alternative for them.

When alcoholics enter treatment, they usually have some or most of the following characteristics:

1. High anxiety level
2. High, rigid denial system
3. Unreasonable fears--especially fear of failure
4. Deteriorated self-image
5. Low self-esteem
6. Depression
7. Feelings of isolation
8. Tendency toward perfectionism
9. Feelings of guilt
10. Compulsive behavior
11. Sex role confusion

12. Severe dependency needs
13. Poor social relationships
14. Out of touch with feelings
15. Accumulated losses in life--family, job, health, self-respect
16. Destructive behavior (suicide attempts)

During approximately the first ten days into abstinence, alcoholics will be in a period known as acute abstinence syndrome. Since they are no longer maintaining the needed blood alcohol level in their bodies, they may experience withdrawal symptoms.

> These symptoms can include tremors, loss of appetite, sweating, vomiting, hyperactivity, confusion, poor memory, feelings of being torn apart inside, hallucinations, delerium, disorientation, convulsions, loss of consciousness, Delirium Tremens (D.T.'s) and perhaps death. (Miller, Gorski & Miller, 1982, pp. 96-97)

According to Miller, et al. (1982), after these first few days, another group of symptoms begins to emerge. These constitute the post acute withdrawal syndrome (PAW) and result from neuropsychological (brain and central nervous system) impairment. These symptoms emerge about seven to fourteen days into recovery and peak in intensity at three to six months. They may continue for as long as two years. The recovering alcoholic will evidence short term memory loss, have mental confusion, be unable to concentrate except for short periods of time, have difficulty with abstract thinking and problem solving. They will be

very sensitive to stress. Stressful situations will aggravate the symptoms of PAW, which may convince alcoholics that they must drink again in order to feel better.

During this time of early recovery, Zimberg, et al. (1978) state that the "alcoholic[s] will prefer large amounts of structure" (p. 22) since they have difficulty with abstractions and decision making. They may also be unable to adequately handle conflict because their central nervous systems are either damaged or impaired. Alcoholics in this early stage of recovery seem to "prefer passivity over active coping. Assertive and active coping tend to bring the person into normal conflict with others" (p. 25) and the alcoholic is unable to handle the stress involved in these situations.

Zimberg, et al. also suggest that

> alcoholics are influenced more by the emotional persuasive appeal than the rational. Leadership styles that are likely to work with the alcoholic are often charismatic, inspirational, and spiritual. It is not that alcoholics cannot operate in a linear, logical and analytical manner. In terms of preference, however, the alcoholic is more often drawn to the warmth of magic rather than the cold objectivity of science. (p. 25)

With regard to treating alcoholics, Laura Root, a professional in the field of alcoholism, feels that

> group therapy is one of the most important techniques in the treatment of the alcoholic. Group therapy is the treatment of choice for most alcoholics because of its effectiveness. . . . Group therapy for alcoholism is more reality based in everyday living situations and in the problems involved in maintaining sobriety. (Pittman, 1967, p. 147)

Developing this idea further, Root also notes:

> Another important factor in this type of therapy is group participation. The group interacts more readily if there is permissiveness and understanding on the part of both the therapist and the patients.
>
> The non-judgemental atmosphere created in therapy sessions helps the alcoholic to begin his "self-inventory," which is a necessary step in his recovery. Furthermore, the group climate helps him to view his behavior in terms of the defense surrounding his drinking problem and his everyday life situations. He is able to gain some perspective, usually for the first time. (Pittman, p. 149)

Pittman (1967) suggests that the person working closely with the recovering alcoholic in a counseling relationship should possess the following qualities to be most effective (p. 155):

1. Have an understanding of alcohol and alcoholism.
2. Be able to accept the concept that alcoholism is a treatable disease.
3. Have insight into his own feelings and attitudes about alcohol and alcoholics.
4. Be able to accept and understand the alcoholics when they appear unwilling to admit they have a disease, and recognize they are not necessarily refusing help.

Even though the disease of alcoholism is not curable, it is treatable. Forward strides are being made in formulating more effective treatment methods to aid in the vital recovery process. Understanding the disease progression, the steps in the recovery process, and the treatment needs of the alcoholic are important factors in making treatment effective.

Alcoholism and Women

Much has been written in an attempt to understand and to explain the nature of the human female. There seems to be a need to dispel the "mystery" that surrounds her thinking, feeling, and behavior. This trend is no less prominent in the field of alcohol abuse. Since the number of women entering treatment for alcoholism has increased steadily in the past few years, leaders in the field have struggled to explain the growing phenomenon, "to establish a more objective identity of the female alcoholic" (Belfer, 1971, p. 540), and to understand its meaning for treatment.

The need to understand this phenomenon is clear in light of the following statistics:

> Until 1950, according to the National Institute of Mental Health, there were five or six male alcoholics in the United States for every female alcoholic. In the 1960's, the estimated ratio dropped to four to one, and today the proportion is nearing, if not already there, fifty-fifty. (Langone, 1976, p. 43)

There are some socio-economic factors that may be directly influencing this apparent rise in alcoholism among women. One of these is the event of women having achieved more equality in the working world, which may bring additional stress to their lives. Also, many women today are coping as heads of families because of the higher rate of divorce in our society. The pressure of earning a living and rearing a family as a single parent brings increased difficulties to the life of today's woman. She may use alcohol as a means of coping with these additional pressures.

In the past, women have primarily done their drinking at home and were protected by their families from the consequences of their addiction. However, since it is now more socially acceptable for women to drink, more women are drinking, as well as being more public about their drinking so that their alcoholism is more apparent. As more women drink, the rate of alcoholism in women will increase. Also, more women are "coming out of the closet" with their drinking problems due to the decreasing stigma on women alcoholics and are seeking treatment for their disease. Some of the encouragement and pressure for treatment may come from family members, who are aware of behavior changes, or it may come from employers, who are aware of the dim-

inished work capacity of women employees.

Studies indicate that a woman's body responds more rapidly to alcohol than a man's does.

> When the average woman matches a man drink for drink, she gets drunk faster because she is smaller and lighter. Even if she and a man are the same size, she will get drunker, reports the NIAA, because the female body contains more fat and less fluid than the male's; thus the same amount of alcohol is more concentrated in her body than it is in his.
>
> Female hormones also make a difference. Studies by the New York State Research Institute on Alcoholism show that a woman's body is more sensitive to alcohol when estrogen levels are low, just before menstruation starts. She gets drunker and more easily nauseated and has worse hang-overs than at other times of the month. (Lake, 1982, p. 73)

Another difference between male alcoholics and women alcoholics is that being drunk does not damage the man's masculine image. However, enough of the double standard still remains so that society is uncomfortable with a woman who is drunk: "A man's problem drinking threatens the household's financial stability . . . but the problem drinking by the wife and mother strikes at the emotional stability of the home" (Lake, p. 78). Most husbands do not choose to stay with a woman who is an alcoholic. Once the feminine image is tarnished and she is no longer able to meet his need to be nurtured, the husband leaves the family. Only one out of ten husbands choose to stay

with an alcoholic wife.

Dahlgreen (1975) suggests that many women alcoholics, as high as 50 or 60 percent, have husbands who are alcoholic or who have a heavy drinking problem. Even if they are married for the second time, the husband is usually an alcoholic. When the woman gets treatment and drastically changes her drinking pattern, the marriage often begins to have serious complications.

Clinebell (1968) suggests that "women alcoholics show a greater personality abnormality than do male alcoholics" (p. 38). He feels that, as a rule, women do not come into treatment until their drinking has progressed to a significant degree. Because of her years of uncontrolled drinking, a woman may be a more disturbed individual than her male counterpart. This condition would result from the long drinking history and the socially punishing consequences, not because she was a more disturbed individual prior to her drinking.

Wilsnack (1973) states that there is a general consensus that women alcoholics show evidence of disturbed feminine identification and that this role confusion is tied up with their drinking patterns. She feels that

> studies of alcoholic women's family backgrounds generally reveal a domineering and

> emotionally distant mother and a weak, passive father. This parental combination in which both parents deviate from normal sex role behavior, does not seem favorable for the daughter's development of a secure, positive feminine identification. (p. 253)

Therefore, Wilsnack points out that this sex role disturbance may be a psychological precondition for the development of drinking problems in women.

Wilsnack also feels that the potential female alcoholic seems to be one who places a strong value on the traditional female role, while at the same time she has a highly fragile sense of her own femininity. Wilsnack's findings indicate that "the woman alcoholic does not necessarily have an unconscious wish to be a man. In fact, a basic wish of the female alcoholic may be to be a more adequate woman" (p. 260). The alcoholic woman seen in treatment programs usually has "learned helplessness, passivity, and dependence upon others as characteristics of the traditional female sex role" (Volpe, et al., 1982-83, p. 34).

Therefore, alcohol for the woman may serve to increase the feelings of femininity that she feels inadequate about, and it may also decrease the more masculine feelings she has that are focused toward a concern with power and assertiveness (Wilsnack, 1974).

External factors may have a greater impact on women and their drinking patterns than they do on their male counterparts. Belfer, et al. (1972) suggest that heavy drinking in women is more closely associated with a precipitating event. Most women can cite a specific life situation that occurred just before their drinking accelerated to an unmanageable degree. This event can be the death of a loved one, divorce, loss of a job, an unhappy love affair, an operation, a family crisis, etc.

However, Gomberg (1974) offers the suggestion that women may use a stressful life situation or event to justify their problem drinking to themselves and to others. She indicates that women may feel the need to do this in order to reduce the stigma that they feel is attached to female alcoholism. Her theory is that in many cases the abusive drinking of these women began before the cited precipitating event occurred.

Since alcohol is a depressant, depression is an accepted fact for women coming into treatment for alcoholism (Volpe, et al., 1982-83). However, as the woman stays sober and experiences treatment to cope with her life situations, depression usually significantly diminishes, although in some cases the depression may pre-date her drinking and may not be

alleviated by sobriety.

Craddick, et al. (1976) suggest that "a woman alcoholic may perceive herself as a victim of external circumstances and may sense a lack of need satisfaction. The close relationship between the way she sees others and herself may result in her having a negative self-image" (p. 90). Volpe, et al. (1982-83) feel the negative self-concept held by the female alcoholic encourages her to develop a self-identity based upon her relationships with others, especially her sexual relationships. "Dependency upon these relationships is paramount for the woman who feels worthless and is guilt ridden about her own inadequacies" (p. 34).

Densen-Gerber (1982) feels that

> since many substance-abusing women have dependent, infantile personalities, dependent relationships are easier for them to select. In forming such relationships they look for the parenting and security they never had; and--destructively--seek the impossible from their partners: fulfillment of all needs and an end to the incredible loneliness they feel. Their damaged self-esteem leads them to demand total acceptance and love. Insecurity and cynicism cause them to test relationships to an intolerable degree. (p. 208)

Sexual abuse for women may be a precipitating factor for the development of alcoholism. A high percentage of women coming into treatment for alcoholism have reported incest, rape, or both in their histories.

There may be a close relationship between this earlier sexual abuse for women and the development of later drinking problems (Volpe, et al., 1982-83).

The issues of low self-esteem, poor self-concept, and dependency are felt by Volpe to be the prominent characteristics of women alcoholics. In order to recover from alcoholism, women need to develop skills that will aid them in becoming self-reliant and aid them in gaining a new identity as women.

An emerging concern in treatment programs for alcoholism and alcohol abuse seems to point out that core issues and needs in treatment differ for men and women with this disease. Volpe feels that

> treatment activities [for women] . . . cannot be limited to recovery from alcoholism and the kinds of inner growth work characteristic of traditional mental health programs. Treatment activities in women's alcoholism programs must also address the personal limitations brought about by role constrictions . . . in order to successfully treat the alcoholism, the behavioral repertoire of their clients must be broadened. Areas for development must include behaviors considered appropriate for a healthy person, regardless of sex. This includes an emphasis--heretofore lacking in coed programs--on assertiveness, vocational development, and clarification of independent goals. Program staff must also work to repair the damage to self-esteem created by both the alcoholism and the roles clients play as women. Self-esteem [should be] addressed in a truly holistic way, and include an increased sense of well-being resulting from better health and increased capacity

> to manage stress; increased skills in communication and building relationships; a better understanding of sexuality; and increased competence in managing both independent employment and daily affairs. (p. 29)

In terms of the treatment method that works best for women, Volpe suggests that because of the dependency needs of alcoholic women, the women who come into treatment usually prefer a one-to-one relationship with a counselor. However, once they are introduced to the group process in therapy, the women seem accepting of this method and respond to it in treatment. The group process is an important modality for the recovering woman (as previously cited by Root) because it is more based in the practical everyday living situations and needs of the alcoholic. However, the group atmosphere needs to be one that is non-judgemental and understanding in attitude.

"Statements have been made in the literature that the sex of the therapist is an important prognostic factor of the treatment outcome of women" (Volpe, et al, 1982-83, p. 35). Role modeling is seen as an extremely important part of recovery programs for women alcoholics; thus, many treatment programs support single sex therapy groups, with a predominance of female staff members to treat women alcoholics. The role modeling by staff can aid in confronting

negative feminine identification from the past that may be causing confusion and anxiety for the alcoholic woman.

Chapter Two: An Art Therapy Program

De Novo Center

De Novo Center is a free-standing extended care treatment unit for women who need more extensive treatment than a primary unit can provide. It offers residential treatment in a home-like atmosphere for approximately 18 to 20 women.

De Novo provides a comprehensive model of treatment for women, ages 18 and over, who have a history of repeated relapses or who have no positive support system to aid them in their recovery after primary treatment. The program's philosophy is to encourage life-style changes by fostering self-awareness, self-responsibility, and ego-development. The focus is on bridging the high denial system inherent in the chemical abuser and encouraging the emerging feelings of the recovering woman.

The general treatment goals of the De Novo program are:

1. To understand the destructive effect of chemical dependency on one's life.

2. To accept abstinence and participation in the AA program as a way of life.

3. To understand feelings and defenses which block the expression of feelings.

4. To accept responsibility for structure and rational attitudes.

5. To build a lifestyle which is functional as to spirituality, good health, and psychological awareness.

6. To accept responsibility for the practical aspect of life.

7. To understand and accept that addiction can be involved in other life areas such as eating disorders.

8. To accept spiritual growth as the primary purpose of life.

("De Novo Center Goals," n.d.)

De Novo's program is composed of three specific phases. Phase I is structured to furnish a clearer, more comprehensive understanding of chemical abuse. An important ingredient of this Phase is the resident's contact with the AA community. The women attend at least two outside AA meetings per week and obtain a sponsor with whom they share personally on a twice-weekly basis. This AA contact and support supplements the information on chemical abuse and Step work they receive at De Novo.

The Phase II component of the program is structured to encourage the resident to begin to take responsibility for her actions, her feelings, and her

life. She attends Rational Emotive Therapy Group, Assertiveness Group, and Self-Awareness Group, along with other program components. At this point in her treatment, the resident also begins to work with a vocational guidance consultant in order to assess her skills for a job, school, or volunteer participation.

After the client completes the first two Phases of the program and appears ready, she is put into the Phase III segment of the program. It is at this time that the resident utilizes her skills in bridging the gap back into the community. Often this is achieved while she is still at De Novo, but sometimes it is worked out through a half-way house setting in another location and monitored by the De Novo staff. This arrangement is particularly helpful for those residents who have come from other states and will be returning there for work or school.

The program at De Novo Center is based on an initial three month time commitment. Most of the residents agree to this length of stay and many find it helpful to remain longer before attempting to make the transition to community living.

Description of the De Novo Art Therapy Program

I designed, developed, and directed the art therapy program at De Novo Center over a four year period

from September, 1980 to June, 1984. The program was based on the De Novo treatment philosophy and objectives, the needs of the women in treatment for alcoholism, and my understanding of the creative process. My primary objective for the art therapy program at De Novo was to encourage self-awareness and to foster self-esteem. Each session had additional specific objectives, based on an assessment of where the individual or group was in the treatment process at that particular time.

The art therapy group usually met in a lounge that contained couches and chairs, but no tables. Therefore, the art was done either on the floor or by means of wooden lap boards that provided a desk-like structure for the participant. The paper used was 19" by 24" for the individual sheets and 36" wide rolls of paper for murals. A variety of drawing materials were provided: crayons, pastels, craypas, colored markers, colored pencils, and water color paints. Clay was used for some sessions.

The individual sessions with residents were held in my office. A round, 42" table was used for the smaller projects and a long wall, covered with plastic, was available for other projects. The wall was especially useful for clients who benefited from the

use of larger gestures and more freedom of movement in the art work.

All of the residents admitted to De Novo participated in the art therapy groups as a regular part of their treatment program. In addition, individual sessions were scheduled when the primary counselor or the art therapist felt the resident could benefit from the additional art contact. These sessions were particularly helpful for the client who used intellectualization for a primary defense mechanism or was extremely out of touch with her feelings, for a client who seemed to have an extremely high denial system, and for a person who found it difficult to express herself in words but responded to the non-verbal expression inherent to art.

The art therapy program at De Novo Center had a dual role. It provided both a diagnostic evaluation of the resident and aided in the therapeutic process of treatment. In addition, it provided the staff with concrete, visual progress of the client. Growth and/or regression was usually seen first in the art projects of the person as changes occurred on a subconscious level during treatment.

Upon entry to the De Novo program, each resident met with me for an initial individual intake session.

This meeting was scheduled before her first art therapy group. The purpose of the encounter was to provide diagnostic material in order to produce a baseline picture of the needs of the client in art therapy. This material became part of the initial staff assessment material which formulated the total treatment plan for the resident. During this first session, I explained what art therapy was and how it could benefit the woman in her recovery process. Also, I explained what the procedure and format was in the art therapy group. I emphasized that the art therapy group was not an art education experience and that her art work would not be judged or criticized in any way. I stressed that anything she did on the paper would be right--she could not make a mistake because she would be symbolizing her thoughts and feelings in her own special and unique way.

In order to further the woman's understanding of the art therapy group, I followed our introductory conversation with an art experience. Usually, I asked the client to draw anything she wanted on the paper or I might suggest she draw a feeling picture. If she were particularly blocked, we used the scribble art technique (as described by Naumburg) as a starting point. Following the first drawing, I asked her to

draw a person as completely as possible. This drawing procedure was a modified version of the Draw-A-Person projective testing that is described by Machover (1980). The drawings from this initial session, along with my diagnostic evaluation of the client based on her art work and our conversation, became part of the resident's treatment file. The results were shared with the clinical staff in a multi-disciplinary review held on each new client.

Since the De Novo program was based largely on two primary phases, the art therapy program component was modeled on the same format. Phase I art therapy was more structured and was geared toward encouraging self-awareness and the expression of emerging feelings. It lasted approximately four to six weeks. The Phase II art therapy sessions were less structured, providing more freedom of expression as the woman's recovery progressed. This Phase lasted another four to six weeks. The goal of Phase II was to continue encouraging self-awareness and expression of feelings (inner world), but the art projects also began to focus more on the environment (outer world) of the client. Emphasis was on unifying the inner and outer worlds in an understandable and workable combination.

To facilitate this unification, an additional

part of the art therapy group format was the inclusion of journal writing. During each session, after the client had completed her project she was given a piece of notebook paper and encouraged to meditate on the finished product of the drawn symbols and images and on the inner process that she had experienced. She could then write down whatever she wanted on the notebook paper. No one saw the paper except the client and she did not have to share it verbally. She was encouraged to keep it in her private journal, which was used in conjunction with other program components. The art work and the written journal paper served to make more concrete the experiences and insights that were occurring in the woman's recovery. Hopefully, this offset the normal short term memory loss that is very prevalent in early recovery.

After the art work was completed and the journal writing was done, the client had the option of sharing her project with the group. One at a time (on a volunteer basis), the women placed their pictures on the wall and explained what they had drawn, with any accompanying thoughts, feelings, or insights. The other group members responded with questions, affirmations, or appropriate remarks. (Criticism or judgemental statements were not considered appropriate and

were discouraged.)

As the art therapist, I tried to be aware of the dynamics that had occurred during the art work, patterns that emerged in the art, and the feelings that were being expressed. In a non-confronting way, I encouraged the client to personalize her art work, to see her patterns of relating to her environment, and to be aware of how all these elements related to her chemical dependency. I particularly pointed out positive changes that were occurring so that she could have a sense of progress and hope.

The art work was left on the wall in the lounge until the next session. This procedure was to promote the feeling that the art work was valued and important. By leaving it on the wall, it was shared with the larger De Novo community. Sometimes the art promoted conversation between the artist and other residents and, hopefully, encouraged in the artist a growth of self-esteem and a feeling of personal importance.

An additional part of the art therapy program at De Novo was a clay workshop for Phase II residents. One morning a week these women were taken to a nearby craft studio to experience a structured learning experience in clay handbuilding or in wheel throwing.

This provided the following elements for the women:

1. Contact with the community in which they resided and with the "normal" world.
2. An addition to the art program that could be viewed as an achievement for them.
3. The element of variety.
4. An experience which could give them a finished product that was based on a timed process to counteract the impulsivity of the alcoholic.
5. The experience of delayed gratification.
6. An experience in working with clay and in forming something solid out of a formless mass.

Many of the women made items (such as vases, ash trays, cups, jars, dishes) they could keep as reminders of their treatment experience at De Novo. These prized finished products aided in the encouragement of their positive self-esteem.

In addition to the more formal elements of the art therapy program, art materials and clay were made available to the residents who desired to use them in their spare time, especially on week-ends.

The Individual Art Program. The individual art sessions were formulated by the art therapist and the client's primary counselor to address her specific areas of need. During the first session, I contracted with the individual for a scheduled time to meet and

discussed what kind of art projects we would work on. I asked for her ideas and preferences in order to promote ownership.

At this first session, I strongly encouraged the use of a creative journal for the client. I suggested she get a sketch book, 8" by 10" or larger, and choose a media she would like to work with, i.e., pastels, pencils, markers, crayons, etc. In the beginning of her journal, she was to write an introduction to herself, including such things as who she was, where she was, what was happening in her life, and what she was doing.

Following the self introduction in her creative journal, the client was to get acquainted with the media and the paper by doodling or drawing lines and shapes, without the feeling that she had to produce a "picture."

At our second session, we discussed ways of using the creative journal on a daily basis. I suggested she draw a feeling from each day or symbolize an experience she had. The journal was her private world to use for her own expression or to share with me if she chose. It continued during her stay at De Novo.

In addition to her use of the creative journal, we also worked on an appropriate art project during

our session together. These projects were organized around the goals set by the primary counselor and myself. The goals might include:

1. To develop a better sense of self.
2. To develop a more appropriate body concept.
3. To provide ways of releasing and coping with emerging feelings, such as anger.
4. To promote the breakthrough of the rigid denial system.
5. To utilize an interest or an ability in art to facilitate the recovery process.

Results of the individual art therapy sessions were documented in the resident's medical chart, as well as shared with her primary counselor on a regular basis.

Table 1 (below and on the following pages) presents project suggestions used in the De Novo art therapy program. This table summarizes the types of work clients engaged in during the two phases of treatment.

Table 1: Art Therapy Project List

Some of the projects used for diagnostic testing were:

1. Free art picture
2. Feeling picture
3. Scribble picture
4. Draw-a-person
5. Family picture
6. Bridge drawing (Hays and Lyons, pp. 208-17)

Table 1 (Continued)

Phase I Art Projects:

1. Draw your initials in large letters on the page. Surround them with symbols of things you like to do or things you like about yourself.
2. Draw yourself as a tree.
3. Draw three things you are grateful for.
4. Draw yourself as a building and place in an environment you would like to be in.
5. Draw your addiction.
6. Draw two fantasy creatures.
7. Draw yourself as a season of the year.
8. Free art picture.

Phase II Art Projects:

1. Draw yourself as a treasure and devise a map that shows how to discover the treasure. (Capacchione, 1979, p. 174)
2. Fold the paper into four sections. Symbolize your birth, past, present, and future.
3. Draw a chasm and devise a way of crossing it, considering you have any means at your disposal.
4. Draw your sobriety.
5. Draw your inner and outer self. (Capacchione, 1979, p. 28)
6. Free picture.
7. Feeling picture.

Table 1 (Continued)

Phase II Art Projects:

8. Devise a safe space for yourself, based on what you know you need in your life and what you need for your sobriety.

9. Seasonal collages, using objects from nature.

10. Collage projects, using pictures from magazines.

11. Design your own shield, with six spaces, each relating to a specific area, such as: something I am good at, something I want to change in my life, etc. When completed, write a fairy tale beginning with the words "Once upon a time" and using all the areas represented on the shield. (Simon, 1974, pp. 81-83)

12. Draw your favorite thing and write a conversation with it. (Capacchione, 1979, p. 132)

13. Draw an animal in some activity.

14. Symbolize your Higher Power in your life.

15. Draw yourself as a place.

16. My ideal self.

17. Draw two masks--the one I wear and the one I would like to be me.

18. Draw a strength and a weakness you feel you have.

19. Draw three doors and what is behind them. (Capacchione, 1979, p. 166)

20. Draw a specific feeling, i.e., anger, love, hate, fear.

21. Something you feel strongly about (person, place, or thing).

22. Create a symbol that represents you.

Table 1 (Continued)

Phase II Art Projects:

23. A De Novo mural that represents what has happened to you while here.

24. A mandala.

25. Projects that give variety:
    a. Sidewalk art--use the sidewalk and chalk for art work.
    b. Take a trip to the art museum.
    c. Work to music--draw whatever you feel.
    d. Work with clay or with fingerpaints.

26. Visualization exercises to use with the art:
    a. A fantasy trip.
    b. A walk in the woods.
    c. A trip to a magic shop.
    d. A fishing trip.
    e. A walk in the past.

27. Holiday projects:
    a. New Year's
        1. My goal for the new year.
        2. Symbolize the new year.
        3. Draw yourself as you would like to be.
    b. Valentine's Day
        1. Make a valentine card and message for someone and one for yourself.
    c. July 4th
        1. Freedom is. . . .
    d. Halloween
        1. Carve individual pumpkins to make jack-o-lanterns.
    e. Thanksgiving
        1. Three things you are grateful for.
    f. Christmas
        1. Draw and place a large Christmas tree on the wall.
            a. Draw yourself as an ornament to place on the tree.
            b. Draw a gift you would like to give yourself and put it under the tree.

Note: An attempt has been made to give credit to the original source of the ideas used for these projects. However, since ideas are passed on by word of mouth, the original source may be lost to this author.

Chapter Three: Case Study

Background Information

The work with Susan described in the following case study was done over a period of three months. Susan was admitted to De Novo Center for continuing treatment for alcoholism.

Susan came into treatment as a referral from a primary treatment unit on the East Coast. Due to financial reasons, she agreed to stay three months, but no longer. After a 23 year history of chronic substance abuse, Susan suffered a severe alcoholic reaction which included auditory hallucinations. During this time, she heard voices, became very disturbed, and physically attacked her husband. She was taken to a psychiatric hospital by the police. From the hospital, she was admitted to an alcoholism primary treatment unit for detoxification. She suffered severe alcoholism withdrawal symptoms and probably experienced D.T.'s at this time.

Susan was a 40 year old Caucasian. She had been

sonality. However, she stated that the alcohol was disruptive and addictive for her from the very beginning of her drinking history.

Susan stated that she had some religious background from her childhood, but it was difficult for her to feel close to God or to use her faith as a resource to work with her addiction.

After college, Susan began teaching English. She enjoyed that profession, but since she was heavily drinking at the time, her memories of that experience were confused and sketchy. She left her teaching job after three years when she married her present husband. She had not worked since. In fact, prior to her recent treatment, she literally had not gone outside of her apartment in Manhattan for three years.

Susan's drug of choice was alcohol, but she also had a long history of other drug usage, particularly valium. For three and a half years, she used over 200 mg's daily. Susan went into treatment for alcoholism in 1976 and again for valium in 1979. Four years later she was hospitalized with a severe alcoholism reaction, which culminated in her admission to De Novo Center.

Upon admission, Susan was quiet and had a ten-

dency to isolate herself. She evidenced a significant number of depressive symptoms and voiced a fear of being homosexual. Susan had a high degree of anxiety, which was manifested in numerous nervous gestures with her hands. She would readily agree to most suggestions from others, but then seemed to resent not being able to direct her own life. She appeared very tightly controlled and seemed to have an underlying anger that was just beneath the surface. She was diagnosed as having low self-esteem, a poor self-concept, and a confused role identification.

The treatment goals for Susan, in addition to addressing her chemical addiction, were to address her low self-esteem, help her cope with her anxiety and fears, and allow her to deal with her anger without repressing it with people pleasing mannerisms. In the beginning of treatment, she was asked to behaviorally follow the program structure until her withdrawal symptoms abated sufficiently to permit her to emotionally and mentally absorb the treatment components.

Since each resident participates in an Art Therapy Group as part of their treatment, Susan was placed in a group with three other residents who were also in Phase I. The other women were younger in age than Susan, but all were recovering from chemical dependency.

Two were also bulimic.

Session I

During the intake session, I requested that Susan draw a person as completely as possible. She complied with the instructions, even though she evidenced a high degree of anxiety. Her anxiety was apparent in her gestures, her body movements, her verbalization, and the way she drew the figure. Susan started three times on three different sheets of paper before she could complete the project. She also erased often and took a considerable length of time to finish her drawing.

She felt that her figure looked sad and withdrawn. She stated that it did not look feminine and would need different clothes and more emphasis on the bust in order to look feminine. Susan also felt that the neck, arms, and chest area were the most difficult to draw. This area, according to her, is where she feels her own anxiety.

According to Machover (1980) the figure's placement to the left of the page suggests that the Subject is more likely to be self-oriented, rather than environmentally oriented. She may also be depressive oriented. The eyes of the drawing indicate that the Subject may have a limited vision that is associated

with more paranoid thinking. She may also be self-absorbed so that she closes out the world around her. The chin on the drawing has been emphasized by a heavier line and by the beginning of two other drawings which were not completed. This suggested the possibility that there might be an attempt to compensate for weakness, indecision or the fear of responsibility.

The neck area was also treated the same way in the drawing. Susan may have some disturbance about the co-ordination of her impulses and her mental control functions, since the neck symbolizes the link between the body (impulse) and the head (rational control) area.

Since the Subject had significant uncertainty about the drawing of the shoulders, with erasures and several lines, it suggested that she might have problems relating to her own physical adequacy.

There was apparently a significant difference in the size and clarity of the drawing of the right and left hands. This difference in the size might refer to the possibility that the person felt more impulsive actions with her own right hand, while the actions with her left were more controlled and stable. The area of the hands on the drawn figure relates to social contacts and productivity. Susan might have

felt a lack of confidence in these areas.

The feet in the drawing seemed fainter in line pressure and indicated there might be some general insecurity implications or lack of assertiveness.

The figure drawing also indicated that Susan was undecided about the way to present the lower part of the body. There was an attempt to draw a more skirt-like form, which was erased and made into trouser-like legs. This suggested that Susan might have some sexual confusion at this time.

My initial assessment for Susan was that she was a very anxious person, who might tend to show depressive and self-absorbed tendencies. She might feel inadequate and insecure in some areas and might tend to withdraw in various ways, both physically and emotionally. Some of her apparent anxiety might be related to her difficulty in making decisions and to her confusion concerning her sexual identity.

The Art Therapy goals which emerged from the initial intake session included the following:

1. To foster self-awareness.
2. To develop a more positive self-esteem.
3. To provide an alternate form of communication and to encourage both symbolic and verbal communication.
4. To aid in the alleviation of her anxiety.

5. To provide a safe arena for the expression of her feelings and to affirm her taking a risk in this area.

6. To provide decision-making experiences.

Session II

The next time Susan participated in an Art Therapy session was her first experience in the weekly group. The project was to "Draw yourself as a tree." Susan again evidenced a high degree of anxiety and had difficulty in making a decision about what she wanted to put on her paper.

According to Hammer, "the subject projects during the process of drawing the tree and makes it a veritable self-portrait" (1980, p. 182). The trunk of the tree acts as an index of the basic strength of the person's personality. The trunk relates to the person's ego-strength and shows her developmental progress and experiences from the roots of the tree upward. Susan's trunk was fairly strong looking, although it was not a large tree. The trunk was drawn with more rigid, straight up and down lines near the top of the tree and corresponded to her rigid, more controlled affect.

Hammer also suggested that the tree roots related to the person's hold on reality. Susan's tree does not show a root system, as such. Instead, the

tree has a sense of fading out at the bottom. There were no lines or color at this point of the drawing. This could indicate a vagueness or insecurity in the client.

The tree's branches, according to Hammer, "represent the subject's felt resources for seeking satisfaction from the environment, for reaching out to others, and for branching out achievement-wise" (p. 186). The branches of a tree correspond to the arms of the person in a figure drawing. Susan's tree branches were drawn with single, narrow lines. The rounded foliage gave the effect of extending outward and then coming back inward and intertwining in the leaves. There was a sense of being blocked, with a controlled or constricted look. Susan might have felt inadequate or thwarted in social contacts or in her productivity.

There was a sense of emptiness in the picture and a feeling of distance. Susan stated, "It [the tree] is lonely." In response to my question, "What would it need to make it less lonely?", Susan answered, "Put in more trees on the light side of the picture."

The light side of her picture was on the left of the tree and the darker side was on the right. The tree seemed to be the dividing line for the in-

tensity of color. If we use the suggestion that the left side is the past and the right is the future, then the coloring might relate to Susan's feeling of anxiety and insecurity about the unknown, the unfamiliar and the future. She might not have felt adequate to reach out to others in the future, but she wished she had others to relate to in her past experiences. Since Susan had remained in her apartment--literally not going out for three years--she might indeed have tended to feel a lack of contact with others in her life. At that point, her life could have seemed empty of experiences that enrich and give a sense of connectedness to the individual. Also, Susan's drinking and drug usage had a strong tendency to narrow her activities to include only those things which would feed her addiction.

This project gave Susan an opportunity to project herself on paper and to verbalize her feeling of loneliness, as she did the feeling of sadness in her figure drawing. Probably she was voicing her own feelings in both of these instances. The art experience gave her the chance to see the feelings at a safer distance and to verbalize them in a caring group. As she stated the picture needed more trees, she had the opportunity to see how she might provide a different

dimension in her own life.

Session III

The next group project that Susan participated in was to "Draw her addiction." Susan had difficulty in beginning her drawing. She stated that she did not know how to draw it. After an abortive attempt, she drew a large spider-like monster with several arms extending downward from the skull-shaped head. The monster was hovering over a pathway. Susan felt she was progressing on that path and the three crosses represented her losses from her addiction. The one loss she could name was her self-esteem.

The colors were lighter under the spider-like creature and became blurry with a black overlay as the drawing extended to the right of the page. About the center of the page, the path divided into two parts--one going upward and the other continuing across the page with a downward slant.

A path or journey, according to Jung (1964), often indicates that a process is beginning in the person's life and may relate to the process of individuation. Susan might, indeed, be accepting on some level that her life was a process which encompassed change and choice. The division might relate to her feeling that she would have to either choose a new life style

or return to her old behavior patterns in the future. Her tendency to depict a lighter color on the left of the page and darker color on the right might again point up her anxiety over the unknown or the future. She had used the same basic color combination in this picture, i.e., green, brown, and black, as she used in her first picture of the tree. The picture and the colors suggested a feeling of depression, emptiness, and constriction.

The art project provided the opportunity for Susan to express these feelings on paper and to see her addiction in symbolic terms. She seemed to connect her feelings of low self-esteem to the consequences of her chemical usage. The drawing was another step in her seeing the alcohol and drugs as the problem in her life and not the solution to her problems.

Session IV

Susan's next art experience was a "Free Day." She was asked to relax and to get in touch with where she was "now." After she allowed herself to be conscious of her thoughts, her feelings, and her bodily sensations, she was requested to symbolize herself on paper in some way. Susan again evidenced difficulty

in getting started with her drawing. She stated, "I don't know what to draw." Since she was feeling angry that day, it was suggested she draw her anger. Susan agreed and produced a large red circle on the paper. The drawing encompassed most of the page; however, the color did not protrude noticeably from the boundary lines of the circle and the lines were not well-defined. This seemed to relate to her inability to be decisive, even when she was feeling a high degree of anger.

The large drawing was representative of how she was experiencing the feeling of anger. She stated she was feeling it in every part of her body, but principally as a tightness in her chest. When she was describing her feeling of anger, she spoke in a soft voice and exhibited controlled gestures.

Susan's anger was related to her husband's planned visit for that week-end and her feeling of resentment that she could not go home with him. She wanted to "get on with my life." She was probably also getting in touch with some anger at having a disease that was causing her to make some drastic life-style changes. Most women who come into treatment experience this anger as they begin to accept the facts and limitation of their addiction. It may well be related to their feelings of loss as they are faced with giving up the

alcohol and drugs that have been so dominant in their lives. Since they are not always able to see the connection of their anger to the disease, they often focus it on more immediate details. Susan identified both her husband's visit and a conflicting program detail that she felt was triggering her feelings.

The art session provided Susan with a constructive outlet for her strong feelings. She drew her anger, saw how it looked, and talked about it to others who accepted the anger and accepted her. Susan's past pattern of behavior had been to stuff the anger and try "people pleasing" mannerisms until she could no longer contain the intensity of her feelings. When this happened, she would use chemicals or act out in a more violent way. She had physically attacked her mother and her husband on different occasions. The art session gave her an opportunity to experience the anger constructively and to allow her to take both an ownership of it and maintain some control over the expression of it.

Session V

In the next art session, Susan was requested to "Draw herself as a building." She again evidenced difficulty deciding what to put on the paper. Finally, she drew a square glass house situated on a

beach. The picture had a feeling of loneliness, distance, and the absence of any life, except a few plants. Susan felt she wanted to invite people in so that the house would not be so lonely.

Susan seemed to have difficulty identifying with the drawing. She stated she had first thought of drawing a library because of her love for books, but she had changed her mind. The emptiness in the picture may relate to her lack of identification with this symbol.

Susan's house lacks a defined roof. Hammer (1980) suggests that a roof on a house relates to the fantasy areas of a person's life. The absence of a roof on a building or a roof consisting of a single line suggests a person who lacks the capacity to daydream or to use fantasy.

In a study done by Weathers and Billingsley (1982), it was speculated that treatment measures for addicted women might be more effective if fantasy were encouraged. The addicted woman's inability to use fantasy and daydreaming was thought to contribute to her remaining trapped in the disease of alcoholism. She was unable to find alternatives for her chemical abuse.

Susan's drawing of a house without a roof suggests that she may not be able to use daydreaming and fantasy to open up her life's possibilities. Her participation

in the art sessions could give her an opportunity to develop her imagination and to encourage daydreaming and fantasy by employing her right brain capacities.

Session VI

The next art project was to make a collage from magazine pictures. The instructions were to find a picture to give each person in the group and to find something for yourself. The purpose of the session was to provide an experience for the individual to:

1. Reach out to others in the group
2. Nurture herself
3. Practice decision-making by deciding which picture to give others in the group, which picture to give herself, which pictures to use in the collage, and how to arrange the pictures in the collage

Susan seemed to like the project and devoted a lot of effort to both choosing pictures and to making the collage. She used each picture that was given to her by others in the group and seemed to feel affirmed by their choices for her.

The experience of decision-making was discussed at the end of the session and compared to the decisions the women were making in their treatment process which was to provide them with a stable sobriety.

Session VII

Another "Free Day" art experience was provided

for Susan. She had to start over once before feeling comfortable with her project. She included things in her drawing that she wanted to put into her life when she left treatment. She symbolized:

1. Her need for AA meetings as a support for her sobriety.
2. Her Higher Power to represent her need for a spiritual resource.
3. Her enjoyment of books to represent her interest in teaching and English.
4. A doctor's office to show her need for continuing therapy.
5. Her apartment building in New York and her husband.

At this point in her treatment, Susan was beginning to focus on her going home date. She seemed to use the art to make more concrete the elements that could both enrich her life and furnish support for her sobriety. To do this, she was combining imagination, daydreaming, and fact.

The drawing did not feel as empty, lonely, or have as much distance in it. She used a greater variety of colors and they were brighter. The black overlay was not present and the split of a light side and a dark side was gone.

Her art project appeared to verify the changes that Susan felt she had experienced in treatment. It provided her and the therapist with another way of

assessing these changes as the art made them more visible to Susan.

The preceding seven art sessions are not the entirety of the art groups in which Susan participated. However, these seven show her initial art work, her progress, and her art work near the end of her treatment at De Novo. During her three month stay at De Novo, Susan was experiencing other therapy groups, AA contacts, and social interaction with the residents. She began to evidence more insight into her actions and feelings. She smiled more often and laughed on several occasions. Her nervous hand gestures decreased and her eye contact became more personal. Susan's isolation lessened and she spent more time socializing, both at De Novo and in the community. She seemed to have very genuine feelings for several other residents and expressed real loss when they were discharged from treatment.

Perhaps one of the most noticeable differences during this time was Susan's growing self-esteem which was evident in the above changes, but was also evident in her new regard for herself. She decided to have her hair cut in a new style and dyed a more complimentary color. Even at De Novo, she did not appear slovenly nor unkempt, but looked appropriate to the sit-

uation.

Some of her growing self-esteem had developed from the emerging spiritual dimension in her life. She had talked personally to a minister and shared some of the past experiences that she felt extensive guilt over. Following this, she attended a worship service at a nearby church and participated in communion. She also spent a weekend at a retreat house. Susan expressed the feeling that her ability to feel forgiven by God allowed her to forgive herself and thus to gain a more positive self-esteem.

Near the time for her discharge, Susan began to obsess about leaving and her feelings of anxiety began to increase. She had made real changes in her life-patterns, but she seemed to be having difficulty owning her new self.

At this time, I encouraged Susan to participate in a culminating project. In order to provide a means for her to solidify the positive events she had experienced at De Novo, I suggested she construct a personal De Novo mural. I provided her with a roll of light blue (a calm color) paper and a box of 16 mixed pastels for her project. Since this art project was too extensive for her to complete in a single session, I suggested she keep the materials in

her room until she was finished.

The objective of the project was to allow her to confirm her own progress by putting it on paper in symbolic form. While drawing the mural, she could also re-experience the positive events and become more aware of her changes. This could both bring closure to the art group experience and allow her to see her entire progress in a concrete, unified form.

She accepted the idea with enthusiasm and worked on the mural for several days. It seemed to provide her with something tangible to concentrate on and firmed up her new sense of self.

During our last session together, we hung the mural on the wall so Susan could discover the numerous events she had portrayed on the paper. She spoke about the drawing with firmness and a wide range of emotions.

Susan had drawn several events on the mural, all relating to her personal experiences. They are too numerous to describe individually; however, I would like to share the patterns and changes that emerged. In the beginning of treatment, Susan's art had evidenced signs of depression, loneliness, distance, absence of people, few colors and less intense colors. These drawings had a controlled, constricted look to them. In contrast, the drawings on the mural were

done with a wide variety of strong and bright colors. The initial depressive affect was replaced by a more cheerful one. Her art style of distance and loneliness had changed to include more people in the activities, which gave it a sign of vitality and life. Susan had stated in earlier art sessions that her pictures needed "more trees," and "people to come in." It would seem she had incorporated these insights into her life while at De Novo because her mural art work shows them in abundance. For someone who had isolated herself in her apartment for three years, her art suggested that she had opened her life up to others and had experienced several enriching events, with significant people, as a result.

In doing the mural project, Susan seemed to gain a stronger sense of her own "wellness." This focus on her present strengths provided a clearer launching pad upon which to return to New York and to re-connect with her life there.

Conclusion

A recovering chemically dependent woman has the difficult job of rebuilding her self-esteem, her sense of worth, and her life. For this arduous task, she needs all the tools she can assemble. Art Therapy provided some additional ones for Susan. The advan-

tages of having Art Therapy as a regular component in her treatment program seemed to be the following:

1. The art, as a form of non-verbal expression, provided her with a safer way of identifying her feelings, especially sadness, loneliness, and anger. Susan had viewed her feelings from a more comfortable distance and had assessed what changes she wanted to make. She particularly identified the need for people in her life and she began to include them in her activities.

2. By viewing her addiction in symbolic form, Susan saw more clearly the way it had brought problems and losses to her life. A major loss was her diminished self-esteem. This different understanding of her disease seemed to re-inforce her desire to take back the control of her life from the alcohol and drugs. This struggle would be a long serious process for her, but she had made a start by identifying the disease as a death-like monster.

3. Another advantage of the Art Therapy sessions was to provide decision-making experiences for Susan and to provide group affirmation of the decisions she did make with the art. Her mother's pattern was to belittle and undermine her efforts at making choices. Susan had a lot to overcome in this area of her life. She continued to have a sense of anxiety and uncer-

tainty about her ability to make competent choices, but she had been given several positive experiences upon which to build.

4. Another positive result of the art for Susan was the development of her imagination and her ability to daydream. She had experienced her own inner-world of fantasy. The feeling of entrapment from her addiction might still be present, but she had experienced another way of opening up the options in her life. It would now be more possible for her to find alternatives to drinking and drug use in her recovery program if she chose to do so.

5. The art helped alleviate Susan's separation anxiety at the time of discharge. The art process provided both a constructive activity to occupy her mind and a way of making her progress in treatment more solid and visible to her.

From a clinical viewpoint, the art gave a fairly clear picture of her starting point in treatment and the progress and changes she was experiencing, even when she was unable to verbalize them. It allowed the therapist to have another way of assessing her readiness for terminating intermediate treatment.

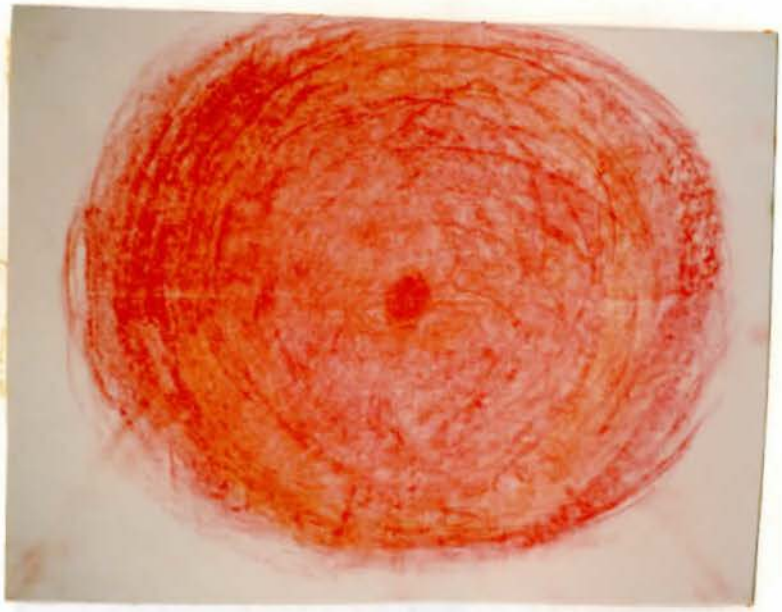
Susan has returned to New York City. It is too

soon to know the permanent results of her treatment experience. However, prognosis is hopeful.

Session I

Session II

Session III



Session IV

Session V

Session VI

(Drawing not available.)

Session VII

Mural

Chapter Four: Summary and Conclusion

Summary

Alcoholism is a growing problem in our society. The cause of this disease is not clearly known. However, the needs of women coming into treatment for alcohol abuse seem to have a high degree of similarity. For one thing, these women appear to have a negative self-esteem that is the basis of their self-concept. Since "self-esteem is the key to man's motivation by virtue either of its presence or of its absence" (Branden, 1981, p. 137), treatment procedures that address this vital issue seem to be of primary importance. Art Therapy, by virtue of its right brain, non-verbal approach has much to recommend its use in treatment facilities. It can be a valuable aid in promoting the development of self-esteem in women recovering from alcoholism by encouraging their self-awareness.

Self-awareness is the groundwork for promoting a better self-esteem that is so essential to the fe-

male alcoholic. The value of self-awareness through art therapy for the women in treatment can be seen in the first three goals set forth by Zinker (1977, p. 96):

1. To move toward a greater awareness of herself--her body, her feelings, her environment. (Alcohol sedates feelings and causes the person to be emotionally frozen. She can begin to regain her sense of self by expressing herself through the non-verbal medium of art.)
2. To learn to take ownership of her experiences, rather than projecting them onto others. (Projection is one of the primary defense mechanisms employed by the alcoholic. It encourages the high denial system that is present with the disease.)
3. To learn to be aware of her needs and to develop skills to satisfy herself without violating others. (The alcoholic has a strong tendency to be self-centered [Zimberg, 1978] and can benefit from learning to understand her own needs and to satisfy them without impinging on the rights or feelings of others in the process.)

Polster and Polster (1974) state that

> focusing on one's awareness keeps one absorbed in the present situation, heightening the impact of the therapy experience, as well as the common experiences in life. With each succeeding awareness, one moves closer to articulating the themes of one's life and closer also to moving towards the expression of these themes. (p. 211)

The emphasis on self-awareness in recovery may encourage the recognition of feelings in the alcoholic. Recovery is a time of change and change is usually accompanied by a variety of feelings. These feelings may be new and intense for the woman who has used alcohol to "not feel" for a large period of her life. As the feelings begin to emerge, it is helpful to have a place to express them that is safe and supportive. Miller, et al. (1982) suggest that "a recovering alcoholic should always express anger in safe surroundings because of the tendency to over-react" (p. 154). Susan's expression of anger (the drawing from Session IV) is an example of this. At the time of the drawing, she was verbally denying that her anger was very intense. However, as it emerged on paper, it was a large red ball that covered most of the page and evidenced an almost overpowering intensity. Susan could not verbalize it, but she could draw it. The drawing aided her in recognizing the degree of the feeling she was experiencing and gave her a safe outlet to

release some of it. As Susan became more aware of the anger, she could begin to experience taking responsibility for working more positively with the feeling and not repressing it.

Not only anger, but other feelings may also seem overwhelming to the impaired nervous system of the alcoholic and to the woman who has sedated her feelings for a period of time. The art can be a safe vehicle for expressing these feelings in a more responsible manner. Rubin (1978) feels that "there is much experiential evidence in art therapy that the giving of form to complex feelings is in itself helpful. Perhaps this is true because it enables the creator to feel some control over the confusion" (p. 255). Therefore, the art can provide a safe, helpful method of being aware of and controlling feelings for the recovering alcoholic.

The denial system of the female alcoholic is a major block in her recovery. Her denial has emerged slowly and is largely unconscious. The alcoholic is usually unaware of its presence in her life or how it is supporting her addiction. Wadeson (1980) believes:

> because verbalization is our primary mode of communication, we are more adept at manipulating it and more facile in saying what we want to say and refraining from saying what we don't want to say than through other communicative modes. Art

> is a less customary communicative vehicle for most people and therefore less amenable to control. Unexpected things may burst forth in a picture or sculpture. . . . This is one of the most exciting potentialities in art therapy. Unexpected recognition often forms the leading edge of insight, learning and growth. (p. 9)

Therefore, the use of art has the potential for encouraging the release of the rigid denial system of the alcoholic. As the person uses her own language of symbol, line, color, and form, she can often see her life and her disease in a new light.

Not only can the art promote self-awareness, provide a safe place to express feelings, and aid in the breakthrough of the denial system, but it can also provide a non-confrontative approach to treatment.

According to Nellis (1980), a "predominant technique in male-oriented treatment settings is confrontation" (p. 144). This is directed at "challenging the patient's perception of self-sufficiency and power rights" in order to aid in restoring a more functional approach to life. However, Nellis feels that for most women, a therapy that is supportive and encouraging instead of confrontative is most beneficial. The woman in treatment commonly has a lack of belief in herself and a need to both discover and to reinforce her own strength. In order to encourage this discovery, a non-confrontative approach seems to work best. Con-

frontation brings added stress which would make progress difficult for the female alcoholic. Art therapy provides a non-confrontative method for the woman to examine her own strengths and to risk new behaviors that can lead to the discovery of different abilities within herself and options for her life. The non-judgemental, non-confrontative approach of art therapy can encourage this important discovery.

Another area that was addressed by the use of art therapy in the De Novo treatment program was the normal post acute withdrawal symptoms that emerge in early recovery. These include a difficulty with abstract thinking and short term memory loss. The art project provided a visual form to serve as an aid to communication and to memory. The symbol or image is concrete and permanent. It is not easily forgotten or distorted by the alcoholic. This act of recording experiences in image form provided a means to offset the normal memory loss and difficulty with abstractions.

At De Novo, both individual and group methods were used with the art therapy. In the individual approach, the client had the possibility of a closer relationship with the therapist and she could work on her appropriate personal issues that might not be possible in a group setting.

In the group approach, as suggested by Fink, Levick, and Goldman,

> production-based interchange forms the basis for increased socialization of the . . . patient. Also, being part of a group fosters the feeling of freedom and safety essential for the expression of transference feelings. These feelings, in addition to being verbalized are expressed in drawings of . . . personnel. Also, associations and verbalizations about each other's work, following a group art activity, frequently produce insightful material sometimes difficult to obtain in a one-to-one relationship. (p. 117)

The group setting provided an empathetic community as well as a caring, confrontative one for the woman in treatment. Women in recovery may understand each other's issues and needs more accurately than the therapist--especially if the therapist has not experienced the process of recovering from alcoholism. The group members were able to both encourage the growing self-awareness in each other and to also point out with sensitivity the denial that was often present. Having worked with their own denial system, they were able to encourage its recognition and acceptance in other group members.

Conclusion and Indication for Further Study

From my experience in developing the art therapy program at De Novo and working as an art therapist

with recovering women, some important conclusions emerged for me. First of all, I strongly recommend art therapy as a viable program component for extended-care treatment for the chemically dependent person. It has the potential of benefitting both the staff and the clients. At De Novo, the art provided both diagnostic material and progress information for the clinical staff, as well as therapeutic experiences for the residents.

However, one of the insights that became apparent to me is that art is not appropriate for everyone. It appeared to be a particularly difficult modality for clients who had low motivational ability. Women who strongly resisted change or experiential activities seemed to resist the art process since it is action-oriented.

One way of addressing this situation might be to release these clients from the art program in the beginning of treatment and to refer them to a group at a later time when their resistance has lessened. Since extended-care programs are usually based on long-term treatment plans, the more resistant resident could participate in the art therapy program later in her treatment process when her fear and anxiety were not so strongly blocking her experience.

Another conclusion that emerged from my experience at De Novo is the feeling that a valuable addition to the art program for extended-care programs would be the use of open sessions. I suggest that a permanent art room be made available and opened at designated times for residents to use art materials under the supervision of the art therapist. This arrangement would provide more access to the art as a therapeutic tool and provide a means to release feelings as they were experienced. Hopefully, it would also encourage the use of art for enjoyment, as well as therapy.

Treatment areas that are related to an extended-care program but not addressed at De Novo by the use of art therapy were the after-care program and contact with family members. These are areas that could be investigated for future art therapy programs. The art might provide insight into the dynamics and relationships of the family of the alcoholic, as well as visually follow her progress in the after-care program. Perhaps regression to old behavior patterns could be spotted through the art and provide clues to the possibility of the impending relapse of the alcoholic.

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