

# Integrating Art Therapy into AN ALCOHOLISM TREATMENT PROGRAM

By PAT BUOYE ALLEN, ATR

School of the Art Institute  
of Chicago Library  
Jackson and Columbus  
Chicago, Illinois

When art therapists must adapt their way of working in order to harmonize with an overall program of which art therapy is a small but nonetheless valuable part, they are frequently faced with a dilemma. On one hand is their desire to work in a style that accords with their cherished theoretical and personal beliefs. On the other is the reality of facility requirements and limitations. In such a situation, one needs to hold fast to a basic belief that some art therapy is better than no art therapy.

Among my cherished beliefs are these: art-making requires involvement over time; patients ought to be as free as possible to choose materials and subject matter; and patients need time to get acquainted with art-making before they can be expected to take risks in imagery. At the same time, as a clinician I believe that art therapy must be integrated with the overall treatment approach.

For two years I conducted art therapy as an integral part of a three-week alcoholism treatment program in an inpatient facility. The program was geared toward a particular goal for clients who shared a common problem. Under these circumstances the most effective means for offering art therapy was not via my preferred approaches but through highly structured procedures.

## The Treatment Program

The program under discussion was based in a hospital and provided a wide

range of services to the alcoholic patient. Depending on the state of the patient upon admission, treatment might begin with medical detoxification and conclude with placement in a halfway house. Even with a patient requiring detoxification, efforts were made to get him or her up and participating in the milieu as quickly as possible.

The program was based on Jellinek's (1960) concept of alcoholism; that is, alcoholism was viewed as a disease (like diabetes and epilepsy) that can be controlled but not cured. Not only the active drinker but all those involved with him or her — family, friends, employer — are thought to be affected by the disease and therefore need to participate in treatment. The program made efforts to involve families and employers, and certain educational activities were designed especially for them.

Program staff members attempted to confront patients with medical, psychological, physical, emotional, spiritual, and even legal ramifications of their disease (Kurtz, 1980). Although the atmosphere was supportive, breaking down resistance to treatment was a primary objective. This was attempted by means of a highly structured program that had both educational and therapeutic aspects.

The educational component consisted of films, videotapes, lectures, and discussions covering such topics as nutrition, physical effects of alcoholism, use of leisure time, effects of alcoholism on sexuality and intimacy, and drug interactions with alcohol. In tandem with factual lec-

tures was a strong emphasis on the principles of Alcoholics Anonymous (AA), which stresses that recovery is lifelong; one is never cured. Staff members who were themselves recovering alcoholics led discussions of AA literature, including the works of Wilson (1939 and 1953). AA meetings were held weekly on the unit.

The therapeutic component consisted of group and individual counseling, occupational therapy, recreation therapy, psychodrama, and art therapy. The therapeutic value of the milieu was emphasized to counteract the alcoholic's tendency to isolate him- or herself. Patients lived and took part in activities together for three weeks; some formed lasting friendships.

As patients progressed and became medically stable, outside passes were issued to encourage them to attend AA meetings in their home areas and to begin reentry into their families.

The comprehensive and demanding program provided structure and clear expectations — something that has been lacking in the life of many alcoholics. Staff members expected all patients to participate, on the assumption that they had much to learn from one another. Many patients were surprised by this expectation.

Identifying themselves as alcoholics was considered the first step in initiating recovery (Wilson, 1939). Despite enormous differences in the ages and educational and socioeconomic backgrounds of the patients, a certain homogeneity was engendered through shared purposes and shared activities day after day. Thus, for art therapy to be compatible with the rest of the program — to encourage the sense of commonality — it was essential that art activities be highly structured.

---

Pat Buoyé Allen, MA, ATR, is currently Assistant Professor in the Art Therapy Master's Degree Program at the University of Illinois, Chicago. Earlier she worked at Sheridan Road Hospital, also in Chicago, where she did the work described in this paper. Ms. Allen is a PhD candidate at the Union for Experimenting Colleges and Universities (Cincinnati, Ohio) in the area of art therapy theory.



## Integrating Art Therapy into the Program

Staff members initially questioned the purpose of art therapy. They regarded it as psychoanalytic and thus potentially detrimental in that it might encourage the alcoholic to shift the focus from drinking to depression or anxiety as the primary problem. The program's philosophy held that alcoholism was the primary disease; depression and anxiety were looked upon as secondary consequences. Frequently psychotherapists not trained in alcoholism theory see drinking as merely a symptom — one that will disappear once an underlying depression is treated (Cahn, 1970, pp. 6, 11; Blum and Blum, 1969, p. 79). Many alcoholism professionals feel that since prolonged drinking causes changes in appetite, sleep disturbances, and mood swings — thus mimicking depression and anxiety from psychological causes — the alcoholic is not amenable to psychotherapy until he or she has been sober for at least a year.

### The Art Lecture

An art therapy group was offered once a week. An additional component was a lecture entitled "Creativity and Recovery." (The lecture format figured in other aspects of the treatment program and was generally well regarded.) My goal in the lecture was to suggest that art is a useful way of integrating internal and external reality. This is a problem for the alcoholic, whose behavior and demeanor often belie loneliness and internal pain. I presented the idea that by making art one can express feelings, lessen isolation, and achieve self-understanding.

I used slides to illustrate universal themes that concern everyone but that may be exacerbated by alcoholism: life and death, family relationships, confusion, achievement, and spirituality. I began with art work done by former patients in the program. These works invariably provoked comments that indicated recognition and identification. A young man's "self-portrait" that consisted of a tornado and a thunderstorm happening together was such a drawing. From patient art works I moved to slides of works by well known artists. I grouped these around such themes as religion and

spirituality, family, death, bar scenes. Both representational and abstract works were included. Patients were invited to comment on the works — for example, on the difference in feeling between Picasso's rendering of "Mother and Child" and a painting by Mary Cassatt on the same theme. As patients reacted to each slide, they projected personal feelings. Often it was a new experience for the alcoholic to see art as connected in any way to life.

The art lecture accomplished several purposes:

- It introduced and enhanced art therapy by associating it with the successful lecture format characteristic of much of the rest of the program.
- It brought art closer to home by making a connection between patient art and fine art.
- It introduced the idea of art as a medium of integration.
- It fostered a sense of mastery as patient reactions to art were encouraged and supported.

Participation in the art lecture, which was offered only once every four to six weeks, invariably enhanced participation in that week's art therapy group. Such sessions saw far greater involvement on the patients' part than those sessions held on weeks when the lecture was not offered.

### The Art Therapy Group

The groups were structured around such issues as self-image, loss, and anger. Also featured were certain themes adapted from AA concepts: "A Higher Power," "Surrender" (Wilson, 1939). Some assignments concerned daily life: "Draw yourself at work"; "Draw your spouse and how your drinking has affected him or her."

Discussion of patients' pictures in the group often brought to the fore the contrast between a patient's wish and reality. For example, a woman alcoholic whose children had been removed from the home by the state made a drawing of a happy, intact family. No attempt was made to relate one group session to a previous session; rather each was treated as complete in itself (Yalom, 1983). My

role was to direct and confront, yet give support. It was clear that as an agent of the program, I would disclose to other staff members any information gained in art therapy. Indeed, I displayed patients' pictures on a bulletin board in the kitchen (where the group met), further making public what took place in the group. Thus, although I offered a different means for helping patients to confront issues, I did so as part of a concerted effort to foster the working through of these very issues.

In contrast to the general practice in psychoanalytically oriented art therapy groups, I placed little emphasis on transference and confidentiality. Such a directive, confrontive approach as ours is useful *only* in treatment situations where a specific goal is being sought with a homogeneous group of patients. In this case, as mentioned earlier, the goal was the breaking down of resistance to alcoholism treatment.

### Comments

In a short-term alcoholism treatment program it is important for all available treatment resources and modalities to have the same focus. If patients receive the same messages in many different mediums, the likelihood of change is greater (Naitove, 1977). Conversely, the art therapist or other staff member who takes a markedly different approach encourages splitting and confusion, and patients may well reject the message altogether.

Needless to say, to be effective in the short-term alcoholism treatment program described above, I had to modify my role considerably. I had to relinquish my goal of sustained relationships with individual patients. It was necessary for me to regard myself as an agent of the program, to work closely with other staff members, and to trust them to work sensitively with material that surfaced in art therapy. I had to hold in check any tendency to read too much into the few pictures I witnessed of each patient. But what was sacrificed in the way of spontaneity and development over time was often offset by the intensity of the images patients made in the demanding situation that prevailed.



I cannot evaluate whether art therapy helped the alcoholic patients in this treatment program. The high rate of recidivism leads health care providers to question whether any treatment, aside from Alcoholics Anonymous, is truly effective in combating alcoholism. Some patients in the program seemed to gain insight through art-making; some found it enjoyable; and many found their defenses challenged. Indeed, this last reaction was the overall goal of the treatment program.

I found storming the ramparts of defense a less congenial role for me than would have been one aimed at offering support. Preparing and delivering the art lecture ("Creativity and Recovery") was, however, a personally fulfilling task. In this case, the limitations of the program's structure inspired me to make an effective and satisfying adaptive effort. Patients repeatedly reaffirmed that art

has deep personal, emotional, and spiritual meanings. To offer art to patients not just as a therapeutic modality but as a part of life was an exciting and nourishing experience. As I spoke of my own passionate love of art, I was helped to establish a real connection to the patients.

It is not necessarily unfortunate that in many settings the role of the art therapist is not yet clearly defined. To struggle with restrictions is often to discover new possibilities inherent in our work, even as cherished attitudes must go by the board. I regard my work in the alcoholism treatment program in this light.

#### REFERENCES

Blum, Eva Maria, and Richard Blum (1969) *Alcoholism — Modern Psychological Ap-*

*proaches to Treatment*. San Francisco, Jossey-Bass.

Cahn, Sidney (1970) *The Treatment of Alcoholics — An Evaluative Study*. New York, Oxford University Press.

Jellinek, E.M. (1960) *The Disease Concept of Alcoholism*. New Haven, College and University Press.

Kurtz, Ernest (1980) *Not God — A History of Alcoholics Anonymous*. Center City, Minn., Hazelden Educational Services.

Naitove, Connie (1977) "Process or Product: Awareness vs. Aesthetics," *Mental Health and Society* 4: 45-54.

Wilson, B. (1939) *Alcoholics Anonymous*. New York, Works Publishing.

(1953) *Twelve Steps and Twelve Traditions*. New York, Alcoholics Anonymous Publishing Co.

Yalom, Irvin (1983) *Inpatient Group Psychotherapy*. New York, Basic Books.

*If you're moving . . .*

**Please notify us of your  
change of address promptly**