



The First Step Series: Art therapy for early substance abuse treatment

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ABSTRACT

The First Step Series (FSS) is a protocol of five art therapy directives designed for the initial stages of substance abuse treatment. These directives target denial to facilitate client identification of ambivalence and eventual acceptance of lifestyle changes necessary for recovery. Motivational Interviewing (MI) [Miller, W. R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people to change* (2nd ed.). New York: Guilford Press] informs a conceptualization of denial as normal ambivalence that occurs during any change process. Normalizing ambivalence sets the stage for the related therapeutic tasks of matching the client's attitude toward treatment, promoting trust in the therapeutic relationship, and gently supporting the client's internal desire for change.

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The use of art therapy in substance abuse treatment (SAT) has a long history. Many authors have described the benefits of art therapy for those with chemical dependency such as bypassing defenses (for example, Julliard, 1994; Moore, 1983), promoting emotional expression (Cox & Price, 1990; Holt & Kaiser, 2007; Kaiser & Holt, 2002), encouraging a spiritual recovery (Feen-Calligan, 1995) and fostering creativity (Allen, 1985; Johnson, 1990). In a review of the literature on art therapy in SAT over 20 years ago, Moore (1983) concluded that art therapy provides an active means of experimenting with imagery to communicate symbolically, offers an outlet for clarifying feelings and attitudes, reduces distorted thinking, and fosters increased insight. Since her review, several art therapists have developed interventions and assessments aimed at decreasing defenses and increasing acceptance of step one in a twelve-step recovery model.

In relation to acceptance of the first step, it is well recognized that one of the major objectives in the initial stages of SAT is overcoming denial so that clients may begin to accept the need for adopting behavioral changes that support recovery (Kesten, 2004). "Denial is the mental mechanism that enables addicts to give up more and more of the things that they find valuable in life. . . Denial is the foundation of addiction, the fertile soil in which it grows and flourishes" (Conyers, 2003, p. 23). Even though this conceptualization of SAT is long-standing and widely used it is beneficial to consider an alternative perspective.

Perhaps a more pragmatic and therapeutic way to approach client defensive strategies like denial and minimization of substance use is to understand why and how people change. Miller and

Rollnick (2002) developed Motivational Interviewing (MI), a treatment model based on a client-centered counseling approach that seeks to enhance intrinsic motivation for change. This approach is often integrated with the framework of the transtheoretical model that suggests behavior change occurs as a series of gradual stages as outlined by Prochaska and colleagues (DiClemente & Velasquez, 2002; Prochaska, Norcross, & DiClemente, 1994; Velasquez, Maurer, Crouch, & DiClemente, 2001). Designated the Stages of Change (SOC) model, it delineates client readiness for change as spanning a five-stage continuum, progressing from *precontemplation*, where the client has not yet considered change, through *contemplation*, *preparation*, and *action*, and finally to the *maintenance* stage where the client works to sustain long-term change. This is in contrast to the often dichotomous position taken when treatment providers view a client as either being in denial or ready to accept the need for treatment and change.

Each stage is viewed as predictable, well defined, taking place over time, and associated with a set of cognitions or behaviors. Change is seen as ongoing as a client—given the optimal conditions and interventions—moves from being unconcerned with altering behavior or attitude to considering change as possibly desirable, then later on to deciding and preparing for changes, until eventually genuine, internally motivated action is taken and, with time, attempts to maintain new behaviors are set in motion. Based on the belief that motivation is necessary for change to occur, DiClemente and Velasquez (2002) emphasized that MI is particularly effective for clients assessed to be in the early stages of change. It has also been found to be effective with clients in the later stages of change, as they prepare for the action and maintenance stages.

MI frames motivation as a dynamic interpersonal process that is fundamental to change, not a personal trait. As such, each

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client is viewed as having the inherent potential for change and responsible for his or her own personal change process (Miller & Rollnick, 2002). Therefore, the task of the therapist is to create a set of conditions that will enhance the client's own intrinsic motivation for, and commitment to altering behavior. MI is a systematic and directive clinical approach for evoking internally motivated change with the primary goal of resolving ambivalence. Ambivalence is normalized as part of a natural process of change, and any resistance or reluctance is understood as inherent to the change process. In this framework resistance is reframed as the therapist's responsibility. Accordingly the therapist's task is to empathize with the client's perspective, however ambivalent he or she may be about accepting treatment.

Research supports the use of MI and the SOC model (also referred to as Motivational Enhancement Therapy) for helping those with chemical dependency (Brown & Miller, 1993; Project MATCH Research Group, cited in Polcin, 2002). Evidence suggests that the use of MET more effectively promotes client engagement in treatment, leads to more positive outcomes at follow-up, and significantly decreases the alcohol consumption of clients with mild to moderate drinking problems (Polcin, 2002).

We were intrigued with the idea of applying MI and SOC to the early stages of substance abuse treatment using art therapy. While developing the FSS, an article describing the use of MI and art therapy was published by Horay (2006). His approach is similar to ours in that he noted that "art therapy seems uniquely capable of bridging the psychological gap between the cognitive-behavioral concerns of MI and the traditional psychodynamic focus on clinical narcissism" (Horay, 2006, p. 17). However, we diverge from his perspective in that we view MI as conceptually compatible with the twelve-step model while he seems to regard it as disparate. The twelve-step philosophy is one of attraction, which supports "working" the program, developing hope, conducting self-inventories of personal shortcomings, examining consequences of drinking, and changing maladaptive thinking. For example, the "Big Book" of *Alcoholics Anonymous* (1976) emphasizes that the principles are guides to progress, that self-evaluation is paramount, and that interpersonal connections through fellowship promote life in recovery. Miller and Rollnick (2002) stated that three critical components of motivation are "readiness, willingness, and ability" (p. 10), similar to twelve-step principles.

As we reviewed our own clinical experiences, the art therapy literature, and principles of MI and SOC we recognized the value of a model that is research-based, is well-matched with the twelve-step model, and corresponds to our beliefs about the importance of relational processes in any clinical approach. DiClemente and Velasquez (2002) noted, "The motivational interviewing philosophy, approach, and methods are uniquely suited to addressing the tasks and emotional reactions of individuals who are moving through the first two stages" (p. 203). Further we believe that MI links well to what has been traditionally viewed as overcoming denial in early SAT. Considering that each stage of change requires that certain tasks be accomplished and specific therapeutic processes be used to evoke change, we reasoned that particular art therapy tasks could be designed to achieve each task.

In this paper we focus primarily on the first two stages, precontemplation and contemplation. Fostering the movement from precontemplation to contemplation by promoting motivation for change requires interventions that are engaging and action-based (Miller & Rollnick, 2002). These qualities are inherent to art therapy in that clients choose their materials, decide how to approach particular directives, and make decisions about their artwork as they revise and rework their imagery. These processes can reduce defensiveness and denial while opening the door for considering change as a viable option. The final artistic product coupled with therapist-

facilitated discussion can provide an opportunity to communicate important feedback that may enable the client to "see" more clearly the reality of the negative consequences of substance abuse and the positive ones associated with recovery.

At precontemplation the person does not see a problem—this is commonly viewed as denial or resistance in SAT but is reframed in MI as normal ambivalence. There is lack of awareness that problem behaviors exist or even an unwillingness to consider the need for change. Individuals engage in little activity that might shift their views, and can exhibit defensive strategies when problem behaviors are pointed out. They are not convinced that negative aspects of their problem behaviors outweigh the positive ones they seem to experience. DiClemente and Velasquez (2002) identified four patterns of thinking and feeling that characterize precontemplators: "reluctance, rebellion, resignation, and rationalization" (p. 204).

In the second stage, contemplation, the person recognizes a problem and also considers whether and how to take action toward a solution. Thus, the problem is acknowledged and possible solutions are explored but there is not yet a commitment to take solution-based action. The aim of the therapist is to help the client "tip the balance" in favor of change (DiClemente & Velasquez, 2002). Understanding these two early stages of change compelled us to reflect on the kinds of art tasks that might help move a client in SAT from precontemplation to contemplation and then toward preparation to change. We next describe the FSS and then turn to the therapeutic processes that are key to successful implementation.

The First Step Series

We began with the premise that "Any activity that you initiate to help modify your thinking, feeling, or behavior is a change process" (Prochaska et al., 1994, p. 25). In line with this and based on our clinical experiences we developed five directives adapted from our previous work, the art therapy literature, and the MI/SOC framework: the Crisis Directive, the Recovery Bridge Drawing, the Costs–Benefits Collage, the Year from Now Directive, and the Barriers to Recovery Directive.

We reasoned that these tasks would encourage motivation as clients actively engaged in the treatment process and depicted their situations, thoughts, feelings, and attitudes. A goal of MI is to evoke "change talk" and statements of problem perception from the client, with the ultimate goal of fostering a client shift in perspective toward perception of a need for change. The client's active process of constructing a concrete and tangible representation of their inner and outer realities and creating personal images fosters a self-evaluation process that reveals his or her reality and makes it difficult to erect defenses that hide critical issues related to treatment concerns. As Harms (1973) asserted:

...The [client] moves from simple doodling and doing something with color to a self-involvement which tries to work out the idea of the drawing or painting [he or she] wants to create. This step of inner involvement gives art its first chance to set foot in the [client's] confused inner experience... [and subsequently he or she] goes into a state of independent creation (pp. 58–59).

This can be empowering and lead to greater insight, help reduce ambivalence, and eventually promote movement toward action. Thus, the act of creating can stimulate active engagement and optimally, set the stage for a change process.

Velasquez et al. (2001) described 10 processes of change that support movement from one stage to the next. We focus on the first group, the "experiential processes," as these give attention to the internal thought processes pertinent to the early stages of

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