Trauma and Addiction: Art Therapy

With the Dually Diagnosed Female Client

By

Yvette D. Nosal, BS, CDCA

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We hereby approve the thesis of

**YVETTE D. NOSAL**

candidate for the

Master of Arts in Art Therapy & Counseling Degree

Approved by:

**Alison Benders, J.D., Ph.D.**

Dean of Graduate Studies

**Gail Rule-Hoffman, M.Ed, ATR-BC, LPC, CCDCIII**

Director of Master of Arts in Art Therapy & Counseling Program

Reading Committee:

**Cecile Brennan, Ph.D., LPCC-S**

**Judith Marinich, LPCC, LICDC, LSW**

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Abstract

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Yvette D. Nosal

Art therapy has been used in the treatment of chemical dependency for many years. A large percentage of women in treatment are dually diagnosed with a serious mental illness. Current research also shows an increasing link between trauma and chemical dependency. Many art therapy interventions, along with various mental health programs, focus on either the treatment goals for addiction or the treatment goals for trauma. This case study identifies which art therapy interventions might best combine these treatment goals within the same program. It also examines how unresolved trauma may affect the recovery process. The art therapy interventions took place over a period of seven months with dually diagnosed women at a residential treatment center.
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Chapter I

Introduction

Statement of the Problem

Research has shown a correlation between trauma and substance abuse (Hein, Cohen & Campbell, 2005). Studies estimate that up to 75 percent of women in substance abuse treatment programs have experienced trauma in the form of sexual or physical abuse (Hein et al., 2005). Comorbid posttraumatic stress disorder (PTSD) rates in this population range from 30 to 59 percent (Najavits, Weiss & Shaw, 1997). In addition, DSM-IV field trials reveal that the longer the duration of trauma and the earlier the onset, more severe symptoms are likely to be co-occurring. These symptoms may include depression, dissociation, somatic complaints, anger management issues and impulsive behavior. By acknowledging that a connection between trauma and substance use disorders exists, treatment must address the needs of these women.

Historically, alcohol and other drug (AOD) programs were developed primarily for the male client within most addiction treatment service models. Women with substance abuse disorders face different social, economic and health-related consequences than men (Green, 2006). Female drug users have poorer mental health and greater levels of depression and anxiety than do male drug users (Webster et al., 2006). Gender specific interventions are necessary in order to develop an integrated trauma-informed addiction service.
Purpose of the Study

The purpose of this case study was to explore the impact of trauma on the lives of women with a substance abuse problem. The overall aim of the study was to examine how art therapy interventions can be used to enhance an integrated trauma and addiction treatment program. Specifically, the Trauma Recovery and Empowerment model (TREM), developed by Maxine Harris (Harris, 1998), the traditional 12-Step model of addiction treatment and cognitive behavioral therapy provided the basis for the creation of art therapy interventions.

Research Questions

In order to treat addiction in dually diagnosed women, it is necessary to address the underlying trauma. How does unresolved trauma affect the recovery process? Would a traumatic events survey provide relevant information on the trauma histories of women in chemical dependency treatment? In addition, which art therapy interventions enable clients to develop personal insight and the coping skills necessary to aid in their recovery and help prevent relapse?

Definition of Terms

Art media refers to the art materials used during art therapy sessions. This may include but is not limited to paint, markers, chalk, pastels, colored pencils and collage materials.

Art therapy is a mental health profession that combines traditional psychotherapeutic theories with the nonverbal, creative self-expression found in
the art making process. It can be utilized with a variety of populations, and it is likely to be found within clinical settings as well as art studio and workshop formats. An art therapist is trained in the use of different art media and has an understanding of the healing, affirmative aspects of the creative process.

Dual diagnosis refers to the concurrent presence of both substance abuse and a severe mental disorder in an individual (Drake et al., 2001).

Emotional abuse consists of many different tactics: criticism, neglect, isolation, shaming and manipulation. Harris (1998) states that several conditions are required for emotional abuse to occur: 1) a woman depends on the abuser for support or affection; 2) a woman feels trapped in the abusive relationship; and 3) the abuser is the one holding power, control and authority over the victim.

Physical abuse is the act of inflicting bodily harm to intimidate and control an intended victim. The abuser will maintain power by keeping a victim in a constant state of fear. Physical abuse, as well as sexual abuse, is generally accompanied by emotional abuse.

Posttraumatic Stress Disorder (PTSD) is a specific trauma diagnosis found within the DMS-IV. PTSD is an anxiety disorder in which the emotional reactions associated with a trauma experience do not go away, become worse over time and eventually disrupt an individual’s life. The main symptoms of PTSD are hyper-arousal, emotional numbness, avoidance of situations that trigger memories of the
event and re-experiencing the event. Not all individuals who experience a trauma develop PTSD.

**Sexual abuse** is any activity that is sexual in nature and is unwanted, forced or harmful to its victim. Sexual abuse is a misuse of power over its victim. Sexual abuse can include harassment, exploitation, incest and being forced to watch sexual acts.

**Substance abuse** refers to psychoactive substance use disorders, which includes abuse and dependence (Drake et al., 2001). The substances can include but are not limited to alcohol, cocaine, opiates/opioids, cannabis, amphetamines, inhalants, hallucinogens and any combination of these drugs. The drugs may be sold or prescribed legally, or they may be obtained through illegal means.

**Trauma** can be defined as either a physical or psychological injury, which is usually the result of an extremely life-threatening or stressful situation. Trauma can be a personal experience, such as a car accident or near-death experience. It can also be a consequence from witnessing the death, injury or threat to another person or family member. Traumatic events may include but are not limited to personal assault, sexual assault, kidnapping, natural or manmade disasters and military combat.

**Trauma Recovery and Empowerment (TREM)** is a model of trauma recovery and intervention developed by Maxine Harris at Community Connections in Washington D.C. Community Connections was established in 1984, and the
TREM model is the cumulative product of 13 years of her work with women in recovery. Harris recognized the need to develop a hands-on method for clinicians who were working with women survivors of trauma. TREM utilizes a group approach to healing from the effects of trauma, and it consists of a curriculum based on 33 group sessions. The model deals with trauma, specifically abuse, as a primary problem of its own requiring treatment (Harris, 1998). The approach can be modified for use with male survivors of trauma.

The Twelve Steps of Alcoholics Anonymous (Alcoholics Anonymous [A.A.], 1981) is a group of principles through which its members recover. The principles are based on spirituality and address issues that include powerlessness, making amends, admitting character defects, recognizing a higher power and helping others dealing with addiction.

Delimitations

As the researcher, I was able to control certain aspects of the group. This study only included participants at an inpatient treatment facility and did not include any outpatients in recovery. All of the participants in this study were women. I selected the art interventions myself, with input from my site supervisor. The treatment goals for these interventions focused on trauma recovery and chemical dependency issues. All of the groups were held the same day, place and time at the treatment facility. A co-facilitator and I led the groups,
and we selected the room in which verbal processing of the art interventions took place.

**Limitations**

The participants’ attendance was controlled through the agency’s policy of mandatory attendance for every group session. Group membership could change at any given time if a participant left treatment or if a new client was admitted. A participant could leave treatment for a variety of reasons: she voluntarily chose to leave before treatment was completed, she completed her treatment goals and was discharged as planned, or she was asked to leave the treatment facility for not following the agency’s rules and regulations. Participants may have been forced to enter treatment as mandated by a court, such as either a drug court case or an open case with the Department of Children and Family Services (DCFS). As a result, initially they were not likely to have had the personal motivation to participate in treatment and recovery. For women who were DCFS mandates, they would not be reunited with their children without completing treatment. However, some research has shown regardless of whether a client was mandated to treatment by a third party, the outcomes were likely to be the same as a voluntary admission (Klag, O’Callahan & Creed, 2005; Sanford & Arrigo, 2005).

Due to the nature of the dually diagnosed client, several factors such as psychotropic medications, poor mental health and physical ailments may have affected the participant’s ability to function in the group. Another limitation was
the location itself. Group sessions could take place only in one of two rooms, and the participants were not permitted to go outside or leave the facility prior to completing treatment. In addition, the participants had a wide range of racial, social, economic, family and psychological backgrounds. Participants were not admitted based on traumatic stress, and they did not have to disclose any experience during treatment that could be defined as traumatic. Finally, this study did not make any attempt to comprehensively cover the causes, extent and treatment of substance abuse. Nor did it attempt to determine all the implications of trauma for multiple populations. It did not address all the populations in which art therapy can be utilized. The focus of this study was to examine the use of art therapy interventions with dually diagnosed women.
Chapter II

Procedures

Characteristics of Qualitative Research

The very nature of qualitative research respects the creative process. Qualitative research is an emerging process, much like the process of creating art. The research questions can change and be refined over the course of the study to influence the outcome, just as the artist experiments with media. The research takes place in the field at the site of the participants and is interactive in its approach to detailing the experiences of the participants. Qualitative research is humanistic and approaches social phenomena holistically (Creswell, 2003). It is an expansive view of the human experience and attempts to create a detailed narrative of the encompassing phenomena.

Since qualitative research is interpretive, the role of the researcher must be considered. The researcher develops the descriptions of the participants and the setting, analyzes themes and interprets the data. From that particular perspective, conclusions are developed that hold personal and theoretical meaning, and further questions are presented. As with the artist, the researcher uses a personal lens to develop the final interpretation of social and political phenomenon. Therefore, the bias and values of the researcher must be acknowledged in the study.
**Qualitative Research Strategy**

The strategy of inquiry for this study was a case study of a group of female clients in substance abuse treatment. The study examined the use of art therapy interventions in a treatment program over a seven-month period. In addition, a traumatic events survey examined the individual histories of each client and helped to determine what percentage of clients had experienced traumatic events.

**Role of the Researcher**

As the researcher, I had been working at the facility as an art therapy & counseling graduate student, and I was completing my internship requirements over a seven-month period at the site. My work with the clients included in this study ranged from 30 days to over 90 days. A possible bias in collecting the research existed in that I had already considered which clients to include in the study. My personal interest in this topic was the result of my previous practicum work at this site. As I worked with the clients, I realized the large majority of them had experienced trauma in one or more forms of sexual, physical and emotional abuse. Many were victimized by sexual abuse as children. A large percentage of the women admitted into this inpatient program were dually diagnosed, and I became aware of the need to treat the underlying mental health issues as well as substance abuse. My heart went out to these women because of the challenges each one faced in their recovery process, and I became aware of
the additional issues women encountered while undergoing substance abuse treatment.

My own background was different from many of the clients in treatment. I am Caucasian, and at least half of the clients were African Americans. Some were raised in middle class families like me, but others had known lifelong poverty, a consequence of either being an addict or due to their family of origin issues. Several were diagnosed with personality disorders, along with other mental illnesses such as depression and anxiety. Many experienced life-threatening situations prior to treatment because of their drug use. Because of the inability of most to retain employment during active addiction, some were homeless or uncertain of their living arrangements after leaving treatment. A few had no other choice than to go back into a situation that contributed to past abuse. I felt very fortunate at the end of the day for not having these issues in my own personal life. However, I acknowledged that my personal feelings possibly contributed to a bias in my research for this study.

Data Collection Procedures

Setting. Art therapy group sessions took place at a chemical dependency treatment program. The program was run by a nonprofit organization focused on social change. The facility was located in a 480-bed acute care hospital in a large metropolitan area in the Midwest. Treatment was short-term residential (30 days or less) or long-term residential (30 + days), depending on the client’s needs.
Admissions were on either a voluntary or a court-mandated basis. The facility was in a locked, secure area of the hospital, and clients were not permitted to leave the floor once admitted. Either the client or one of several participating social programs paid for services. These programs included Medicaid, public funding through the local drug boards and funding supplied by the court mandating treatment.

Group art therapy took place in one of two rooms. The first, where the participants created their artwork, was the dining room. The room was large, with white walls and vinyl tile flooring. Fluorescent lighting as well as two large windows provided light. The room had a sink and four large conference size tables with plenty of chairs and adequate space for art making. The art supplies were kept in a locked cabinet, which was located across the hall in the staff lounge. Verbal processing took place after art making in either this room or in a second room. The second room was the group therapy room located at the end of the hallway. It was a large room, with similar lighting and windows. The room was carpeted and had light blue walls. Many chairs were available to accommodate all of the participants.

Participants. The participants ranged from 18 to 50 years of age and were female. Several of the participants had a dual diagnosis of a serious mental illness combined with chemical dependency. The number of women living at the facility at any given time ranged from 12 to 16. Some participants had been in recovery
before and had relapsed, leading to their admission. Abstinence was a mandatory requirement for residency in the program, and drug tests were required weekly. If a participant failed a drug test, they were required to immediately leave the treatment facility. The participants were a mixture of ethnic backgrounds, but the majority of participants were either Caucasians or African Americans. Many had children and came from a range of different family situations. Some brought infants and toddlers into the facility with them. Some had children cared for by family members or foster homes during treatment. Several no longer had custody of their children. Their socio-economic status varied from poverty to middle class.

Methods of Gathering Data. There were several methods of gathering data at the site. The first was observations at the site, and the researcher participated as an observer. The observational protocol consisted of descriptive, reflective and demographic notes taken during group sessions. I kept a reflective and visual journal to process personal thoughts, feelings and images during the study. Daily staff meetings with the counseling team provided insight to each participant’s progress. Artwork from art therapy sessions were valuable sources of data. Additional participant records from the site, such as intake notes and personal histories, were collected for data purposes only on an as needed basis.

Data Analysis Procedures

Data analysis in this case study involved developing a detailed description of the setting and the individuals. Notes of group sessions were coded and reviewed
for common themes and issues. The artwork produced by participants in art therapy sessions was photographed and then labeled and organized with notes for further coding. Assessment of the artwork interpreted content and themes. This involved utilizing art therapy manuals and discussions with other art therapists at the site to look for themes within the art. Site notes and observations were compared with studies and articles from the literature review. I reviewed my personal journal in order to maintain a perspective on the bias of the researcher. In addition, input from clinical supervisors and colleagues aided in coding and organizing the data.

**Strategies for Validating Findings**

Several strategies determined the validity of this study’s findings. Multiple data sources, including current literature, were used to triangulate the data and justify the emerging themes. Peer debriefing and examining the researcher’s bias enhanced the accuracy of the study. An external auditor provided an objective review of the material.

**Narrative Structure**

After developing a detailed description of the setting and the participants, I described the artwork produced by the participants. I then assessed the themes and content of the artwork. I also described each participant’s verbal associations gathered during processing of the art tasks. Discussion of the results of the art therapy tasks and whether or not they meet the intended goals for treatment
followed. Finally, I listed my conclusions based on the study. The complete narrative consisted of descriptions of my fieldwork experiences followed by analysis of the cases.

**Anticipated Ethical Issues**

As the researcher, I had to adhere to the codes of ethical practice and professional conduct for the American Art Therapy Association, as well as the codes of the Ohio Counselor, Social Worker and Marriage and Family Therapist Board. Participants needed to sign an informed consent form before data could be collected. Due to the sensitive and personal subject matter regarding trauma and addiction, I had to ensure the confidentiality and privacy of the participants and all individuals involved in this study. Names and other identifying, descriptive information were concealed to ensure confidentiality.

**Significance of the Study**

A case study of art therapy interventions used in treatment of the dually diagnosed client was important for several reasons. First, it expanded upon the literature that already existed in the mental health field regarding the connection between addiction and trauma. Second, it added to a very limited number of studies that examine gender specific treatment of chemical dependency. Third, it aided in validating that underlying trauma must also be treated in substance abuse treatment. In the field of art therapy, the literature on an integrated approach that addresses trauma within chemical dependency treatment was very limited.
Finally, it enabled me to determine which art therapy interventions were successful in meeting the needs of this population’s treatment goals.

**Expected Outcomes**

This study proposed to show the effectiveness of art therapy as a mode of intervention in working with dually diagnosed chemically dependent clients. It would confirm the link between trauma and addiction, specifically in female clients. It would identify the need to develop appropriate coping skills and self-soothing abilities to support recovery and aid in preventing relapse. Finally, it generated art therapy interventions that enhanced an integrated, holistic trauma-informed addiction treatment program.
Chapter III

Literature Review

In order to understand the mental health issues and daily challenges facing dually diagnosed women, a review of related literature was necessary. This review includes information on trauma, its impact on individuals and different treatment approaches. An overview of art therapy and its use with trauma, substance use disorders and dually diagnosed clients follows. Last, the gender differences in substance abuse treatment are examined.

Trauma and Its Consequences

Messina and Grella (2006) conducted a study of 500 women who had been inmates in the California prison system. The results found that between 77% and 90% of the participants had histories of emotional, physical and sexual abuse. The prevalence of childhood trauma was extensive: 14.5% had experienced physical neglect; 30.6% had been physically abused; 45.1% had been sexually abused; and 47.6% had witnessed family violence. The women who had five or more childhood traumatic events became involved with drugs and crime at the earliest age, with 16.5 being the mean age at the time of their first arrest. The results further indicated that childhood trauma increased the likelihood of having an eating-related disorder, an alcohol problem, engaging in prostitution and requiring the need for mental health treatment. The greater the number of traumatic childhood events, the poorer the participants’ mental health outcome became. It
did not find a positive relationship between childhood trauma and intravenous drug use. The study concluded there is a strong need for early prevention and intervention with females.

U.S. epidemiological studies have shown that the origin of trauma in most women is childhood abuse (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). These studies also suggest that women are twice as likely as men to have PTSD, and it is the most frequent type of anxiety disorder diagnosed among women. Fifty percent of the PTSD cases found in women are related to sexual assault. Brunello et al. (2001) states that only 10-20% of people exposed to a traumatic event will develop the pathological response of PTSD, and this represents approximately 3% to 6% of the general population. Unfortunately, most of these people are diagnosed incorrectly and are left untreated (Brunello et al., 2001; van der Kolk, Roth, Pelcovitz, Sunday & Spinazzola, 2005). Diagnosis of PTSD can be difficult and appear disguised as anxiety, insomnia, depression, dissociative disorders, attention problems, aggression, impulse control or difficulty in interpersonal relationships (Herman, 1992; van der Kolk et al., 2005).

Van der Kolk (2002) states:

At the core of PTSD lies the concept that the imprint of the traumatic event comes to dominate the total organism and how victims organize their life- people with PTSD perceive most subsequent stressful life events in the light of their prior trauma. (p.382)
The sensations, images and emotions related to the traumatic events are dissociated and do not change over time. Neuroscience has determined that the area of the brain responsible for analyzing an event and formulating a response to a threat, the dorso lateral prefrontal cortex, is deactivated (Van der Kolk, 2002).

In addition, Broca’s area, the part of the brain responsible for speech production and understanding language, functions inadequately under high levels of arousal. The person is literally unable to put their experience into words. The limbic system generates an inappropriate response to stimuli that would generally be normal or only stressful. It is at this point that a person begins to rely on actions, such as fight or flight, or inappropriate self-soothing such as substance abuse, eating disorders or self-mutilation.

Two of the main factors in the development of PTSD after a traumatic event are coping strategies and perpetrator status (Gutner, Rizvi, Monson, & Resnick, 2006). A study was conducted with 122 women participants, 74 who were rape victims and 48 who had been physically assaulted. Results indicated that if victims increased the use of such coping strategies as social support, expressed emotion and cognitive restructuring over time, the symptoms of PTSD decreased. Social withdrawal and wishful thinking were two coping strategies that created little improvement over time in overall PTSD symptoms.

The study also determined that perpetrator status was more important to reducing PTSD symptoms as opposed to assault type (Gutner et al., 2006). If the
victim knew the perpetrator, the likelihood of social withdrawal led to an increase in PTSD symptoms. However, the victim could improve recovery after the trauma with an increase in social interaction. Herman (1992) states that the length of time needed for recovery after trauma is connected to the quality or stability of a victim’s intimate relationships. Stronger relationships will help decrease the length of recovery. However, if the person who would normally provide protection, support and safety is the same person who violated the sense of trust, whether parent or spouse, then the fear and isolation will increase.

Recovery from trauma has three stages (Herman, 1992): 1) reestablishing safety, 2) remembrance and mourning, and 3) reconnection with daily life. The first stage of establishing safety begins with the victim restoring a sense of power and control. Initially control focuses on the body and consists of meeting the basic needs of food, sleep, symptom management and any medical concerns. Control of the environment follows, with the focus on safe housing, financial security and social support. Establishing a safe environment may include protection from an abuser, identifying healthy relationships or creating a plan for protection.

The second stage of remembrance and mourning is the trauma narrative, telling the story of the trauma. The narrative must include detailed images and emotions related to the traumatic experience. This enables the trauma survivor to begin translating the images into words and transform the traumatic memories. Telling the narrative story brings about a sense of loss, followed by grief. After
working through this stage, the survivor is finally able to come to terms with the traumatic event. Empowerment continues to be a key component of recovery.

The final stage of reconnection is the creation of a new self. The survivor may explore ways to fight back or confront others. There is also a renewed capacity to trust, and the reconnection with others begins. Some survivors may engage in social action because of their personal experiences and the desire to help others. Herman (1992) states that “Resolution of the trauma is never final; recovery is never complete” (p. 211). Life events, new milestones or daily stressors may trigger issues related to the past trauma, and the survivor may have to revisit issues addressed previously.

*The Use of Art Therapy with the Dually Diagnosed Client*

In much of the literature, treatment and the use of art therapy focuses on trauma, PTSD or substance abuse disorders. Very little clinical research has been done on the concurrent treatment of trauma and substance abuse. This section will explore the literature that exists in utilizing art therapy with the different populations.

The major components of interventions with the PTSD client are reexposure to the traumatic experiences and memories, developing a trauma narrative and cognitive reframing (Steele, 2003). Reexposure to the memories is important in bringing the experience back to the consciousness. Once it is brought back to the conscious level, the experience can be reordered in a way that is manageable in a
safe environment. Cognitive reframing enables the removal of the emotions and behaviors driven by the dysfunctional thoughts (Steele, 2003).

Art expression, specifically drawing, provides a means of exposure that assists in constructing and organizing a traumatic narrative (Steele, 2003). Drawing provides a way to connect with dissociated memories and bring them back into the consciousness. The nonverbal qualities of art allow the memory to take visual form on paper, giving the client the opportunity to verbally express the trauma narrative (Malchiodi, 2001). Drawing provides a “symbolic representation of the trauma experience in a language that is external and concrete and therefore manageable” (Steele, 2003, p. 149).

Reexposure to the event must be done in a careful and structured way. In order to avoid overwhelming the client with traumatic memories and details, interventions should be designed around themes as opposed to focusing on symptoms of the trauma (Steele, 2003). A client can be given an art task with a specific directive to address a theme, such as fear, anger, worry, hurt or revenge. An example would be a directive to draw “What Happened”. Malchiodi (2001) states that this task provides structure, and it allows the narrative to be told in detail. The client may experience a sense of relief in finally being asked about a traumatic event. In a case of sexual or physical abuse, it is important to address the trauma in a less direct way. An example of such an art task would be to create an image depicting “two relationships – a healthy and an unhealthy one”.

During processing of the image, the therapist must ask trauma specific questions (Steele, 2003). This allows the therapist to be a witness to the client’s experience. It also allows the therapist to help the client stay focused on the theme of the art task and add details to the narrative. The questions should focus on physical sensations as well. This helps the client to establish control and facilitate cognitive reframing.

Cognitive behavioral therapy (CBT) has been effective in treating PTSD, substance abuse, depression, anxiety, phobic reactions, eating disorders, personality disorders, schizophrenia and obsessive-compulsive disorder (Rosal, 2001; Fuller & Hiller-Sturmhofel, 1999). Given its wide range of applications, it follows that CBT would be an effective treatment approach with the dually diagnosed client. CBT is an “umbrella term” for several therapeutic interventions: cognitive restructuring therapy, coping skills therapy and problem-solving therapy (Rosal, 2001).

Many CBT techniques have been adapted for use in art therapy interventions (Rosal, 2001). These include cognitive mapping, relaxation techniques, problem-solving, systematic desensitization, externalizing internal processes, personal constructs and mental imagery, to name a few. Art making is in itself a cognitive process, and imagery is a common tool in CBT.

The primary goal of CBT is to help a client develop an internal sense (locus) of control (Rosal, 2001). In the treatment of PTSD, this is a crucial step in the
telling of the trauma narrative. Art therapy can externalize internal processes and restructure dysfunctional thought patterns (Rosal, 2001). Art tasks to aid in this process might include drawing “Before, During and After” states of an experience. Masks or self-boxes depict an inside/outside self, which also addresses this goal. A self-box is an art therapy intervention in which a client is directed to take an empty box and embellish the outside to show what she allows others to observe and know about her. On the inside of the box, the client is directed to create an image of what is private and is not shown to others.

In substance abuse treatment, shame is an issue at the core of all addiction and is connected to denial (Wilson, 2003). CBT techniques enable the art therapist to address denial and other defense mechanisms used to mask the shame. Cognitive mapping helps to identify these faulty thinking patterns. An art task of drawing situations and events allows the client to shift the focus from the external to the internal locus of control and identify primary defense mechanisms. Another effective art task is drawing the internal and external consequences of addiction. Identifying forms of denial and becoming aware of situations that trigger acting out allows the client to address the issue of shame and utilize problem solving to avoid these situations.

Art therapy was used in conjunction with CBT in the treatment of sexually abused children and adolescents. After eight weeks of group therapy the participants showed reduced symptoms of anxiety, depression, PTSD,
dissociation, sexual concerns and sexual preoccupation on the Trauma Symptom Checklist for Children (TSCC) (Pifalo, 2006). The greatest reduction of symptoms was found on the scales for PTSD, dissociation-overt and sexual concerns, the core symptoms typically found in childhood victims of sexual abuse. The results indicated this combined use of therapies was an effective intervention and reduced the symptoms associated with PTSD.

The American Art Therapy Association (AATA) Research Committee conducted a survey in 2005 of registered art therapists who treat clients with PTSD. A content analysis of the survey identified seven therapeutic mechanisms of art therapy which can help reduce the symptoms of PTSD (Collie, Backos, Malchiodi & Spiegel, 2006). They were listed as: 1) reconsolidation of memories, 2) externalization, 3) progressive exposure, 4) reduction of arousal, 5) improved self-esteem, 6) reactivation of positive emotion, and 7) enhancement of emotional self-efficacy. Also, the foundation of their therapeutic work was based upon emotional safety, self-efficacy and self-worth.

In the traditional 12 Step approach of A.A., the first step places an emphasis on powerlessness, and the overall treatment approach is confrontational (A.A., 1981). A large subgroup of clients within the substance abuse population also has a history of childhood incest (Messina & Grella, 2006; Glover, 2004; Kessler et al., 1995; Van der Kolk, 2002). The long-term effects of incest include feelings of
shame, self-blame, worthlessness and isolation (Glover, 2004). As adults, they may continue to have feelings of powerlessness and helplessness.

A woman who has been victimized and uses alcohol or drugs to cope has very low self-esteem. She is more likely to benefit from treatment that focuses on empowerment rather than powerlessness (Glover, 1999; Harris & Fallot, 2001). Art therapy interventions should strive to increase self-esteem and empower the client. The confrontational approach may trigger previous abuse or other violence resulting from substance abuse. Instead, it should be replaced by clear and honest feedback about a woman’s behavior and the consequences of her actions (Harris & Fallot, 2001). If verbal processing is part of the art therapy intervention, it needs to be in a way that respects the client’s dignity.

Gender Differences in Treatment

It is important to consider gender differences in the treatment of dually diagnosed clients. Women are greater consumers of health care and counseling services than are men (Kearney, 1999; Office on Women’s Health [OWH], 2000). They have more doctor visits, use more prescription and nonprescription drugs and utilize the majority of Medicare and Medicaid funds. Nearly two-thirds of women are the decision makers in the family when it comes to health care, and they tend to be the primary care-givers for aging, disabled or ill family members (OWH, 2000).
However, women were excluded from early medical studies of illnesses and treatment (Kearney, 1999). The diseases women were traditionally expected to acquire were reproductive issues, and these health issues were considered insignificant by medical researchers. Heart disease and AIDS are currently the two leading causes of death for women (Centers for Disease Control and Prevention [CDC], 2006). Yet women were excluded from the initial treatment research on these two diseases. As a result, women tend to have different outcomes from medication and treatment than men, and they have lower survival rates, particularly for heart disease (Kearney, 1999).

The research on alcohol and alcohol related problems also has traditionally focused on men, primarily because men drink more than women (Nolen-Hoeksema & Hilt, 2006). Males have higher rates than females for all measures of drinking, 57.5% versus 45%, and they are twice as likely as females to have met the criteria for alcohol dependence or abuse in the past year, at 10.5% versus 5.1% (Substance Abuse and Mental Health Services Administration [SAMHSA], 2007). Men also are more likely to disclose problems with alcohol or substance abuse (Mangrum, Spence & Steinley-Bumgarner, 2006). Alcohol use is a more acceptable activity for men and fits in with the stereotype of the male gender role. Consumption by women is not as socially accepted. As a result, these factors have contributed to men being the focus of alcohol-related research.
However, the effects of alcohol and alcohol abuse are different for women than they are for men. From a physiological perspective, women are at greater risk for alcohol-related diseases such as liver and heart disease, and women become intoxicated more quickly than men with smaller quantities of alcohol (Walter, et al., 2003). Women have a faster progression of brain damage resulting from alcohol use, and they experience a faster progression from first use to alcohol dependence or abuse as compared to men (Nolen-Hoeksema & Hilt, 2006; Walter et al., 2003). There is the risk of fetal alcohol syndrome in pregnant women who are heavy drinkers.

From a psychosocial perspective, the consequences seem to be much greater for women than men. Alcohol use disorders (AUDs) and comorbid major depression is more likely to be found in women (Nolen-Hoeksema & Hilt, 2006). Sexual violence is more prevalent with the use of alcohol over any other drug, and it is associated with 73% of all rapes (The National Center on Addiction and Substance Abuse at Columbia University [CASA], 2006). Women are more likely to have children that need to come into treatment centers with them. Women may not readily seek help because of the fear of losing care of their children during treatment (Walter et al., 2003).

In regards to overall substance use disorders, women are more likely to have histories of either physical or sexual victimization (Magnum et al., 2006). They are more likely to engage in prostitution or sex trading for drugs. Whereas men
tend to abuse alcohol as a primary substance more than women do, women more often use illicit drugs such as cocaine, crack and opiates as primary substances (Magnum et al.).

Webster et al. (2006) examined the gender differences in treatment motivation in a drug court setting. Female drug court participants reported higher severity in mental health problems and higher levels of distress than males. This included more symptoms of depression and anxiety and more stress across all aspects of functioning. The study found that females had a higher level of problem recognition and a greater desire for help than the males did. One explanation for these outcomes included the different social norms for men and women when asking for help. Women are more likely to reach out to others for assistance. Another explanation was that higher levels of distress, regardless of gender, would motivate a drug court participant of the need for treatment. The study concluded regardless of the reason for the outcome, the gender differences in treatment motivation need to be considered when designing treatment plans for drug court participants. It also recommended that further assessment of this population was necessary given the high levels of mental health problems and distress found among the women.

The American Psychological Association Health Care for the Whole Person Task Force has recognized a need for gender specific treatment. The Women’s Health Committee recently published a paper recommending an integrated
biopsychosocial approach in addressing women’s health care needs across the life span (Jarrett, Yee, & Banks, 2007). It examined several factors contributing to both the physical and mental health of women: women’s multiple roles in society; socioeconomic status; cultural variables affecting treatment; access to health care insurance; violence and victimization; and gender-related factors in medical diseases. It recommended a life span approach to address the changing health and psychosocial needs of women as they age. In addition, it urged psychologists to promote holistic, integrated physical and mental health services for women and to utilize research data in advocating change at the local, state and federal level.

Breslin, Reed and Malone (2003) recommend such a holistic treatment model. They run an outpatient substance abuse treatment program for the Veterans Administration Maryland Health Care System (VAMHCS). The goals of the program are to promote abstinence from alcohol and drug use, decrease medical and psychiatric risk, and improve psychosocial functioning.

In addition to providing traditional treatment modalities such as individual, group and family therapy, they offer holistic modalities. These include dance/movement therapy, Tai Chi, art therapy, leisure and recreational skills, spiritual growth and development, and vocational services. Cultural awareness groups are available as well as a Fathers in Recovery group. Physical and mental health is promoted through psychoeducational groups, which include HIV/AIDS management, HIV support group and Hepatitis C education group. Breslin et al.
(2003) believe the program is unique in its approach, and that it enables patients to develop more self-esteem, self-confidence and a stronger sense of identity while managing their physical and mental health issues. Although this program targeted a predominantly male population, its approach would also therapeutically benefit the female client. Many of our veterans in treatment at facilities such as this are likely to have a dual diagnosis of substance use disorder and PTSD.

**Conclusion**

Despite numerous calls for a gender-based recovery model for women, there has been very little research done on the topic (Najavits, Rosier, Nolan & Freeman, 2007). The few studies that have been done have shown that an integrated treatment model does significantly reduce PTSD and substance use disorder symptoms (Najavits et al., 2007; Morrissey et al., 2005; Cohen & Hien, 2006). Each study was brief and had limitations that needed to be further explored. However, each also recommended the need for future studies to continue to expand this body of knowledge. Research that addresses the needs of the dually diagnosed female with a history of trauma is still in its infancy.

The need to expand on the available clinical research with PTSD and trauma has been noted in the field of art therapy. In an editorial in *Art Therapy*, the Journal of the American Art Therapy Association, Kapitan (2007) acknowledges this void. Due to the large number of veterans returning from Iraq with PTSD, art therapists have increasingly become involved in treatment. Yet very few funding
sources are aware of the successes of art therapy within this population. Kapitan states that since PTSD treatment is applicable to a wide range of clients who are not veterans, the importance of documenting clinical studies is of utmost importance. She states it is our duty as art therapists to disseminate the knowledge we accumulate. By sharing our results with others, we enable every art therapy client to benefit from it.
Chapter IV

The Traumatic Events Survey

The treatment facility utilized several different theoretical approaches in the treatment of the dually diagnosed female patient. These included, but were not limited to, cognitive behavioral therapy (CBT), solutions-focused therapy, psychoeducational therapy, family therapy, 12 Steps of A.A., motivational therapy and the TREM model of trauma recovery and empowerment.

The TREM model consisted of 33 possible topics for the development of a trauma treatment program (Harris, 1998). The curriculum around which I developed my art interventions was based on 26 of these topics. The facility determined the topics, and the curriculum started over at the first topic when the sequence was completed. The order and selection of topics was consistent throughout my time there.

The topics consisted of the themes of empowerment, trauma recovery, advanced trauma issues and closing rituals. The empowerment selections stimulated discussion on what it means to be a woman, physical and emotional boundaries, self-esteem, self-soothing, intimacy and trust. The trauma recovery topics focused on defining the types of abuse (physical, sexual and emotional), abuse and relationships, physical safety, psychological and emotional symptoms, and addictive or compulsive behaviors. The advanced topics were current family life, decision-making, communication, self-destructive behaviors, feeling out of
control, blame, acceptance and forgiveness. The closing ritual topics consisted of closure, rituals for healing and the truths and myths about abuse.

Occasionally the treatment team utilized other perspectives for treating trauma and PTSD. The *Seeking Safety* model by Najavits (2002) influenced the curriculum with the use of additional group topics and activities. Exercises from *The PTSD Workbook* (Williams & Poijula, 2002) also complemented the TREM model.

One of the limitations of the trauma group was the inconsistency in the range of topics each client might be exposed to during their treatment. The trauma group was an open group, with clients joining and terminating at different times. As a result, a woman may have entered treatment when the group was in the middle of advanced trauma recovery topics. These intensely personal topics might have been a shock to the new client in the group, especially since some had previously been incarcerated or otherwise isolated without a support system. This also affected the level of trust and sharing within the group, because newcomers were less likely to openly share. A client might also have missed an important topic and be participating in the group without a full understanding of the discussion points. An example might be the truths and myths of abuse or the definitions of the different types of abuse. The trauma group therapists did reiterate at the beginning of each session the goals of the group, and verbal participation was voluntary.
The Traumatic Events Survey

In order to develop a baseline regarding the shared traumatic experiences of the group, a therapist administered a traumatic events survey at the beginning of the curriculum. The treatment team could utilize several different surveys, but one in particular was always administered (see Appendix A). It was from *The PTSD Workbook* (Williams & Poijula, 2002), and it listed 28 possible traumatic events.

During my time at the treatment facility, 32 women completed this survey. Not every client was in treatment at the point in the curriculum when the survey was given, so not every client I worked with completed it. Each woman filled out the survey privately. Although it had a place to list age at the first occurrence of an event, it was not always reported by the client. Many women utilized the description field to add specific details of the event, and some wrote in their own events. The survey did not ask for the number of occurrences of any particular traumatic event.

Survey Results

The minimum number of traumatic events listed by any client was three, and the maximum was sixteen (see Table 1). Sixty-three percent of the clients had experienced a traumatic event in childhood, defined as physical violence, neglect, sexual abuse or emotional abuse as a child. Forty-one percent of all clients completing the survey experienced sexual abuse as a child. The ages listed in the
comments ranged from 4 years of age to 15 years of age at the time of the first occurrence.

Table 1

Results of the Traumatic Events Survey

<table>
<thead>
<tr>
<th>Event</th>
<th># of Respondents</th>
<th>% of Total (n=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surviving a natural disaster</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td>Surviving a fire</td>
<td>5</td>
<td>15.6</td>
</tr>
<tr>
<td>Witnessing a natural death</td>
<td>9</td>
<td>28.1</td>
</tr>
<tr>
<td>Witnessing a violent death</td>
<td>13</td>
<td>40.6</td>
</tr>
<tr>
<td>Being in an automobile accident</td>
<td>13</td>
<td>40.6</td>
</tr>
<tr>
<td>Surviving an assault or mugging</td>
<td>15</td>
<td>46.9</td>
</tr>
<tr>
<td>Surviving a robbery or burglary</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>Having a murder in my family</td>
<td>4</td>
<td>12.5</td>
</tr>
<tr>
<td>Experiencing physical violence as a child</td>
<td>11</td>
<td>34.4</td>
</tr>
<tr>
<td>Experiencing neglect as a child</td>
<td>6</td>
<td>18.8</td>
</tr>
<tr>
<td>Being sexually abused as a child</td>
<td>13</td>
<td>40.6</td>
</tr>
<tr>
<td>Being emotionally abused as a child</td>
<td>6</td>
<td>18.8</td>
</tr>
<tr>
<td>Experiencing physical violence as an adult</td>
<td>17</td>
<td>53.1</td>
</tr>
<tr>
<td>Being raped by someone I knew</td>
<td>9</td>
<td>28.1</td>
</tr>
<tr>
<td>Being raped by a stranger</td>
<td>7</td>
<td>21.9</td>
</tr>
<tr>
<td>Being raped by more than one person at a time</td>
<td>4</td>
<td>12.5</td>
</tr>
<tr>
<td>Having some sort of involvement in pornography</td>
<td>5</td>
<td>15.6</td>
</tr>
<tr>
<td>Experiencing a job-related trauma</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td>Having a traumatic move</td>
<td>5</td>
<td>15.6</td>
</tr>
<tr>
<td>Surviving torture</td>
<td>6</td>
<td>18.8</td>
</tr>
</tbody>
</table>

In addition, 53.1% of the clients had experienced physical violence as an adult. From comments written by the clients, I was able to determine 65.6% of them had been in relationships with domestic violence. Not all of the women
reporting domestic violence on the survey categorized it as “experiencing physical violence as an adult”. Some listed it as “surviving an assault or mugging” or as “surviving torture”. Concerning sexual assault as an adult, 28.1% of all clients reported rape by someone they knew, and 21.9% reported rape by a stranger. The total number of women who had experienced sexual assault or abuse at any time in their life was 69%. In addition, 12.5% reported having had a murder in their family. Two women noted in the comments that they had been kidnapped and held hostage.

Conclusion

The survey results indicate the high levels of childhood abuse and violence experienced by women in this type of treatment program. If the respondents had not been exposed to violence during their childhood, their lifestyle during active addiction was a significant risk factor for experiencing violence as an adult. The percentages in this survey are higher than previously reported studies mentioned in the literature review. The implications of these results show the tremendous need to address underlying trauma in the treatment of substance abuse.

A future recommendation for this survey would be to determine whether the respondents had ever been incarcerated or homeless. During my work at the treatment facility, I had noticed through conversations with the clients that these two factors are very prevalent in this population. I would also recommend that these surveys be administered at the beginning of the individual client’s treatment,
as opposed to a set point in the trauma curriculum. It would allow the therapists to better align individual treatment goals outside of the group experience, instead of discovering past traumatic events at a midpoint in treatment.
Chapter V

The Beginning Sessions

Due to the constant changes in the group membership, this chapter begins with a brief description of the clients whose artwork appears in the following sessions. These sessions detail my first art interventions at the site, and they were my introduction to working with this population. All of the following participants had a dual diagnosis of a serious mental illness combined with chemical dependency. Diagnoses included depression, anxiety, psychosis, schizophrenia, bipolar disorder and personality disorders. At least half of the clients required medication to assist in controlling their comorbid mental illnesses.

Individual Clients

Tammy. Tammy was a 36-year-old Caucasian female. She was 5’7” tall with a slender build, blond hair and hazel eyes. She was the mother of three children ranging in age from 18 months to 14 years of age. Tammy was addicted to heroin and crack, and she had previously been in an outpatient treatment program. She admitted using prostitution as a way to get money for drugs. She said she had been an addict for almost 15 years. She stated she had started with alcohol and worked her way up to heroin over the years. Tammy had been diagnosed with Major Depressive Disorder, recurrent, and Postpartum Depression. She was also diagnosed with PTSD and a possible Borderline Personality Disorder.
Her husband was also an addict and they had been married for 15 years. He physically and sexually abused Tammy. She had left him in an attempt to get sober, and she had recently been dating a man who seemed to care for her and was sober. Her husband’s family was taking care of the children during her treatment. Tammy never spoke about her parents or other family members while in treatment. Tammy verbally participated in group on a regular basis. She did not disclose the abuse her husband had inflicted upon her until after she was in treatment for a few weeks and felt safe enough to do so.

Jennifer. Jennifer was a 31-year-old Caucasian female. She was 5’7” tall and slender, with red hair and green eyes. Jennifer came from an upper-middle class family. She was intelligent and had gone to college for two years before her addiction made her drop out. Jennifer had a Borderline Personality Disorder and had a very difficult time articulating her feelings, emotions and thoughts. At the beginning of treatment, she described herself as “laid back and easy-going.” However, further into her treatment she became aware of her repressed anger. She was also diagnosed with depression. Jennifer’s drug of choice was heroin. She originally became addicted to pain killers after a shoulder injury, and from there she progressed to a heroin addiction.

Jennifer’s history included self-mutilation and a previous suicide attempt. She came into treatment at her family’s insistence. She was generally quiet during group sessions, and she would occasionally become frustrated when she could not
articulate her thoughts. Jennifer did not disclose any abuse or other traumatic events in her personal history. She did state her older sister had a physically abusive and controlling husband. She was creative and had artistic abilities, but she would become irritated in art therapy sessions when her images did not “look right”.

Rachel. Rachel was a 39-year-old Caucasian female. She had long blond hair, blue eyes and was about 5’9’ tall with a medium build. Rachel had been a heroin addict for over 20 years. She suffered from severe Major Depressive Disorder her entire life and was currently on Lithium. Her medical history included hepatitis and hypertension. She had been incarcerated and was referred to treatment through drug court.

Rachel had an 8-year-old son, and she had given birth to her second child shortly before entering treatment. Her son was in the permanent custody of her sister, who also had temporary custody of her newborn daughter. Her trauma history was extensive. Her father had physically abused her mother. He had also physically, emotionally and sexually abused Rachel, but she spoke about it very little in group sessions. Rachel was creative and artistic, and she had previously earned a living as a piano teacher. When she arrived at the treatment facility, she was homeless and unemployed.
Higher Power Drawing

The art intervention was “Draw your higher power.” There were 13 clients in the session. The materials provided were 12” x 18” white paper, chalk, markers, craypas, colored pencils, glue sticks, scissors, and collage materials. The directive was to “draw an image of your higher power.” This art task tied into the third step of the A.A. 12-Steps for developing a plan in recovery. The goal of the task was to be able to relate to how the higher power can help in the recovery process.

![Figure 1. Tammy’s higher power drawings.](image)

Tammy had been in treatment long enough to be doing this art task with us for the second time. Her first drawing of her higher power had been a gray cross with the words “Save me from myself” written below it (Figure 1, drawing on the
left). Her second drawing, done this session, was of a waterfall in a nature setting (Figure 1, drawing on the right).

During processing we compared the two drawings. Tammy stated in her first drawing, she felt desperate and self-destructive. At that time, she had stated she knew there was a higher power because with all the terrible things she had experienced, she “should be dead.” For her second drawing that she had completed on this day, she felt more hopeful and said the higher power represented “peace and the strength to help me through recovery.” She said she believed her higher power gave her “only what she can handle”.

In comparing the two drawings, there are distinct differences in the expressive components of each one. The strokes used for shading the cross and background of her first drawing are broken and sketchy, reflecting anxiety and hesitancy (Hammer, 1980). The light pressure she used in this drawing may have indicated a low energy level, depression and lack of self-confidence (Hammer, 1980). In her second drawing, the shapes and lines are more fluid, and the drawing was more integrated than her first. Tammy used heavier pressure and filled in the entire paper with chalk. This second drawing was reflective of her more relaxed state, increased self-esteem and lower levels of anxiety.

Jennifer’s drawing of her higher power could not be as easily interpreted from simply viewing the image (Figure 2). In the center of her drawing was the black and white symbol of Yin and Yang, the traditional Chinese symbol for
complementary opposites. On the right side of the symbol were images of nature: a pine tree, a stream, a flower and the sun. Written over these images were the words “honest, caring, reliable, friendship, content, safe, hope and willing”. To the left of the Yin/Yang symbol were the images of a bunny’s head, fire and a gun, along with the words “depressed, selfish, crime, unreliable, consequences, dishonest, degradation, sick, anger, fear and lonely”.

![Jennifer’s higher power drawing.](image)

Jennifer had been frustrated while she was drawing these images because she could not remember how to draw certain items. She stated she could not believe “how drugs had fried my brain…I used to be a really good artist. Now look at this crap I draw.” During processing, she said very little about what this image meant to her about her higher power. She giggled inappropriately while contemplating
her image, which she tended to do when she was confused about her thoughts and unable to articulate them. All she said was that the right side represented all the good things about her before drugs, and the left side showed the bad things that happened in her addiction without her higher power. From comments she had made during the art making process, I knew the bunny represented her days when she was working as a stripper to earn money. Nature represented her higher power because it was beautiful and God had created it. She was also interested in Buddhism and Eastern philosophies, which was reflected in the Yin/Yang symbol. The gun was not explained.

Clients with chemical dependency issues tend to have distorted thinking, commonly referred to as “black and white” thinking. Those diagnosed with a borderline personality disorder tend to view everything in extremes and have the inability to see in shades of gray (Shea, 1998). For example, a person is either “all good” or “all bad” to such a client. The thought of “I do bad things sometimes, but mostly I’m a good person” is difficult to comprehend and accept. Jennifer was diagnosed with a borderline personality disorder, and this drawing reflects her inability to integrate both “good” and “bad” qualities into her self-image. She always discussed these traits separately, and she had an easier time talking about her “bad” side. When she tried to articulate her “good” qualities, she seemed unable to vocalize these thoughts.
Rachel’s image of her higher power was of a large eye that was crying blue tears (Figure 3). Inside the pupil of the eye was a sunset, and below the image was written the words “a vision of hope”. Rachel stated during processing that the eye represented “God crying” during her active addiction. The sunset in the pupil represented “new beginnings” available to her in recovery with her higher power’s assistance.

![Figure 3. Rachel’s higher power drawing.](image)

The faintly drawn lines, impoverished features and the light pressure of her strokes reflect the depression Rachel constantly struggled with throughout her life. The image of a stylized, disembodied eye such as this one is a distinct, reoccurring graphic form found in the artwork of women known to have
experienced sexual abuse/assault and subsequently developed PTSD (Spring, 2004). The disembodied eye “suggests an emotional response to traumatic events, particularly guilt, which may or may not be acknowledged” (Spring, 2004, p.201). This can be related to concepts of sin and punishment related to religious beliefs, hypervigilance, sadness and watching/being watched.

The higher power concept is an important step in the recovery process. Most all of the group members relied on it to give them strength, hope and the ability to face their traumatic past and their addiction. In viewing the images from the group, many of the clients who were newer to the group had images that were limited, impoverished and somewhat childlike. The effects of chemical dependency were visible in the lack of emotion and personal insight in their first drawings. Throughout the course of treatment, many were able to develop more self-expression in their artwork, along with more detailed verbal processing. This transformation was evident in Tammy’s two drawings. Jennifer’s drawings remained consistently chaotic throughout her stay at the treatment facility. Rachel’s drawings repeated the disembodied eye theme throughout the course of treatment.

Group Mural – Symptoms of Addiction

The art intervention was “Draw your symptoms of addiction” and was done as a group mural. There were 16 clients present for the art task. A large sheet of 3’ x 15’ paper was rolled onto a table and the clients were instructed to take a seat
around the table. The media included markers, colored pencils, chalk, crayons and craypas. The directive was to “draw the symptoms of trauma. Identify one of your own symptoms and draw its effect on you.” Prior to beginning, I had the group list some of the psychological or emotional symptoms of trauma. Some of the responses were anger, depression, anxiety, self-mutilation, drug abuse, substance abuse, isolation and mistrust. The goal of the art task was twofold. First, it was to identify the symptoms that may have originally developed as responses to trauma and explore the link between abuse and dysfunctional behavior leading to addiction. Second, as a group mural, the goal was to promote group cohesion, build empathy and trust, and develop commonality among members.

After each person had completed their drawing, I took the paper and turned it around on the table. Each individual now had in front of them another person’s drawing from the other end of the table. The directive was given “now please add something to the image placed in front of you.” This part of the task examined personal boundaries and developed trust among members. A few of the group members were visibly anxious about what the other person would do to their image. However, all of the clients respected the images and drew around or next to them, without touching the original drawings.

During processing, clients commented on the vulnerability of drawing their symptoms as well as trusting someone else to respect their images. All of the clients verbally expressed how they were touched or moved by the empathetic
comments written by others, and that they all shared many of the same symptoms. Processing centered on the idea of not being alone in their symptoms. The clients also discussed their own feelings regarding boundaries and issues of trust.

Figure 4. Tammy’s symptoms of addiction drawing.

Tammy’s image was of herself during active addiction, engaging in prostitution to get money for drugs (Figure 4). The image was a blond figure in a short orange skirt and orange high heels, with her arm raised in the air. Green dollar signs floated in the air near her head. A brick wall was nearby, indicating “the streets she walked”. Her symptoms of addiction were written in red around the figure: “crying, emotionally hurt, drug use, anxiety, rebelling and self-mutilation.” Tammy said during addiction, “I found myself doing things to get drugs that I would never do sober”. In response to her drawing, another client
drew herself crying and wrote, “I been there, I know what it feels like using drugs and crying about how I feel, made me feel bad inside”.

Ironically, when the paper was turned around, the image in front of Tammy was another client’s depiction of her own domestic violence situation (Figure 5). The other client drew her anger over the emotional abuse she received from her husband. In response Tammy wrote, “I understand your domestic violence and feel your anger. You deserve better!! Let the anger go.” The women spent some time discussing how they had come to find themselves in such a situation, and how difficult it seemed to be able to find a way out of the relationship.

Figure 5. Tammy’s response to another client.
Jennifer’s first image included a razor blade and a needle, both dripping with blood, and an image of her hiding behind a wall (Figure 6). She drew herself seated on the ground and had depicted the scars on her arms. She stated the symptoms she wanted to show were self-mutilation and drug abuse. The wall represented the isolation she felt from her friends and family during active addiction. In response to her drawing, another client placed herself standing behind the wall with Jennifer, so she “wouldn’t be alone any more. We are all here for the same reason and understand what pain feels like.”

![Figure 6. Jennifer’s symptoms of addiction drawing.](image)
In response to another client’s drawing of a bomb, next to it Jennifer drew the bomb exploding and wrote, “When I get frustrated and explode with rage I cut myself.” (Figure 7) Jennifer discussed how her anger was something she kept inside, and she would cut herself to deal with these feelings. The other client expressed she understood what Jennifer was feeling. She thanked Jennifer for the response to her drawing, as well as respecting the lines she had drawn in pencil around it to “protect” her image.
Rachel’s image was of a crying, disembodied eye (Figure 8). The pupil was dilated and the eye appeared to be bloodshot. Sparse eyelashes and a thin brow completed her drawing. Rachel stated her symptoms of addiction were depression and crying. In response to her image, another client wrote, “I can feel your pain! Have faith in your higher power and he will help you make it through this.”

![Image of Rachel’s drawing](image)

*Figure 8. Rachel’s symptoms of addiction drawing.*

When the images were exchanged, Rachel was presented with the image of a client who was suffering from depression and grieving over the loss of her infant son (Figure 9). In response to the image, Rachel drew an angel and told the client to “have faith in your higher power, your son is now in heaven.” This sincere gesture touched the client deeply since she blamed herself for her son’s death.
This art intervention allowed the clients to identify their psychological or emotional symptoms and to understand the connection between abuse, dysfunctional behavior and addiction. As a group project, it created cohesion among the group members through their shared experiences of addiction and previous trauma. The art intervention was significant because each client realized they were not the only one dealing with these symptoms, behaviors and experiences. The exchange of images required the establishment of empathy and trust. As a result, several women were moved by the responses they received from their peers.

Prior to ending the group discussion, clients were asked if they could list alternative behaviors and positive coping skills to be used in place of the self-destructive behaviors drawn on the group mural. Some of these alternative
strategies given by the clients included: taking a walk, talking to a sponsor or another sober support person, praying, attending a meeting, keeping busy, getting a job and reading. Exercise, meditating, listening to music or relaxation tapes, journaling and cleaning the house were a few others.

Masks – Inner and Outer Selves

The art intervention was making masks. There were 14 clients in the session. The clients had used pre-formed molds and plaster gauze to make masks during a previous session. During this session, the media provided to decorate the masks included paint, glue, beads, feathers, glitter, ribbon, collage materials and other found objects. The directive was to portray the “outer” self on the outside of the mask that they let others see, and on the inside of the mask portray what they do not show, or hide, from others. The goals of the art task were to identify the roles they portrayed and identify defense mechanisms, as well as understanding how each contributed to and fed their addiction.

Tammy decorated the outside of her mask with feathers, beads, glue and cotton (Figure 10). On the inside of the mask, she used paint and divided the mask into large horizontal stripes (Figure 11). The colors were blue, black, red, white and yellow. She glued the word “Blessings” on the yellow stripe. During processing, Tammy said the cotton on the outside represented “my head is up in the clouds because I am a dreamer.” The black beads represented her addiction that she was trying to lose. Green represented her distorted thoughts. The cross
was her higher power, yellow represented her “bright ideas”, and her eyes are clear because “you can see right through me.”

Figure 10. Tammy’s mask, outside  

Figure 11. Tammy’s mask, inside.

On the inside of the mask, each color represented her different feelings that she kept hidden. Blue was sadness, black was loss, red was anger, light blue was calm and yellow was happiness. Tammy said her colors were the same on the inside and out, because she “is an open book. I can overwhelm others with my emotions.” The co-therapist whom I was working with commented to Tammy that she said she was an open book, yet admitted she hides her sadness, loss and anger.

It is also interesting to note Tammy listed both “positive” feelings (calm and
happiness) as well as “negative” feelings (sadness, anger and loss) that she kept hidden from others.

Jennifer’s mask portrayed two very different images on the inside versus the outside. The outside was sparkly and iridescent, with pretty colors for the face (Figure 12). One single blue bead created a tear under one eye. The hair was gold and white ribbon cut into long strips. The features of the face were well defined. The inside of the mask was completely painted red, with two black circles for eyes (Figure 13). Several jagged black lines were in the area of the forehead. A small sticker that read “baby” was in the middle of the forehead.
Jennifer said she wanted the outside of the mask to look like a Mardi Gras mask. She said she did not like being in Ohio. She liked the idea of being from the south, since she had happier times living there. She used blue for the outside because it meant “safety and comfort”. She wanted hair because she uses her hair to hide her face “because I think I am ugly.” She had used red inside the mask to represent anger. Anger was something she had recently discovered in treatment that she “had a lot of. I always thought I was so laid back.” The black eyes “look through people.” The sticker represented that she was the baby in the family, “a role I feel comfortable in. I like being taken care of.”

Jennifer’s mask portrayed the anger that was lying underneath her calm, cool exterior. She stated her belief was “anger is depression turned inward.” Jennifer was intelligent, and she had progressed far enough in treatment to be able to recognize that she had no coping skills. Addiction and self-mutilation had been the only coping skills she had up until this point. She was an attractive girl, and she continued to think of herself as ugly. Her comfort in being taken care of reflected the neediness and dependency of a person with borderline personality disorder.

Rachel’s mask was trimmed around the edges with gold braided ribbon (Figure 14). Two red sequins created pupils in large, open eyes. The word “deep” was on the forehead. She had glued a large, black rectangle made of fabric over
the mouth. She had difficulty in deciding what to do with her mask. The inside was blue and black, with white tears coming from the area of the eyes.

![Rachel’s mask, outside.](image)

Rachel said she was generally deep in thought and quiet most of the time. The inside represented fear, pain, insanity and sadness. She said the fabric over the mouth was because “she was tired of crying, there was nothing left to say”. She felt she was confused as to what her fears were, perhaps a “fear of success or wanting to stay a certain way”. She seemed uncertain as to which of these fears had contributed to her relapse. She had been in treatment before and had been questioning what would happen again once she left. Rachel felt that if she could manage her depression and the resulting isolation, she would be able to maintain her sobriety in recovery.
The clients stated how much they enjoyed this art task. During group processing each was able to identify the differences between her inner and outer selves. In addition, the task built self-esteem and created a non-verbal way to express feelings and emotions. Identifying the repressed negative feelings and verbally addressing them was critical for the recovery process. Many of the clients had been numbed by their addiction and had not experienced these buried feelings and emotions for a long time. Addiction enabled unhealthy self-soothing behaviors. However, the clients did have some difficulty in understanding how the defense mechanisms portrayed in the masks enabled their addiction. Further work was needed for them to understand how their defenses kept them ill. Additional art interventions would provide opportunities to examine defense mechanisms and allow for personal insight.
Chapter VI

The Middle Sessions

This chapter will examine the work of the three clients mentioned in the previous chapter, as well as three new clients. During these next three art interventions, Jennifer was discharged because she completed her treatment goals. Ronni, Candace and Shirley entered treatment during this time. Before discussing the art interventions, the individual background data for these three clients will be given.

Individual Clients

Ronni. Ronni was a 29-year-old African American female. She was 5’8” tall and of a heavy build. Ronni was mandated to treatment by drug court. Her drug of choice was crack, and she stated she had tried to hide her addiction from others for several years. She was diagnosed with Major Depressive Disorder and Dysthymic Disorder. Ronni was also diagnosed with a Borderline Personality Disorder and exhibited traits of a Narcissistic Personality Disorder. She liked being the center of attention and her physical appearance was very important to her. She liked expensive clothes, jewelry and cars, and all of her boyfriends, including her fiancé, were much older men with money. One ex-boyfriend was in prison serving time for murder.

Ronni’s had experienced both physical and sexual abuse. Neighbors molested her as a child, beginning around the age of four. Ronnie participated often in
group sessions, but she did not disclose her abuse history until later in treatment. During the end of her stay in treatment, she emerged as a negative group leader because she tried to manipulate other clients into doing what she wanted. In the role of group leader, a client would act as a monitor and ensure others followed the agency’s rules during group sessions. These rules included no cross-talking, no interrupting others, no food or beverages other than water and no sleeping during sessions, to name a few. Ronni used her authority as group leader to play favorites among group members and single out clients she did not like. She overlooked the fact when certain clients did not follow the rules in order to get favors from them later.

*Candace.* Candace was a 34-year-old Caucasian female. She was mandated to treatment by drug court and brought directly to the treatment center from jail. Her drugs of choice were crack and alcohol. She admitted to using prostitution to get money for drugs. Candace was not married, and her mother was caring for her two daughters. Candace stated she had issues with her father and did not trust men. He was chemically dependent, and Candace spoke briefly of the abuse he inflicted upon her when she was young. She struggled with severe anger issues and had a history of violence. She was diagnosed with an Antisocial Personality Disorder and Depression NOS (not otherwise specified).

Candace actively participated in the verbal group sessions. She initially did not like drawing in the art therapy sessions. However, over time she began to
learn from her images and gain personal insight. Unfortunately, there was a constant conflict between Ronni and her. Ronni continually went out of her way to antagonize Candace. Candace walked out of treatment after two months and did not complete her full course of treatment. Four days after she left, she was arrested again and sent back to jail.

Shirley. Shirley was an African American woman in her mid thirties. She was 5’5” tall and had a slender build. She had been admitted to treatment for crack and cocaine use. She had four children ranging in age from 18 months to 16 years. Her longest relationship had been with the father of her first two children, and it had lasted 18 years. However, he was now serving time in prison and had very little contact with her.

Shirley was diagnosed with Major Depressive Disorder, severe with psychotic features. She also seemed to have some cognitive deficits. She had difficulty grasping abstract concepts and metaphorical statements, a common characteristic of psychosis. Shirley said she hid her drug use from friends and family. For her, the biggest challenge upon completing treatment would be going back to her old neighborhood. She would need to avoid the drug users that she had previously spent time with during active addiction. She admitted to engaging in prostitution as a way to get money for drugs. One of her goals was to get a “real job” when she left treatment. Shirley participated verbally in groups, but she never openly admitted any past trauma or abuse history. Basic needs such as food
and housing came up repeatedly in her art. Because of her addiction, she was underweight when she came into treatment.

_The Bridge to Recovery_

The art intervention was “Draw your bridge to recovery”. There were 15 clients present for the art task. The art materials supplied were 12” x 18” white paper, 18” x 24” white paper, markers, colored pencils, oil pastels, watercolor paints and brushes. The clients were told to think of a bridge that would symbolize their journey from addiction to recovery. A book about bridges was available to help with the visual aspects of a bridge. The clients were directed to draw this bridge on paper, with their past on one side of the bridge and the future or goals they wanted to accomplish on the other. Each client was directed to place herself somewhere on the bridge, and the bridge represented treatment. Underneath the bridge, clients were directed to place obstacles that would prevent a successful recovery and possibly lead to relapse.

The goals of this art intervention were to identify what each individual’s obstacles would be in completing treatment and to list specific coping skills or tools that would aid in recovery. The question posed during processing was “How will you cope with these obstacles?” Giving visual form on paper to future goals, obstacles and coping skills was a reflective way for each client to determine where she was at in treatment. There were those clients who were unable to identify obstacles or healthy coping skills. Without new coping skills to replace
the unhealthy self-soothing and numbing effects of drugs and alcohol, the likelihood a client would relapse was high.

*Figure 15. Tammy’s bridge to recovery.*

Tammy drew her bridge in colored pencils (*Figure 15*). On the left side of her bridge she had a sign post with the words “alcohol, lying, bad health, miserable, abandon children, bad relationship, abuse, affairs, crack, addiction, stealing.” On the right side was another sign post with the words “serenity, coping skills, hope, good self-esteem, pride, family, God, good health, children, caring & healthy relationship, love yourself.” She placed herself at the beginning of the bridge, and her obstacles in the water were “self” and “stinkin’ thinkin’”. She stated she was her “own worst enemy”. She listed acceptance, learning to forgive and forget,
prayer, and trying to increase her self-esteem as the coping skills needed for her recovery.

Jennifer drew two separate bridges. One represented the past and addiction (*Figure 16*). The other represented the future and recovery (*Figure 17*). She described her past as an “unsteady, broken foot bridge.” She has an image of herself hanging from the bottom of the bridge. The lines of the bridge of her past were hastily drawn, sketchy and fragmented. According to Hammer (1980), lines such as these are an indication of anxiety.

![Figure 16. Jennifer’s bridge of addiction.](image)

Her bridge of the future appears as a bridge made of stronger materials and solid pillars for support (*Figure 17*). She said this bridge was “much more stable, with healthy relationships, spirituality and education.” She had written the words
“peace, serenity and family.” Several stereotypical images of a rainbow, heart, sun and butterfly were drawn above the bridge. She had placed herself on the left side of the bridge, and included a picture of a cat’s head and a bunny. To indicate her obstacles to recovery, below the bridge she wrote “depression, complacency, self-mutilation, boredom and anger”, and she drew a dollar sign as well as a car. Jennifer stated these things along with impulsive destruction would lead to her relapse.

Figure 17. Jennifer’s bridge of recovery.

Jennifer listed her coping skills for recovery as having her mom handle her money, getting rides from other people or taking a bus, slowing down, going to meetings, and continuing her medication. She stated going to meetings and her
medication were critical components to her recovery. Jennifer was able to identify her obstacles with a great amount of personal insight. Her listed coping skills reflected her self-awareness that these obstacles fed into her addiction, and a dramatic change in lifestyle was necessary to remain sober. In addition, her inability to integrate both her good and bad traits into one image was further evidence of her borderline personality disorder.

![Image of a drawing](image)

*Figure 18. Rachel’s bridge to recovery.*

Rachel took a very long time before beginning to draw her bridge, because she could not decide what type of bridge she wanted to create. She finally began to draw with colored pencils. Her bridge did not show a connection to land on either side. It was a continuous bridge across the paper (*Figure 18*). Rachel stated there was no end to her bridge because “there is no end to recovery.” She placed
an “X” in the middle of the bridge to represent herself and wrote the word “hopeful” above it.

She stated that in the past she was “lifeless, fearful and bored.” In the future, she saw herself being “alive, with family and being healthy.” She listed her obstacles as “worry, isolation, depression and pain.” She placed her shark underneath the bridge, which represented predators. She listed medication as a way to cope with her depression, as well as talking to someone like a sponsor. She listed the need to keep busy and place her recovery first as ways to cope with her worry and isolation.

![Ronni's bridge to recovery](image)

**Figure 19.** Ronni’s bridge to recovery.

Ronni’s bridge appeared to be floating in the air without support (*Figure 19*). On the left she put dark clouds and the phrases “on the streets using, can’t do this
anymore, didn’t want to live, may God be with me.” She drew an image of herself hanging from the bottom of the bridge. On the right, she drew a smiling sun and her family, with the words “recovery, me and my family.” Underneath the bridge, she listed her objects as “not focusing, not doing, people, places, things, old behaviors, not going to meetings, not reading my big book.” She placed a tiny figure of herself in the middle of the bridge in treatment.

Ronni stated during processing that she was too complacent about the past. She had been sober for almost two years before she relapsed. She stated in order to prevent relapse, she had to “be around clean people, change old behaviors and stay monogamous”. Ronni stated she was angry with herself for relapsing.

Describing future goals for recovery, reflecting on where one is at in treatment and listing obstacles gave a good indication of whether or not a client was able to be realistic about recovery and addiction. The bridge drawing was a challenge for many of the more literal, less abstract thinkers in the group. They were unable to grasp the metaphor of a bridge representing treatment and recovery. Several were unable to describe healthy ways to cope and what obstacles they need to be prepared to face in recovery. Unfortunately, without being able to identify obstacles and alternative coping skills, the chance for relapse was greater.
Johari’s Window

The art intervention was “Johari’s window.” There were 14 clients in the session. The media provided was 18’ x 24” white paper, colored pencils, markers, chalk, crayons, and craypas. The directive was to “divide the paper into four sections. In one section, draw what is public: what to known to yourself and to others. In the second section, draw what is secret or private: what you only see and what is kept hidden from others. In the third, draw what is blind to you: what you do not see but others do see. In the final section, draw the subconscious or your hidden mind: what neither you nor others can see.” The Johari window was created by Joseph Luft and Harry Ingham. It is sometimes referred to as a disclosure/feedback model of self-disclosure.

The goals of Johari’s window were to identify the denial and delusion associated with addiction. By identifying the known and unknown aspects of self, each client could further explore the defense mechanisms driving behavior. The art intervention utilized self-disclosure and feedback from peers to understand one’s own personality. All but one client asked for feedback from peers to complete the “blind” section, that which you do not see but others do. The unknown section was the most difficult for the clients to draw, since it represented the unconscious. This was an abstract art intervention, and some of the clients were “concrete” thinkers, meaning they had limited cognitive abilities. Abstract ideas were difficult for them to comprehend and visually represent on paper.
Used in a group setting, the Johari window provided information on how an individual communicates with herself and others. It examined how a client presents herself to the world, and how she perceived her place in the world. It also enabled trust to develop among group members through the disclosure process.

Figure 20. Tammy’s Johari window.

Tammy’s drawing was in colored pencil (Figure 20). She identified what was public knowledge in the upper left corner as being “smart, intelligent, religious, a people person and outgoing.” She drew a wall, a brain and a sun in the upper right corner as to what she kept private. She said the wall represented the isolation and distance she put between herself and others. The brain meant she was “up in my head, thinking a lot”, and the sun meant she was a daydreamer. She stated others
saw her as a “kiss ass” and drew this image in the bottom left corner. What was in her subconscious was that she could have “just one more”, and this was drawn in the bottom right corner of the page.

![Figure 21. Jennifer’s Johari window.](image)

In her public section in the upper left corner, Jennifer drew a book, a bicycle and a blanket from her childhood (*Figure 21*). She said the book represented that she liked to read and the bicycle indicated the outdoors and physical activity. The blanket represented an object from her childhood, which she was attached to while growing up. The story of the blanket had been shared in previous group sessions. In her secret section in the upper right corner, Jennifer drew a monkey with symbols, an alien figure, a monk, the Yin-Yang symbol, and the word “philosophical”. Jennifer said the monkey was her addiction, which she had
hidden from others, and the alien was all of the” weird, disturbing thoughts I have.” The other three symbols represented her interest in Buddhism and philosophy.

In her blind section in the bottom left corner, she drew a nature scene that represented beauty. She said, “People tell me all the time I am beautiful, but I just don’t see it.” She said she saw herself as “ugly”. She had a difficult time talking about this, so she moved on to the next section. In her subconscious area in the bottom right, she drew a devil and wrote “passive-aggressive.” She said, “I come off like this laid-back person, but inside it’s all anger and bad feelings.

Jennifer’s drawing gave insight to her personality disorder and the disconnection she felt regarding parts of herself. The blanket was significant because she had previously stated “the most important relationship I have ever had was with my blanket.” The alien and devil indicated the repressed anger and emotions she was unable to articulate.

Rachel’s Johari window reflected themes and images seen in her past drawings (Figure 22). Her image in the public section, located in the upper left corner, was a woman with her mouth taped shut. Rachel stated that she was “quiet and did not like to talk much.” She had depicted this same image in her mask. She drew a shark in the upper right corner to represent what she kept private. She said she liked sharks “because they are predators and will eat anything.” Music notes were in the section for what others saw and she did not, located in the bottom left
corner. This represented others seeing her as being talented and smart. For her subconscious area, which was located in the bottom right corner, she drew a window. She said that she dreamt about windows a lot. To her, this meant, “I am inside, and outside is where it is safe.”

Figure 22. Rachel’s Johari window.

Ronni’s Johari window had more writing than images (Figure 23). Her images were primitive stereotypes and looked as if a child had drawn them. Her public knowledge area in the upper left corner reflected her narcissism: “the way I dress or the way I were my cloths [sic] or my appearance or my hair must be neat.” In her private section in the upper right, she wrote, “my dreams are my secret only unless I am willing to share them with someone.” This reflected her unwillingness at this point to share her past history with other group members.
What others saw and she did not was written as “that I am proud and very giving and very bossy, my peers say to me”, and this was located in the bottom left corner. In her unknown/subconscious section located in the bottom right corner, she wrote, “I love my kids and they don’t know it. I love myself and don’t know it right now. I love my family but they don’t know it right now.”

![Ronni’s Johari window](image)

*Figure 23. Ronni’s Johari window.*

Candace used a pen and a very limited range of marker colors to draw her image (*Figure 24*). In her public section in the upper left corner, she placed the different masks she wore as well as her aggressiveness. She also depicted her jail time, drug use and prostitution. She stated, “It was there for everyone to see. I wasn’t even trying to hide it.” In her private section in the upper right corner, she
drew a woman crying and wrote, “Some secrets will keep you sick. Some things are better left unsaid.” She also wrote in big letters “You are not allowed to know. If I tell I have no secrets.” As for what others know about her in the bottom left corner, she drew a dark, black scribble and labeled it “anger”. She drew herself and wrote “outgoing” above it. She also depicted coffee as her replacement for drugs and getting high. In her subconscious area in the bottom right corner, she drew the drugs and alcohol that fed her addiction.

![Figure 24. Candace’s Johari window.](image)

Candace was able to draw personal insight from the task. She stated most of her defenses had to do with her wanting to control. She related the masks she wore, her anger, her aggression, and her unwillingness to tell her secrets as her
way of dealing with how out of control she felt. She was surprised that others saw her as outgoing. She felt she “gave off an antisocial attitude most of the time.” For her, being vulnerable and emotional was a weakness.

For this art intervention, many members of the group had a difficult time identifying different personality traits and defenses, in particular what may be in the subconscious or what is unknown. The self-disclosure and self-discovery gained from Johari’s window helped to identify personal beliefs and attitudes that contributed to chemical dependency. Many of them did create images of drugs and their addiction in the subconscious/unknown area.
Chapter VII

The Final Sessions

This chapter will examine two of the final sessions I had with this group of clients. Most of them would be gone by the final task, and the group was undergoing a change in membership. During this time, the tension between Ronni and Candace continued to escalate. Rachel had been discharged and had gone to a three-quarter house (sometimes referred to as a half-way house), a transitional group housing option until she would be able to live on her own again.

The Uniqueness Metaphor

The art intervention was “the uniqueness metaphor”. Thirteen clients participated in the session. The materials provided were 12” x 18” white paper and glue. Each client received a tray with the same number of collage materials. The collage materials were various shapes cut from tissue paper, buttons, sequins and foam shapes. I chose bright colors to represent spring, and each client could choose to use all the items or only a select number.

The goals of the art task were to explore the personal experience and uniqueness of being a woman and to build self-esteem. It promoted self-esteem in that the only skill required to complete the task was gluing shapes onto paper. The design each woman created from the same objects was a metaphor for how we all started with the same materials and then created our own unique selves.
approach for this task was art as therapy as opposed to the previous insight-oriented tasks.

Figure 25. Tammy’s uniqueness metaphor image.

Although this directive was simply to create a pleasing image from the shapes, all of the women related their images back to their addiction. Tammy had layered most of the shapes in the middle of her paper (Figure 25). She said that the layered shape “represents me. I consist of multiple layers. The shapes flying out from the center are what I am trying to shed.” She described the green triangle with the black button as her addiction. She generally used black to represent her addiction. The overall gestalt of the image appears confused and disorganized.
One of her peers commented that she was simply giving “lip service” to her addiction.

![Image](image.png)

*Figure 26. Rachel’s uniqueness metaphor image.*

Rachel struggled with creating a shape from the given materials (*Figure 26*). She tried to get extra pieces from others, but she was told that she could use no more than what she had been given. She said she wanted to show change in her image. The rain represented her addiction, and the flower represented a new beginning. While she was creating the image, she initially placed the blue teardrop shapes as the petals of the flowers. She changed it because she did not want her flower to “be sad.” One could hope this was also a metaphor for her
recovery; perhaps she was beginning to be able to manage her depression. The flower, although somewhat isolated, stands tall and is colorful.

Figure 27. Ronni’s uniqueness metaphor image.

Ronni used all of her materials and created a design of two faces and a cross (Figure 27). As a client who generally struggled with abstract ideas, she was able to grasp the metaphor and relate it to her own unique design. During processing, she expressed that she enjoyed playing with the shapes and “not having to create anything with meaning or explore any issues today.” One of her peers commented that it looked like the face in the middle was crying. Ronni countered that it was not crying. She said the bright colors reminded her of spring and that she really enjoyed the art task. Ronni definitely displayed increased self-esteem after completing her image. She stated she did not know she was capable of creating a
“pretty image like this”. She said her mood was lifted by looking at the results of her image, and her facial expression was congruent with her statements.

![Image](image.png)

**Figure 28.** Candace’s uniqueness metaphor image.

Candace described the cross in the middle of her image as her higher power (*Figure 28*). She said, “I know my higher power is necessary for me to stay sober.” The image in the upper left was the moon and the stars, and the bird in the upper right corner “was dysfunctional, just like me.” Overall, she said she enjoyed the art task because she did not have to draw, and the bright colors made her feel happier. The only thing she said she would have wished for was brown to create a “proper” trunk for her tree.
All of the clients enjoyed the simplicity and fun in creating their design. Many were creative in their designs, and almost all of them did project personal meaning into the final image. An art task such as this served as a reminder that not all art interventions needed to try to delve into deep, insight-oriented art therapy. It was important to include a mixture of art tasks simply designed to build self-esteem, experiment with media and just have fun with the process.

*Past, Present and Future Image*

The art intervention was “Who I was, who I am, and who I want to be.” There were 13 clients in the session. The art materials included markers, pastels, colored pencils, scissors, glue, 18” x 24” white paper, magazines and assorted collage materials. Addiction-specific phrases were photocopied and given to the clients to use if they so desired. The directive was “create a collage representing change in your life. Create an image of who you were in the past, who you are now, and who you want to be in the future.”

The goals of the art task were to develop an awareness of change in oneself over time and to develop an understanding of how changes brought about by addiction affected each client in different aspects of her life. These included social, familial, health related, psychological and economic changes. It required each client to consider her values and the consequences of making choices. Another goal was to reestablish hope in the future by allowing each client to
visualize what that meant to her. A final goal was that the group would build cohesion and trust by sharing past and present experiences.

![Tammy's past, present, future collage.](image)

*Figure 29. Tammy’s past, present, future collage.*

Tammy used both images and words to complete her collage (*Figure 29*). Her past include family issues and the phrase “mother as she never was.” Her present image included “trying to pick up the pieces, the wrong man, worst of times, and witness to war”. These were all references to her abusive marriage and her struggle in dealing with the past. Her future included getting her children back and feeling “safe, smart, and secure”. During processing, Tammy said all three sections of past, present and future overlap because “they all have an impact on
each other. My past is carried into the present, and the future has to deal with both.”

Figure 30. Ronni’s past, present, future collage.

Ronni had difficulty in looking at the past (Figure 30). She alluded to her family issues with phrases such as “are you the child of toxic parents, the darkest days, worst of times, drug-proof your kids.” The word “Stop” was placed prominently in the center of her past. For her image of “who I am today”, she had “sober times, second time around, secure boundaries, a better future” and a picture of a bride and groom. She said she wanted her future to look positive. She
chose two images to represent her future. One was of Beyoncé and the other was of a well-dressed, smiling woman.

Candace used one side of her poster board to create her past and present (Figure 31). On the back of it, she created an image of her future (Figure 32). She had some of the words and phrases leaving the edges of the poster. She had developed this theme of images leaving the edges of the paper over the last few art interventions. This was likely the result of her antisocial personality disorder, manifesting itself in the desire to violate the “rules” or limits placed upon her by the size of the paper. She typically refused to conform to, or aggressively and verbally protested against, the norms placed upon her by her peers or the facility.

Figure 31. Candace’s past, present collage.
Candace said her past and present (*Figure 31*) were on the same side because “there was some overlap, because the present cannot get away from the past yet.” In her past and present image, she depicted her abuse as a child and her issues with her father, who also had a drug and alcohol problem. Some of her phrases were “a life stolen early, what happens if you die, taking terror to the limit, learn that love doesn’t have to hurt, sounds of silence, where dread fills the air, no pain no gain.”

*Figure 32*. Candace’s future collage.

For her future (*Figure 32*), she said she wanted it to be positive, and that it would not happen without her daughters. They were the most important thing for her. Some of her phrases for her future included “sober times, blossom into life, I
can, secure boundaries, facing choices, issues never end, the stakes are high.” It was painful and very uncomfortable for Candace to look into her past. However, she gained hope and increased her self-esteem by looking into the future.

Collage proved to be a very effective method for insight-oriented art therapy. The mixture of words and images provided visual clues into the issues and challenges of each client. Collage was not an intimidating art form, and the clients enjoyed looking through the magazines almost as much as creating the images. It provided more group interaction during the actual art making process. As a result, it helped in building self-esteem as well as providing insight.

One of the themes that emerged throughout the clients’ artwork was the reference to past traumatic experiences. If they chose not to mention it during verbal processing, the selection of images and phrases alluded to these past events. In addition, all of the clients were able to visualize a positive, hopeful future. Many also stated addiction and the past would continue to follow them into the future, indicating recovery was a life-long process.

A Safe Place

The art intervention was “natural materials montage: creating your safe space.” There were 14 clients in the session. The materials included white poster board, glue, tape, scissors, branches, stones, seeds, shells, moss, twine, yarn, handmade paper, vines, beans, leaves, tiny bird’s nests, bark and feathers. The session began with a brief discussion of what a safe place would look like. The
clients were asked to close their eyes if they were comfortable with doing so, and to take a few moments to visualize their very own safe place. Then, the directive was given “using these natural materials, create an image of a safe place of your own.” The specifics of the image and assemblage of materials were up to each client to decide.

The primary goal was to identify each individual’s perception of personal safety. Reestablishing personal safety is one of the first and foremost steps of trauma treatment (Herman, 1992). Another important goal was to build self-esteem. The women had very low self-esteem due to past trauma and the shame of addiction. By creating an image from natural materials, each would be able to reconnect with her positive qualities and understand how abuse of all types affected self-esteem. Additional goals were to experiment with different materials and improve decision-making skills.

Ronni chose a wide variety of materials for her montage (Figure 33). She again enjoyed experimenting with different media and “simply making something beautiful”. Her safe place represented home, family and church. Participating in the activity reminded her of “what it felt like being sober.” She chose the largest piece of poster board available for her image, which was typical of her narcissism. In previous activities, she generally had the largest image and consumed the most art materials among all of the group members.
During processing, Ronni said her greatest accomplishment and biggest boost to her self-esteem was “helping someone else in giving their image strength and a solid foundation.” Ronni helped Shirley in giving a solid foundation to her image so that it would remain upright. This was an important step for Ronni, because she recently emerged as a group leader. However, her role as group leader was a negative one. Other group members accused her of instigating arguments, manipulating passive clients and dividing the group. By helping to stabilize Shirley’s image, she took a step in assuming a more positive leadership role.
Shirley was one of the few clients who tried to get her image to become three-dimensional and leave the actual plane of the paper. Shirley created a tree trunk from a small bundle of sticks and pine branches, and she used tape as the “root system” to attach it to the paper. She used autumn-colored silk leaves to create the crown of the tree. At the very top of her tree, she balanced a tiny nest among its branches (Figure 34). She was determined to get it to stay upright, and with Ronni’s help she was able to do so. She surrounded the base of the tree with moss.

Shirley stated she was trying to create a palm tree, because she loved islands, palm trees and the water. She said she was very proud of herself for “creating such a beautiful thing. I didn’t know I could do something like this.” Her personal
identification with a safe place included her family. She said the tree with its nest reminded her of her family and friends, and when she was around them, she “felt good about myself, because I know they care.” She also stated that she knew in order to continue increasing her self-esteem after treatment, it would be important for her to get a job again. Working made her feel good about herself, and she really wanted to be able to keep a job this time. Before coming to treatment, she had been unable to work because of her addiction.

My concern going into this task was whether the clients would be able to understand the directive of creating a safe place from natural materials. I was happy to see not only did they understand it, they enjoyed it tremendously. During the group discussion after the art making process, we discussed the use of visual imagery as a coping tool in dealing with overwhelming feelings. Many said they would be able to visualize a safe place of their own in the future when confronted with a stressful situation. In addition, the increase in their self-esteem and pride was evident. Many were amazed by the images they created from the natural materials. The preparation for the art intervention and the gathering of materials required a lot of effort and planning on my part. However, the clients enjoyed the task so much and seemed to benefit from it, so it was time well worth the effort.
Chapter VIII

Conclusions and Recommendations

There is a definite need to address the trauma histories of women in chemical dependency treatment. The results of the traumatic events survey and the personal stories shared by the women in their artwork underscore the need for a comprehensive treatment plan. If the trauma was not a result of childhood abuse, as it was for 63% of the clients, then a lifestyle of drug use and addiction placed them in unsafe or violent situations as adults.

I believe the drug use of most of these clients was a dysfunctional self-soothing behavior, and it had developed over time to numb the unresolved pain and grief from past traumatic experiences. As I worked with these women, I witnessed the slow process of disclosure and self-awareness. The combination of addiction and internalized trauma elevated the level of shame and denial each had to overcome. Most would only briefly allude to past trauma in the beginning of treatment, if they spoke of it at all. As time went on and group members began to share experiences, I would see the dawning realization that they were not alone. Others in treatment struggled with similar issues and could relate to their experiences. The majority of the women had never spoken about or shared these painful memories with anyone before. Many would become very angry towards the end of treatment, and this anger was generally directed at their perpetrators.
Unfortunately, 30 to 90 days was never enough time to resolve a lifetime of substance abuse, mental illness and unresolved trauma.

The nonverbal attributes of art therapy allowed for personal insight in regards to chemical dependency as well as trauma issues. It provided a means for clients to shift from an external locus of control during active addition to an internal locus of control during treatment. Without this shift, the distorted thought patterns of addiction would never change, and this would most likely contribute to relapse. The artwork created by the clients allowed them to integrate the traumatic memories into conscious memories and present-life experiences. Through this cognitive reframing, the women were able to change their personal narratives to one of survivorship as opposed to being a victim.

One of the art therapy interventions that best connected the treatment goals for both trauma and addiction was the “draw your symptoms of addiction” group mural. First, listing the emotional and psychological symptoms of addiction and then drawing the symptoms enabled clients to generate personal insight. Second, a discussion of what possible trauma or abuse could have caused these symptoms allowed clients to understand how symptoms developed as coping strategies. This was truly an “aha” moment for most of them. The development of a list of alternative coping skills enabled them to begin to restructure the past self-destructive behaviors. Finally, done as a group activity, the commonality of their experiences affirmed their stories and allowed the healing process to begin.
The three treatment goals that apply to both chemical dependency treatment and trauma are shame reduction, addressing denial and allowing for cognitive restructuring. The art therapy interventions of mask making and Johari’s window provided an opportunity to explore current defenses, addressed denial and provided insight into coping strategies. These treatment goals were crucial components of chemical dependency treatment, specifically cognitive restructuring. By externalizing internal processes with these two art interventions, distorted thought processes were examined and challenged in order to help change behavior.

Low self-esteem was a trait of all of the women in treatment. The art therapy interventions of the “uniqueness metaphor” and the natural materials “safe place” image helped to elevate individual levels of self-esteem. Since both interventions used media other than drawing materials, the clients were able to enjoy the experience more without the resistance or anxiety generally brought on with drawing interventions.

The “past, present and future collage” enabled clients to examine aspects of both trauma and addiction from the past and present. It instilled hope through contemplation of the future. By drawing the before, during and after states, it also provided a means of externalizing internal processes. During this particular art task, I have worked with clients who were unable to complete the “who I was” section of the collage. In my experience, this inability to examine the past was
directly related to a high level of traumatic events. In these cases, it was important to recognize what the client was capable of sharing in the moment and not overwhelm her by pushing her to reexperience the memories before she was ready.

The “higher power drawing” and the “bridge to recovery drawing” are art therapy interventions that are traditionally used in chemical dependency treatment. The higher power drawing is important if the 12 Steps of A.A. are part of the program. Everyone has a different concept of what the higher power is, and this intervention allowed each client to find her own meaning. I have found the bridge to recovery drawing to be very effective in determining where a client is at in her treatment. Was she able to look accurately and honestly at her past addiction or was she still in denial? Could she visualize an accurate image of what recovery meant to her or was it unrealistic? Was she able to cut through her defenses and describe the obstacles related to her recovery? The placement of the self on the bridge to indicate where one is at in recovery is important. One client did not even place herself physically on the bridge or anywhere else in the drawing. She was unable to see the significance of it, even when her peers tried to point it out to her. If she did not place herself on the bridge, what was her commitment to completing treatment? Could she visualize herself making it through to a successful recovery?
I would like to point out that not all clients in treatment for addiction have experienced previous trauma. However, I feel that addressing the trauma along with addiction will allow for the development of coping skills that can be used in the future during recovery. Not everyone exposed to a traumatic event will suffer future PTSD. However, those in recovery may be more susceptible to relapse without the awareness and understanding of their own traumatic events.

When I began the graduate program in art therapy & counseling at Ursuline, I had no idea I would come to work with this population. My experience and interest in chemical dependency and trauma was a result of fulfilling my practicum requirements. As I worked at the treatment facility, I realized that I strongly believed in a connection between trauma and addiction through hearing the stories of these women. As a result, I have a desire to continue to work with this population, and I would like to become an advocate for trauma integrated addiction treatment, as well as other women’s issues.

People have asked how I can work with this population without becoming discouraged, since estimates put the rate of success at about 50%. This means about half of the clients I worked with would relapse after treatment. Self-care and clinical supervision are critical to avoiding burnout as an art therapist. I also respond that the need is too great to ignore. Most all of the women I have worked with have children. What would the implications be for future generations if we do not try to stop the cycle of addiction now? For those who have a more fiscally
minded approach to life, let me state the argument another way. Substance abuse
costs our society more financial loss than any other medical condition (Inaba &
Cohen, 2004). For every $1 spent on treatment, $4 to $20 is saved through a
reduction in prison costs, lost time on the job, health care costs and extra social
services (Inaba & Cohen, 2004).

My recommendation would be that there is a continued need to explore the
connection between trauma and addiction. Specifically, more research needs to be
done in art therapy that addresses an integrated approach to trauma and chemical
dependency treatment. As I mentioned in my literature review, there is more
written in the general mental health field regarding the connection between
trauma and addiction than in the field of art therapy. The opportunity exists for art
therapy to contribute to a more holistic approach in substance abuse treatment.
References


## Appendix A: Traumatic Events Survey

*Identifying and Writing about What Has Happened to You*  

<table>
<thead>
<tr>
<th>Event</th>
<th>Age(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>surviving a natural disaster (tornado, hurricane)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>surviving a fire</td>
<td></td>
<td></td>
</tr>
<tr>
<td>witnessing a natural death</td>
<td></td>
<td></td>
</tr>
<tr>
<td>witnessing a violent death</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being in an automobile accident</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being in a plane crash</td>
<td></td>
<td></td>
</tr>
<tr>
<td>surviving an assault or mugging</td>
<td></td>
<td></td>
</tr>
<tr>
<td>surviving a robbery or burglary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>having a murder in my family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being exposed to war</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being a combat soldier</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being a refugee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>experiencing physical violence as a child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>experiencing neglect as a child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being sexually abused as a child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being emotionally abused as a child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>experiencing physical violence as an adult</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being raped by someone I knew</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being raped by a stranger</td>
<td></td>
<td></td>
</tr>
<tr>
<td>being raped by more than one person at a time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>surviving cult abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>having some sort of involvement in pornography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>having some sort of involvement in snuff films</td>
<td></td>
<td></td>
</tr>
<tr>
<td>experiencing a job-related trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>having a traumatic move</td>
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<td></td>
</tr>
<tr>
<td>surviving torture</td>
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<td></td>
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<tr>
<td>surviving a holocaust or genocide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As you think about all the traumatic experiences you have had, remember that you survived them and that you used many positive character traits to do so (Cohen, Barnes, and Rankin 1995). The following exercise refers to some of those traits.
Appendix B: Art Therapy Release Form

ART THERAPY RELEASE

I, ______________________, hereby agree that my art work or representations of my art work may be used in professional or educational training. I understand that my name will not be used in conjunction with the presentation or discussion of the work.

Signature ______________________ Date __________

Witness ______________________ Date __________