Stories of substance:

Story-making in art therapy with substance-abusing mothers and their children

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Abstract

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This research proposes a short-term art therapy treatment program that aims to address poor attachment between substance-abusing mothers and their children. Although there are a number of studies linking impoverished attachment patterns to intergenerational psychosocial problems, including continued substance abuse, there are relatively few treatment programs designed to address this issue. There are fewer still within the creative arts therapies that attend to the bond between substance-abusing mothers and their children. This paper proposes a model for a program that combines narrative therapy and art therapy within the framework of attachment theory. For this research project, a short-term art therapy program was developed with a focus on story-making as a means of relationship-building between substance-abusing mothers and their children, ages 3-6. An exploratory trial program was implemented at a residential rehabilitation centre for chemically-dependent mothers and their children. Feedback from the mothers and children, in the form of questionnaires and field observations, served as the impetus for the development of the program as presented here.

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Introduction

> I like that art is not on the surface. It's like we have a bubble, and we can
>
> go deep into our bubble. A bubble is like what's going on in my head – I
>
> don't know how to explain it…

These are the words of Kay[1], a young woman participating in art therapy at a residential

rehabilitation centre for substance-abusing mothers and their children. She was one of 7

participants (including 3 mothers and 4 preschool-aged children) involved in an

exploratory trial program to determine how best to integrate a story-making component

into an art therapy group program. Given a relatively unstructured environment, a wide

choice of art materials, and the simple directive to "make a story," I observed how the

mothers and young children in this study worked together. I collected participant

feedback, my own personal observations, as well as literature drawn from attachment

theory, research on substance abuse, narrative therapy, and art therapy, to form the basis

for this structured story-making program that can be utilized with similar clients in the

future.

  Rationale. Substance-abusing mothers are an underserved group who face many

barriers to treatment, including stigma from society in general, from friends and family,

and from the service providers who purport to help them (Suchman, McMahon, Slade &

Luthar, 2005). Even mental health practitioners find addicts difficult to work with

because they are viewed as unmotivated, manipulative, and ambivalent towards their own

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[1] Not her real name. All participant names in this paper are pseudonyms, used to protect their
confidentiality.

recovery process, leading drug users to feel additionally rejected by helping professionals (Waller & Mahony, 1999). Unlike other victims of mental illness, individuals who abuse drugs are often blamed for their problems, while substance-abusing mothers in particular are vilified for putting their families in jeopardy, sometimes facing incarceration, mandated treatment, or even forced separation from their children. Substance abuse is, however, an intergenerational problem, with many psychosocial risks and attendant co-occurring mental illnesses (Luthar & Walsh, 1995).

Historically, it was believed that women who were prone to addiction had dysfunctional personalities and were therefore incapable of mothering (Harmer, Sanderson & Merton, 1999). This idea has been difficult to overcome because of personal and community biases towards addiction, and as a result drug-dependent mothers lose their children to foster care more often than other mothers (Suchman et al., 2005). Further compounding this problem is the fact that many substance-abusing mothers report having had poor relationships with their own mothers and numerous studies link drug use to previous childhood experiences of familial hardship, conflict, abuse and/or neglect (Harmer et al., 1999). Thus problematic relationships become an intergenerational problem, which cannot be ignored. Although many substance-abusing women report difficulties with their parenting skills, perhaps due to their own experiences of being parented, it has been found that most do actually love and care for their children and are concerned about their parenting role (Harmer et al., 1999). Treatment programs designed to support the attachment between substance-abusing mothers and their children, in addition to drug counselling, are thus recommended as preventative measures to stop the cycle of intergenerational substance abuse. Due to their

didactic approach, the various psycho-educational behaviourally-oriented parenting training programs that are currently available are not always effective (Suchman et al., 2005), and thus a client-centered, narrative, arts-based treatment model is presented here as an alternative or adjunctive treatment to the existing programs available today.

Research questions. The primary research question that this study aims to address is: how can story-making in an art therapy group be used to support attachment between substance-abusing mothers and their children? Subsidiary questions, which help to direct this research, include: how can attachment-focused therapies address and hopefully prevent the multi-generational cycle of relational difficulties and substance abuse? And finally, how does one integrate attachment theory, a modernist, biologically-determined view of the human condition, with that of narrative therapy, a post-modernist theory, which emphasizes the multitude and subjectivity of human experience?

<center>**Literature Review**</center>

A review of the current literature pertinent to the development of a story-making art therapy program for substance-abusing mothers is presented below. Literature, on the themes of substance abuse in women, attachment theory, narrative therapy, and art therapy, is summarized from the related fields of psychology, psychiatry, social work and the creative arts therapies.

Substance Abuse & Dependence

Definition. The *Diagnostic and statistical manual of mental disorders* (DSM-IV-TR) defines substance abuse and dependence[2] as a "maladaptive pattern of substance use,

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[2] The DSM makes a clear distinction between substance abuse and substance dependence (the latter with more rigorous criteria, including the possibility of tolerance and/or withdrawal symptoms). For the purposes of this paper, however, these terms will be used interchangeably along with the terms "chemical dependence" and the more colloquial term, "addiction." The criteria presented here are those for substance

<center>3</center>

leading to a clinically significant impairment or distress" (APA, 2000, p. 197). A

dependent individual may compulsively use drugs despite such symptoms as: deleterious

effects to his/her social and occupational activities; the experience of *tolerance*, or the

"need for greatly increased amounts of the substance to achieve intoxication" (p. 192);

withdrawal, or the problematic behavioural and physiological changes when the

individual discontinues use of a substance after prolonged periods; and despite obvious

knowledge of the substance's harm. The substance is often taken for longer periods, or in

larger doses, than was originally intended, and the user may have tried to abstain but

cannot without great difficulty.

Substance abuse is a pervasive disorder that, according to the diagnostic criteria,

has the capacity to affect all arenas of daily life, including social, occupational, and

recreational functioning. Substance abuse is particularly detrimental to families: the

DSM notes that, "while intoxicated, the individual may neglect children or household

duties…and the person may continue to use the substance despite a history of undesirable

persistent or recurrent social or interpersonal consequences (e.g. marital difficulties or

divorce, verbal or physical fights)" (APA, 2000, p. 199). An individual may try, without

success, to abstain, however relapse is very common, particularly in the first twelve

months of recovery. Drug use is a dangerous cycle, which can quickly spiral out of

control, leaving a victim helpless and desperate.

The DSM is purely descriptive and offers no explanations as to the causes of the

various conditions it classifies. There are various hypotheses of the aetiology of

addiction: some regard it as a disease with a clear genetic predisposition (Erickson, 2007;

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dependence. Note that all women participating in this study met the requirements for the diagnosis of
substance dependence.

Johnson, 2010); symptomatology of other mental illness (APA, 2000); a result of familial, learned patterns of use and abuse (O'Gorman, & Diaz, 2004); or as a way of coping with trauma (Hans, 2000; McClean, 1999). In contrast to earlier views, which regarded addiction as a punishable, immoral vice, there has been an effort to determine the causes of addiction, by looking to neurophysiology, psychosocial risk factors, and trauma models (Muzak, 2009; Sanders, 2006). Most researchers agree that substance abuse is a complex, progressive, and chronic bio-psychosocial disease with many underlying factors (Matto, 2002).

Concurrent mental illness & polysubstance use. The DSM notes that "substance use is often a component of the presentation of symptoms of mental disorders" (APA, 2000, p. 204). Common concurrent mental disorders presenting with addiction include: conduct disorder in adolescents, and antisocial and borderline personality disorders in adults, as well as schizophrenia, bipolar disorder, mood disorders (typically depression and anxiety), eating disorders, and post-traumatic stress disorder (PTSD) (APA, 2000; Reed & Evans, 2009). Concurrent mental disorders tend to increase the individual's risk of poor outcome and these must be carefully considered when creating treatment plans for substance-abusing individuals. For example, the risk of suicide is high for individuals with a history of trauma. Furthermore, individuals with a diagnosis of substance abuse/dependence may actually use several different substances, termed *polysubstance abuse*. For example, an individual may use one substance to counteract the negative side-effects of another.

A number of studies have found that the psychiatric concurrentity of addiction with certain mental illnesses (typically eating disorders, PTSD, mood disorders, and

personality disorders) is generally more common for women than for men. For example, the prevalence of bulimia nervosa is approximately ten times greater in women than men; correspondingly, the prevalence of bulimia is about ten times greater in women with addiction than in the general population (see Reed & Evans, 2009). Prevalence rates for depression are much higher for women than men, with corresponding rates among those who use substances (Reed & Evans, 2009). These findings may be confounded with incidences of childhood sexual abuse, which are also associated with depression, bulimia and substance abuse.

The medical disease model. According to the American Medical Association, substance abuse is a disease with a clear genetic predisposition towards using and then abusing substances (Erickson, 2007; O'Gorman, & Diaz, 2004). The disease model of addiction, which views chemical dependency as essentially chemical imbalances in the brain, came about in an effort to reduce some of the moralistic and judgemental blame associated with the Temperance and Prohibition eras (Sanders, 2006). Sanders notes, however, that although this model does remove some of the blame and stigma associated with addiction, it has the potential to be equally oppressive. The disease model pathologizes the individual, labelling addiction as an illness residing within the person, while disregarding the socioeconomic and cultural context in which addiction typically occurs. The psychosocial risks of addiction will be discussed in greater detail below.

Neuroadaptation theory. Regardless of whether or not one subscribes to the theory of genetic susceptibility, it is recognized that drug users may easily fall into the virtually inescapable pit of addiction, as ongoing drug use causes structural and functional changes in the brain at the neuromolecular level (Erickson, 2007; Johnson,

2010). This is a function of *neuroplasticity*, a popular concept which suggests that the brain can change itself as a result of both internal and external (environmental) factors. These changes may not be permanent but they are quite persistent, and make recovery a difficult process for both the client and mental health practitioner alike (Johnson, 2010).

Chemical dependence is a dysregulation of neurotransmitters, or chemical messengers, in the brain. The drugs involved in dependence typically act by mimicking the actions of neurotransmitters, particularly those in the mesolimbic dopamine system (MDS), the pleasure or "reward centre" of the brain. These drugs essentially fool neuroreceptors into maintaining higher levels of the neurotransmitters that cause pleasurable feelings (Erickson, 2007; Johnson, 2010). The *neuroadaptation* theory suggests that dysregulation of the MDS occurs with chronic drug use, and is particularly pertinent for individuals with genetic susceptibility to addiction (Erickson, 2007; Matto, 2002). Overtime, the brain will adapt to the chemical dependence, attempting to maintain equilibrium, by either producing more/or less receptors and/or levels of neurotransmitter, and thus the user requires more and more of a drug in order to enjoy its desired effects (i.e. *tolerance*). Chronic drug use produces changes in three main functions of the brain: somatic function, the reward system (including motivation and volition), learning and memory (Johnson, 2010).   As the effects of drug dependence are many and far-reaching, it would follow that treatment should address many processes, including bodily, affective, and cognitive functions.

There has been little research done on the differential effects of substance abuse among men and women at the neurophysiological level. This is an interesting avenue for further research, as it has been found that the varying hormonal changes throughout

women's menstrual cycles differentially affect their experiences of drugs, particularly of stimulants (Reed & Evans, 2009). Conversely, substances can have effects on women's fertility and pregnancy cycles (Zilberman, 2009). Metabolism and sex differences due to body weight may play a role in addiction as well. Interestingly, it has been found that women respond to stress differently than do men, with some reports of elevated stress hormones in women (see Reed & Evans, 2009). This is important to consider as the stress hormone cortisol has been found to increase drug cravings. These findings hold further implications for therapy for substance-abusing women, particularly in regard to strengthening coping skills in response to stress.

Conditioning. Emotion and learning play a role in the neuroadaptation theory of substance abuse. Memories of an emotional nature are long-lasting, and an individual's pleasurable experience of a drug will be remembered and easily triggered by external cues that have become associated on a behavioural and neurological level through the processes of conditioning and reinforcement (Johnson, 2010). Even without the presence of the drug itself, the external cues may induce relapse without the client's conscious awareness (Erickson, 2007). As a result, changes in neural structure, combined with the quick association of environmental stimuli and pleasure, makes drug use difficult to overcome. It is likely that chemical dependence is a combination of neuromolecular changes, external cues, and various contextual factors. Environmental risk factors that may interact with a genetic vulnerability to addiction include childhood trauma, poor attachment experiences, malnutrition, toxic pollutants, and concurrent mental illness, to name but a few (Johnson, 2010).

Self-medication hypothesis. Individuals with chemical dependence cite a number of reasons for using drugs: to feel good, to numb emotional pain, to ease interpersonal interactions, and to relieve stress (Perlmutter, 1992). Drugs are most commonly used as a form of self-medication to help cope with psychological distress – as a way to fill the "emptiness" described by many users, to compensate for negative feelings, or to block out intrusive traumatic memories (Dempsey, 2009; Suchman et al., 2005). Initially the drug makes living easier and/or more enjoyable, however after this "flirtatious" period comes a period of dependence, tolerance, and ultimately betrayal (Perlmutter, 1992). It becomes a vicious cycle in which the user may take drugs to help cope with psychological distress, however she may then have trouble coping with the physiological and social repercussions of drug misuse (Matto, 2002).

Trauma is cited as one of the most common reasons for using drugs. Statistics vary, however it has been estimated that between one and three-quarters of all drug-users have a history of abuse (Harmer et al., 1999). Traumatic childhood experiences in particular (e.g. emotional neglect, and physical and sexual abuse), if left unaddressed, can make people more vulnerable to distress later on, and ultimately distrustful of intimate relationships, resulting in difficulty coping and possible drug use (Luthar & Walsh, 1995). Addiction leads to profound isolation, as an addict's primary relationship is with his drug of choice and not with other humans (Wilson, 2003). Thought distortions and denial are common responses to isolation, and many substance-users experience their compulsive behaviour as a total loss of control over their lives (Wilson, 2003), resulting in low self-esteem, helplessness, and expressive communication difficulties (Waller &

Mahony, 1999). It seems that intense feelings of shame, worthlessness, powerlessness, low self-esteem and a sense of failure lie at the core of addiction (Wilson, 2003).

There are some studies to suggest that women may use drugs to self-medicate more than do men. Adolescent females may begin taking drugs for different reasons than do their male counterparts: the majority of boys begin drinking or experimenting with drugs out of a sense of curiosity or from peer influence, while girls typically begin taking drugs or drinking to cope with feelings of low self-esteem, shyness, anxiety, and/or depression (Zilberman, 2009). An American national survey found that college women who had reported childhood sexual abuse had higher than normal co-occurrences of mood disorder and/or anxiety, substance abuse, and sexual dysfunction (as cited in Zilberman, 2009). It is also important to note that childhood sexual abuse is more common among women than men. Statistics vary, but of the women polled who were in treatment for substance abuse, as many as 80% have been victims of childhood sexual abuse (Simpson & Miller as cited in Reed & Evans, 2009).

Psychosocial risk factors. There are numerous psychosocial risk factors associated with substance abuse, including low-income, minority status, a loss of social-support, history of criminal activity, family history of drug and alcohol use, victimization and stigma (Luthar & Walsh, 1995). Women seem to be particularly vulnerable to the effects of these psychosocial risk factors. For example, Reed and Evans (2009) noted higher rates of alcoholism among women with family histories of alcoholism. The negative outcomes of chemical dependence are particularly difficult for substance-abusing mothers who face more psychosocial obstacles to recovery (Luthar & Walsh). Addicted women with children are more vulnerable than men because of the financial

and legal demands of abusing drugs whilst caring for their families (Harmer et al., 1999). Financial difficulties may force substance-abusing mothers into crime or prostitution in order to pay for their children and/or drug habit, and they are often involved in abusive relationships, causing their children to be removed and put into institutional or foster care (Waller & Mahony, 1999). Various environmental risks tend to accumulate, and the dual-diagnosis of depression and substance abuse is quite common for mothers, particularly for those who are of minority status and are single-parents from low socio-economic backgrounds (Beckwith, Howard, Espinosa & Tyler, 1999). Substance-abusing women, especially mothers, tend to battle more social stigma than addicted men, and are further victimized because of it (Suchman et al., 2005). Suchman and her fellow researchers claim that substance-abusing mothers represent one of the most underserved groups in need of assistance within the field of mental health.

Risks for substance-abusing mothers and their children. The misuse of drugs during motherhood undoubtedly has an effect on the children who grow up in its shadow. The adverse effects of substance abuse during and after pregnancy are well-documented (see Zilberman, 2009), including higher incidences of miscarriage and stillbirth, pre-term deliveries and generally low birth weight, slower development (e.g. Foetal Alcohol Syndrome), some behaviour problems (including problems with attention and impulsivity), and later substance abuse. Fortunately, and perhaps due to the greater awareness of the effects of substance use during pregnancy, there is evidence that more and more women reduce or even stop using drugs during pregnancy. The challenge for these women lies in maintaining abstinence after their children's birth.

Declining incidences of prenatal substance use should be celebrated cautiously, however, for in regard to children's mental health, William and Ross find that the physiological and psychological effects of prenatal cocaine exposure are practically non-existent when the effects of psychosocial risk factors like malnutrition, socioeconomic status, and maternal age are considered (as cited in Zilberman, 2009). In one study of substance-abusing mothers, Hans (2000) found that the mothers tended to experience more chaotic lifestyles, were living in possibly dangerous conditions, were more likely to have experienced sexual abuse as children, and were more likely to be currently living with abusive partners. It is important to note that these risk factors likely have an effect on children's development independent of substance abuse, as it is difficult to tease out the effects of substance abuse from risk factors. In the study, Hans (2000) assessed the mothers on 9 different psychosocial indices, all of which were found to have some influence on their children, including: socioeconomic status, course of pregnancy, antisocial behaviour, psychosocial stressors, intelligence, education, age at childbearing, social support for childrearing, and marital status. An accumulation of risk factors was most associated with poor parenting, and also related to the children's poorer mental, motor, and social development. Consistent with the self-medication hypothesis of addiction, drugs are often used by women to defend against the anxiety caused by painful childhood experiences. An experience of mistreatment during her childhood will affect a mother's capacity to care for her own child, causing an intergenerational cycle of trauma (Harmer et al., 1999). Before discussing the effects of intergenerational trauma and substance abuse further, it is important to have a basic understanding of attachment theory.

Attachment Theory

  The evolutionary value of attachment. Bowlby (1969) defined attachment as

the emotional bond between a primary caregiver, usually the mother, and her child. This

bond is instinctual, and serves an evolutionary purpose which maintains the child's safety

and security. Bowlby, drawing on Harlow's earlier work with rhesus monkeys, found

that infants have basic physiological needs, not only for food, but also for warmth and

touch. Infant "signalling behaviours" like clinging, crying, and smiling, all work to

ensure a child's proximity to his mother, who maintains the comfort and security of her

vulnerable and defenceless child.   A sensitive and attuned caregiver responds to her

baby's needs, showing the infant that protection and care is always available and that he

is worthy of affection (Ainsworth, Blehar, Waters & Wall, 1978). Attachment is a

reciprocal phenomenon, in which the child's behaviour ensures the mother's care, and the

mother's constant attention reinforces the child's attachment behaviours. Winnicott

(1988), renowned paediatrician and maternal-infant mental health specialist, summarizes

the mother's care with the concept of *holding* – she literally holds the baby to prevent

him from falling, ensuring his physical safety, and metaphorically contains him with her

soft gaze and soothing actions (e.g. murmuring, caressing). This gaze further acts as a

mirroring function to teach reciprocity and empathy. Winnicott (1988) says that infant

mental health and development depends on the good holding of a caring adult.

  Children begin to develop a preference for attachment figures usually after eight

months (Hanson & Spratt, 2000). At this point, the child actively seeks to be close to this

figure through "goal-corrected" behaviour in which she anticipates what her caregiver

will do, provided that the caregiver is reasonably consistent (Bowlby, 1969; Ainsworth et

al., 1978). As the child matures, she becomes more curious, and is able to use her mother as a "secure base from which to explore" the world (Bowlby, 1969, p. 208). The child makes brief forays away from her mother, always returning at times of distress to seek reassurance and comfort. These periods of separation and exploration promote autonomy and help the child to gradually separate from her mother. As a result of the gradual and healthy process of maternal distancing, or gentle "rebuffs," the child comes to understand that her mother has independent motives and feelings. This is a more sophisticated form of attachment formed at approximately three years in which the child internalizes her caregiver's goals and values to form an unconscious *internal working model* of interpersonal relationships that affects her later relationships. This internal model consists of expectations of the behaviour of herself and others, an internal representation of herself as worthy and lovable, and her basic sense of trust in the world. This internal working model forms the basis for an individual's patterns of relating to others, and thus her subsequent intimate relationships have their roots in these early caregiving relationships. Winnicott (1988) recognized the role of attachments in forming internal working models which affect later relationships – he says, "the [first relationship] sets the pattern for the child's capacity for relating to objects and to the world" (p. 64).

Attachment has direct implications for healthy development from a physiological perspective. More recently, neurobiologists have supported the attachment theory, theorizing that the attunement between a mother and her infant impacts the maturation of the baby's brain, particularly in the first two years when neural circuitry is being established (Schore, 2001). The emotional exchange between infant and caregiver promotes the development of neural networks, particularly in the right hemisphere, and

those areas responsible for affective processing, self-regulation, and stress modulation (Schore, 2001). Thus brain maturation depends on early affective inter-relational experiences, which ultimately forms the basis for emotional regulation and one's implicit sense of self (Hardy, 2007; Proulx, 2003; Schore, 2001).

The relationship with mother is the child's first, and her constant care promotes physical and emotional security, or *secure* attachment, and models a way of interacting with others later in life (Bowlby, 1969; Ainsworth et al., 1978). Winnicott (1988) suggests that most mothers are "good-enough" mothers, who follow their instincts in creating a facilitating environment that is supportive yet not suffocating (p. 11). At first, the mother completely surrenders herself to the needs of the baby, supporting him, and helping the child to regulate his needs and emotions, until the point at which he *needs* her to fail occasionally in order for him to develop autonomy. The *developmental paradox* refers to the idea that emotional closeness between parent and child ultimately requires some distance in order to promote the child's autonomy (Senekjian & Trad, 1994). Winnicott notes that, at first, "to a large extent she is the baby and the baby is her," but then "… what with luck grows into a baby, and becomes autonomous, biting the hand that fed it" (p. 6).

Insecure attachment. At its most basic level, attachment involves the process of using others to help manage threat. Securely attached children reasonably come to expect that when they are upset, a caring adult will come to comfort them, and they in turn seek out reassurance. In some circumstances, such as mental illness, or addiction, adults may be completely unavailable or inconsistently available to comfort their children, resulting in *insecure* attachment (Ainsworth et al., 1978). Children may develop short-term coping

strategies to deal with this disruption of care: for example, clinging to an inconsistent parent, or numbing their emotions in order to avoid becoming hurt further. Ainsworth and her fellow researchers (1978) greatly contributed to the field of attachment theory by creating the "strange situation" in which children, upon being reunited with their parents after a brief separation, were found to react very differently, depending on how they had bonded with their parents. Some were happy to be reunited (*securely attached*), some were clingy, anxious and angry (termed *resistant/ambivalent*), some feigned disinterest (*avoidant*), and some were disoriented (*disorganized*). These attachment styles tend to persist into adulthood, resulting in corresponding adult attachment patterns.

As attachment is noted as being an interactional process, attachment problems may arise as a result of a child's unique temperament or disability, or as a result of the emotional or physical unavailability of his caregiver (Bowlby, 1969). This may be due to a caregiver's physical or mental illness, addiction, disability or extended periods of separation resulting in what is termed *pathogenic care* (Wilson, 2001). A child develops a negative internal working model in which he conceptualizes the world as a dangerous place, in which he is unlovable and thus no one will help him – pathogenic care leads to insecure attachments resulting in a child's poor self-esteem and low expectations of his relationships with others (Winnicott, 1988; Hanson & Spratt, 2000). Securely attached individuals are comfortable showing their distress in order to obtain support and assistance from others, while those insecurely attached individuals may have learned that they don't receive support and so fear being vulnerable and displaying their suffering (Dallos, 2006). Thus, those who need help the most are often those most afraid to ask. Such is the case with addiction: unaccustomed to support from intimate others,

individuals may turn to drugs for help in coping (Flores, 2004). Springham (1998) additionally suggests that clients with addiction problems typically use substances as a replacement for meaningful relationships with other people, as others typically fail to offer the perfect reciprocity and empathy that was lacking in their childhood.

Contrary to popular notions of the resiliency of children, those with attachment difficulties are generally more susceptible to life stressors (Hardy, 2007). An association has been found between later physical or mental illness and attachment problems (Fonagy et al. as cited in Hardy, 2007). Biologically, early relational trauma can alter a child's neurochemistry, especially that of hypothalamic-pituitary adrenal (HPA) axis, which hyperactivates the child's stress response and can affect her immune system (Hanson & Spratt, 2000). Psychological implications of right-brain deficits from early trauma include the poor processing and integration of social, emotional, and bodily information (Klorer, 2005). While trauma has clear detrimental consequences to infant development, under-stimulation from emotionally unavailable parents can be harmful as well. Stimulating parent-child interactions help to "wire" the brain, strengthening and/or pruning certain synapses in the brain (Schore, 2001). Stimulating communication between parent and child is mutually beneficial, affecting the child's personality development and her overall social and emotional development.

A number of clinical practitioners today are critical of attachment theory, slating it as a form of "mother-blaming" (Dallos, 2006). Post-modernist theorists are typically wary of any theory that attempts to categorize individuals, and suggest looking at socio-cultural norms of what is considered to be good parenting instead. It is important to note, however, that Bowlby was himself wary of typecasting. Winnicott (1988) too was

cautious of mother-blaming, and developed the term *good-enough mothering* in order to prevent over-idealizing a mother's role, or the expectation of perfection. It should also be emphasized that attachment theory highlights the interactional nature of the mother-child relationship, in which one's behaviour affects the other, and vice versa (Bowlby, 1969). Attachment needs of parents and children are mutual – not only do children require love and support but parents need physical contact, smiling, and reciprocity in order to feel bonded to their children. Inborn tendencies in a child may exacerbate certain disciplinary styles in her mother which later affects the child's behaviour – thus attachment problems can be cyclical and compounding (Proulx, 2003). Furthermore, a mother's relationship with her child must be regarded within the greater context of her family, for the way she relates to her child is undoubtedly a product of her own internal working model, developed in childhood. Winnicott recognizes that "[the mother] has memories of being cared for, and these memories either help or hinder her in her own experiences as a mother" (p.6). Thus a mother's own internal working model, based on how she was raised, subsequently affects the way she parents her child. These relationship difficulties may be most significant when a child reaches the age at which her mother may have had a traumatic experience (Proulx, 2003). Attachment difficulties become an intergenerational problem, with more and more entrenched familial patterns developing after several generations.

Attachment between substance-abusing mothers and their children.
Numerous studies link drug use to familial substance abuse and many addicted mothers report having difficult relationships with their families, particularly with their primary attachment figure (see Harmer et al., 1999). Hans (2000) conducted a ten-year

longitudinal study of mothers using opioids during pregnancy (n=36). He looked at later parenting styles and compared these with non-using mothers (n=41). In general, Hans found that, in the first two years, substance-abusing mothers were less warm, responsive, and attuned to their babies; however, they were similar to controls in providing stimulating activities with enthusiasm and energy. These results were consistent with other studies in which substance-abusing mothers were found to be less socially engaging (as evidenced by less physical and eye contact) and to have less positive affect. These women also experienced the role of motherhood to be less rewarding.

Later parenting problems have been noted with respect to parental discipline and control. Substance-abusing parents are described by Cork (1969) as either completely permissive or authoritarian. One child said, "We all get away with anything and they don't care…They don't know what's happening to you. You feel sort of alone" (p. 9). In a study of children's perceptions of their substance-abusing mothers, Marcus and Tisne (1987) found that children subjectively experienced lax discipline and non-enforcement of rules in general; however, the discipline that was used incorporated psychological guilt as a form of control. The authors hypothesize that the mothers themselves felt guilty, and to cope with its associated anxiety projected that guilt onto their children. Finnegan et al. (1981) note huge variations in the parenting skills of substance-abusing mothers (as cited in Hans, 2000). Those mothers grappling with concurrent personality disorders, depression, and chronic stress along with substance abuse displayed the most insensitive parenting styles and trouble with discipline.

Caregiving disruptions in early life clearly have an impact on children's development. These disruptions are especially problematic in the first 18 months of life

as a child does not have the opportunity to securely attach to one parent (O'Gorman &

Diaz, 2004). Many preschool children experience disruptions in maternal care. Statistics

vary, but between one-quarter and half of the young children of cocaine and heroin-

addicted mothers are cared for by extended family members, foster families, or are living

with multiple families along with their mothers (Hans, 2000). These numbers tend to be

even higher with school-aged children. Alarmingly, it has been suggested that there is

little difference between the quality of care offered in extended family members' homes

and the substance-abusing parent's home. It would seem likely that both environments

contain the same psychosocial risk factors that contributed to a mother's initial drug use.

In the substance abuse literature, there is a marked difference in family

functioning that is dependent on *wet cycles*, when a parent is using, and *dry cycles*, when

a parent is sober – terms first described by Bowen (as cited in O'Gorman & Diaz, 2004).

Typically, during a wet cycle, the family is more engaged with each other, both talking

and hugging, and then fighting, called the "intimacy ritual" (O'Gorman & Diaz, p. 158).

The dry cycle, conversely, is characterized by an absence of contact, alienation, and

fragility. It seems that being connected, even if painfully so, is more desirable than

alienation, as it is during this period of withdrawal that family members try hard not to

trigger another bout of substance use – and when they do, inevitably, they feel guilty.

Conflicting familial rules generate a sense of learned helplessness, as children

find that their behaviour is rewarded at some times but not others (Seligman as cited in

O'Gorman & Diaz, 2004). Children become hyper-vigilant and sensitive to external

cues, quickly learning to assess family dynamics in order to decide which set of rules to

follow. Because children of substance abusers react to others' feelings, and not their own

internal sense of right and wrong, it has been suggested that they have difficulty in developing a sense of self. This learned helplessness causes anxiety, and becomes generalized to other relationships and life problems. Other common effects of parental substance abuse in children include *parentification* (a role reversal in which the child takes care of the parent-figure); isolation due to family secrecy, stigma, and shame; internalizing problems (anxiety or depression) or externalizing emotional problems (behavioural problems and delinquency); and confusion concerning inconsistent parenting (Bubbra et al. 2008). The effects of parental substance abuse on children are diverse, and affect children differently. Why some children are affected more than others may be due to individual differences in *resiliency*, or one's capacity to cope with stress.

Cork (1969) performed one of the first definitive studies of children's perspectives on living with addiction.   She interviewed 115 children, all of whom had one or more parents with an addiction to alcohol. Alcoholism is considered to be one of most common substance abuse disorders (Zucker et al., 2000). This is likely due to the fact that alcohol is both legal and affordable as compared with other substances, yet its effects are just as damaging to family relations, as can be seen in the children's remarks. One twelve-year-old said this about what it means to be addicted to alcohol:

> It's somebody that has a problem. Like my Dad not being happy in
> childhood. Alcoholics don't want to think of anything but themselves, or
> they want to forget something. It's like there's a door and they won't
> open it because they're afraid, so they drink. Sometimes it's like he's not
> there.   (p. 10)

The children's viewpoints are important, as it has been noted that children's perceptions of their parents may be more important to their future development than actual parental behaviours (Marcus & Tisne, 1987). The children in Cork's study described many adverse effects of living with alcoholism. The main problems described were: negative effects on interpersonal relations; parental rejection; a lack of self-confidence; feeling constantly ashamed and hurt, and prone to excessive crying; and anger and hostility to parents and other authority figures. Other concerns included anxiety, worries about the future, problems with school, thoughts of escape, feeling burdened by responsibility, and feelings of hopelessness, depression, and fear. It has been found that children of substance abusers are nearly three times more likely to be abused than other children and as much as four times more likely to be physically and emotionally neglected than their peers (see O'Gorman & Diaz, 2004). As a result of these abusive and dangerous living conditions, as well as parental drug-related criminal charges, incarceration, illness, violence, and death, many children of substance abusers are faced with parental separation and loss. Children of substance abusers account for many cases of foster care placements and child maltreatment cases in courts.

Treatment

   Treatment of substance abuse. There are numerous approaches to the treatment of substance abuse. Some commonly used models of treatment for addiction include the 12-steps approach (i.e. Alcoholics Anonymous, and Narcotics Anonymous), peer support groups and therapeutic community (TC)[3], motivational interviewing and solution-focused

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[3] An in-depth exploration of the variety of treatment models for substance abuse is beyond the scope of this paper. The therapeutic community (TC) model, however, will be elaborated on briefly as it is the model espoused by the rehabilitation centre in which this research took place. TC was originally a grassroots concept founded by recovered addicts that grew out of the notion that a group made up of people with

therapies, relapse prevention coaching, and cognitive-behavioural therapy (see Johnson, 2010). Some of these methods advocate total abstinence while in therapy, while others may be used in conjunction with a harm reduction approach and other pharmacological treatments (methadone maintenance, for example, in which methadone is taken in lieu of heroin to counteract the physiological effects of withdrawal). These methods are available in a variety of formats, including intensive outpatient day-programs, short-term hospitalization, 28-day residential treatments, specialized long-term residential programs, community housing-placements, weekly support groups, and individual psychotherapy (see Matto, 2002). More and more, as researchers are coming to recognize the complex bio-psychosocial nature of addiction, they are supporting the need for multi-faceted and comprehensive approaches that address the varied individual needs of those with substance abuse. The American National Institute on Drug Abuse calls for comprehensive treatments that attend to all avenues of an individual's life, including: employment, mental health, medical, educational, legal, financial, housing, family, and child care (as cited in Matto, 2002).

Treatment needs of substance-abusing mothers. Substance-abusing mothers have additional treatment needs above what the standard addiction recovery methods provide, such as those that address experiences of sexism, trauma, and difficulties related to parenting. Substance-abusing mothers cite financial difficulties and social stigma as the most common reasons for not seeking and/or receiving treatment (Zilberman, 2009). Wilson (2003) notes that feelings of shame, worthlessness and personal failure lie at the

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similar experiences has the potential for healing. Healing factors are thought to include: catharsis through the public confession of inner conflicts, empowerment through responsibility, and playing a role in the community hierarchy. The first example of TC for addictions treatment was *Synanon* in Santa Monica, California in 1958. TC led to a change in the organizational structure of hospitals whereby tasks were delegated to patients, giving them greater authority (Forizs, 1959).

core of many addiction problems. These feelings are so toxic that substance-abusing individuals resist treatment or, whilst in treatment, try to mask them with denial, anger, and non-compliance. These hostile behaviours may be further accentuated by a fear of judgment regarding parenting skills (Parashak, 2008). Contrary to the traditionally confrontational approaches of substance-abuse counselling, it is imperative that treatment for substance-abusing mothers be non-judgemental and supportive. Interestingly, research suggests that clients with different attachment patterns respond to therapy differently. Indeed, Janzen and others (2010) have found that, unlike clients who typically have secure interpersonal relationships, clients with dismissing or fearful attachment styles respond best to supportive rather than confrontational or exploratory therapeutic interventions. Supportive treatment may further help to contradict these individuals' expectations of constant rejection.

Luthar and Walsh (1995) suggest designing treatments that speak especially to women's particular lifestyles and gendered relational styles. Women may be more suited for discussion-focused group therapy than didactic psycho-educational parenting programs. Additionally, substance abuse treatments must address the needs of the overwhelming number of women who have experienced childhood sexual abuse, as their needs may differ from other women and men with substance abuse disorder (Reed & Evans, 2009). Substance-abusing individuals who have also suffered from abuse are more vulnerable to the development of PTSD, and thus these treatments must first address underlying emotional and relational trauma before treating the symptom of addiction.

Greenfield et al. (2007) note that single-gender treatment groups are common for men and women with addiction, however they do not find that these models are more effective than mixed-gender models. Instead, it is found that programs that target specialty subgroups, such as those for substance abusers with concurrent depression, or for substance-abusing mothers with children, are more helpful. Behaviourally-oriented psycho-educational programs to teach parenting skills are the dominant treatment modes for substance-abusing mothers, however Suchman et al. (2005) find that these kinds of parent training programs have "limited success" in improving relationships, thus attachment-based programs are needed. The cyclical nature of attachment difficulties needs to be addressed in treatment by examining mothers' own experiences of being raised and their current experiences raising children (Harmer et al.,1999). Fraiberg (1975), a pioneer in dyad therapy for mothers and infants, notes the importance of connecting a mother's current difficulties with her past in order to exorcize the "ghosts in the nursery." She says, "the ghosts, we know, represent the repetition of the past in the present" (p. 102). Many addicted mothers experience fear, guilt, concern, and confusion over the quality of their child-rearing skills (Luthar & Walsh, 1995), thus showing them the cyclical nature of attachment difficulties removes some of the blame and helps them to understand its contextual nature. Treatment of substance-abusing mothers should address not only addiction, but also such diverse concerns as inadequate parenting skills, social isolation, poor self-esteem, relational trauma, and reduced emotional expression.

Group therapy. Group therapy is cited as one of the many ways in which treatment can meet the specialized needs of substance-abusing mothers. Group therapy has been advocated by such therapists as Yalom (1985), as clients have the opportunity to

be helped by helping others. Social support has been found to be a "critical buffer" for the stress associated with the multiple socio-demographic risks for substance abuse (Suchman et al., 2005). Addicted women are generally socially isolated from former friends and family, while drug-using peers tend to provide distorted support which is often lost when the user decides to seek counselling (Harmer et al., 1999). Having children tends to further restrict mothers' social involvement, subsequently causing them to lose what little social support they have (Luthar & Walsh, 1995). A gender-based model suggests that women can be understood better in the context of their relationships (Luthar & Walsh, 1995), thus women benefit more from a nurturing and supportive communal environment. Group therapy offers women a chance to support, validate, and empower each other by experiencing the universality of their problems and concerns, and by sharing strategies and resources, thus learning from each other's experiences. The group process can break down the barriers of mistrust, establishing relationships between members, thereby providing the much-needed social support that many substance-abusing women lack (Harmer et al., 1999; Luthar et al., 2005).

Dyad therapy. Therapy in which mothers have the opportunity to work with their children together, can additionally support the relationship problems between substance-abusing mothers and their children by working in the "here-and-now" (see Yalom, 2005), or at the "kitchen sink" (Fraiberg et al., 1975). As Winnicott (1988) notes, there is no baby without his mother. Thus infant and maternal behaviours cannot be viewed without the context of the other. Observing parents and children playing together provides important information on family structures and internal models of relationships (Proulx, 2003). Family therapist Byng-Hall (2001) describes dyad therapy from an

attachment theory framework. He notes that the transference relationship between the therapist and her clients in therapy can similarly act as a secure base from which families can explore their interpersonal problems. Families can try out new ways of relating to each other, knowing that the therapist is there, like a watchful mother, in case of trouble. Security within therapy is not only important for members to feel safe enough to explore difficult emotions, but it also provides a kind of reparative parenting relationship which can serve as a model or parallel for parents within a parenting group. Thus, rather than teaching parenting skills to substance-abusing mothers, group dyad therapy for mothers and their children is suggested as an alternative to dealing with attachment difficulties as they arise. It is worth noting here that attachment theory is one of the few psychological theories that has not given rise to one particular mode of therapy (Dallos, 2006). Various treatment models have been utilized from the theoretical basis of attachment theory. A case for a narrative approach to attachment theory is presented below.

Narrative Therapy

      Post-modernism. Narrative therapy (see White & Epston, 1990), rooted in systemic family therapy and post-modern philosophy, is a relatively new treatment modality that may be helpful in responding to the unique experiences and treatment needs of substance-abusing mothers. In contrast to modernism, which seeks to discover the objective truth through observation and scientific experiment, *post-modernist* thought suggests that our daily experiences are the only thing that is truly knowable (Payne, 2006). Post-modernism suggests that there is no "right" way of being in the world; rather, each of us has a subjective experience of the world heavily influenced by cultural and social lenses. *Systems theory* looks at behaviour in context – it suggests that the way

we act is a product of our role in the system, be it the family system, institution, or greater social system. *Social constructivism* further suggests that our reality is in fact a product of our own construction – we shape and reshape our understanding of the world based on our interactions with people. These philosophies promote a collaborative approach to therapy, for if there is no right way of being in the world, than we must work together to co-construct a reality that affirms each person's particular experience in a positive and personally fulfilling way.

Collaborative, *client-centred* approaches to therapy regard the client as the expert of her own life, rather than the therapist assuming the expert, or teaching role (White & Epston, 1990). A collaborative approach to therapy has been found to be particularly empowering to chemically-dependent individuals, who may be resistant to positivist treatment approaches that are judgmental and confrontational (Groterath, 1999). *Empowerment* can be defined as self-efficacy (Bandura as cited in Wallace-DiGarbio & Hill, 2006). It involves taking responsibility for oneself in order to develop a personal sense of agency or power. Empowerment theory aims to change the client's belief in her own control and in the manageability of her problem, in this case addiction, and subsequently her life (Shearer & King, 2001). This theory is particularly pertinent to substance-abusing women who may have experienced a great deal of social stigma, leading to feelings of disempowerment and helplessness. Female addicts are subject to a great degree of guilt and shame because of their constructed social roles as nurturers (Muzak, 2009). Even when seeking health services, many women feel objectified and devalued by the medical profession, leading to increased psychological distress – anger, depression, and feelings of victimization (Malchiodi, 1997). Zilberman (2009) advocates

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the importance of early prevention for adolescent girls as they are prone to self-medication through drinking and drug use. Campaigns to reduce stigma are also necessary as Greenfeld et al. (2007) find that women are less likely to enter addictions treatment than men, although when they do their retention is generally comparable. Furthermore, Johnson (2010) suggests a psycho-educational component to treatment to educate users and their families about the neurological aspects of addiction in order to empower them and allow them to better understand and cope effectively with their illness.

Narrative therapy. White and Epston (1990) developed narrative therapy by drawing on the writings of Foucault and other social theorists on ideas relating to the position of language in knowledge and power. Narrative therapy is based on the premise that people conceptualize and express their experiences of reality through narratives. We are interpretive beings who come to understand ourselves and our place in the world through the stories that we tell ourselves. Narratives structure our mental processes, thus influencing the way we think, act, and relate to others and the world.

Post-modernist thought recognizes that knowledge is socially influenced and linked to our positions of power. Payne (2006) notes that people's narratives are typically "partial, selective, inconsistent and influenced by conceptual assumptions derived from wider society" (p. 6). Narrative therapy employs some techniques borrowed from cognitive therapy which encourage a re-structuring or re-framing of understanding in order to live more fully and happily. For example, the primary therapeutic technique, *externalizing*, in which a client is encouraged to name his problem, helps him to consider the wider socio-political contextual issues that might negatively

affect him.   The narrative therapy process then unfolds as follows: the client first tells his

dominant story, the "thin description" which is usually problem-saturated; by reflecting

on contextual factors and "unique outcomes" when the problem did not occur, the client

is encouraged to develop a richer narrative that considers diverging perspectives. Other

key narrative therapy techniques include: the use of therapeutic documents, such as the

creation of letters, memos, statements, lists, essays, contracts, artwork, or certificates,

which can be used later for consolidation; finding support in role models – termed the

"club of life"; and the use of "outsider witnesses" – such as inviting an audience to listen

to the client's story. These techniques support the client and hold him accountable, as

they are based on the recognition that words hold more power when others hear them and

read them in print (Payne, 2006). Narrative therapy has many commonalities with other

person-centred approaches in that the therapist does not take an expert stance, but rather

regards the client as an equal. The therapist's role is merely to accompany the client on

his journey, while fostering an atmosphere of acceptance. The primary goal is to

mobilize the client's own internal strengths and skills for living. Finally, the use of the

client's unique, individual story helps the therapist to personalize treatment and avoid

stereotypes.

Attachment narrative therapy. Although they stem from fundamentally

different philosophies, both attachment theory and narrative therapy attempt to explain

how human beings develop a sense of self in relation to the world, albeit with different

vocabularies and approaches. While narrative therapy looks at meaning and language to

see how problems become constructed, attachment theory describes how children form

internal working models of relating to others, which may become entrenched behavioural

patterns. The search for meaning is an emotional experience, inherent to the human

condition (Dallos, 2006). We make meaning by creating stories to explain our lives,

which may be based on the internalized beliefs and values we have learned from parent-

figures, through both their words and actions (Dallos, 2006). Personal meaning-making

comes from inner dialogues, where one examines and contrasts experiences to form

cohesive representations of things, termed cognitive *schemas*, a term attributed to

developmental psychologist Piaget (as cited in Bost et al., 2006). These schemas, or

models of how the world works, are useful in helping people to mentally try out new

behaviours and to make predictions when faced with new experiences (Craik as cited in

Dallos, 2006). These schemas are similar to the internal working models described by

Bowlby (1969). Newer research in attachment theory suggests that people guide their

responses to new relational figures based on narrative *scripts*, or if-then scenarios about

their security that correspond to their attachment style (Waters & Waters, 2006).

Individuals may behave in ways which elicit the expected response from the people they

interact with, thus confirming their scripts. Thus, patterns of relating become entrenched,

even if maladaptive.

Attachment theory can be linked with narrative therapy by further examining

these schemas or representations (see Main, Kaplan, & Cassidy, 1985; Bost et al., 2006).

Researchers now recognize connections between family relationships and internal

representations of the experience, termed *attachment representations,* or sometimes

attachment narratives (Bost et al., 2006). As parents tell stories (or scripts) to their

families, their children attempt to make sense or meaning of the experience, forming their

own internal representations and their own way of responding. These internal models

include beliefs and expectations about the self and others, definitions of words, shared understandings, and include what one is allowed to communicate about these. For example, children quickly learn the unspoken "family rules" (Dallos, 2006). This helps the dyad share a common perspective (May, 2005). There has even been research supporting the notion that attachment experiences influence not only content but manner or style of speech as well (Bost et al., 2006). Attachment thus may be reconceptualised as a way of communicating. Bowlby (1969) may have had an understanding of this when he noted that securely attached dyads had freer, more flowing communication. Thus, the narrative construction of experience, considered to be fundamental to the human experience, is actually made up of schemas, beliefs, and scripts learned in childhood. It has been found that poorly attached, disorganized children have not yet developed this skill – their narratives are found to lack internal organization and overarching structure, and they may be chaotic and disjointed (May, 2005; Dallos, 2006).

There are a few emerging treatment models combining narrative therapy and attachment theory. Attachment-focused therapies today focus, not on pathologizing or blaming the mother, but rather on making visible internal family dynamics to help mothers and children relate better and work as a whole (Dallos, 2006). Dallos proposes a model which examines personal narratives that specifically relate to the emotional content of intimate relationships. In the context of systemic family therapy, this would involve each member telling their own personal story and comparing perspectives. His model is based on four stages: the creation of a secure base (an emotional connection), exploration of personal narratives, exploration of alternatives and change, and integration and maintenance of the emotional contact. The therapist may take a more active role,

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such as that of an adjudicator, playing a role in the system itself. May (2005) developed

a form of family attachment narrative therapy for traumatized foster children who have

difficulty in attaching to their new parents. In her model, children's chaotic narratives

(internal working models) developed during their previous attachment experiences are

replaced with new reparative narratives told by the foster parents, which emphasizes their

understanding of the child's feelings and focuses on their love and care. This idea is

based on the research suggesting that listening to a story is essentially the same as

actually experiencing or observing the situation (Zwaan as cited in May, 2005).

Reflective dialogue that shows the children's understanding correspondingly helps

parents to feel more empathetic and bonded to their children. Interestingly, May found

that the parents' stories were most believable and effective when they were improvised,

and with genuine emotion, rather than when they were following a script created by the

therapist. This concept could be applied to the treatment of substance-abusing mothers

and their children. As substance-abusing mothers work to process emotions, they may

develop new ways of relating to their children. Telling their children new, parallel stories

may work to support secure attachment. Thus, rather than learning parenting skills in a

pre-fabricated psycho-educational parenting group, co-creating meaning through story-

making is hypothesized to be an effective method of supporting attachment in a treatment

group for substance-abusing mothers and their children.

Art Therapy

   The benefits of art therapy for substance-abuse. Art therapy, the use of

creative arts processes in psychotherapy, is one treatment modality that can be easily

applied to a group dyad format for substance-abusing mothers and their children. Art

therapy is recommended as a treatment of choice for individuals with substance abuse because of its non-threatening nature and ability to obtain a great deal of information quickly (Matto, 2002). Typically resistant clients may find the art process fun and alluring instead of confrontational and anxiety-provoking. Therapists typically describe chemically dependent individuals as some of the most difficult clients to work with, as they seem to be functioning neurotypically and yet constantly resist treatment and relapse despite knowledge of the drug's disastrous effects. It is important to note that drug cravings easily develop without the user's awareness of it, as the major portions of the mesolimbic dopamine pathway involved are subcortical, while it is the neocortex that is responsible for unique higher-order cognitive functioning, including meta-awareness (Erickson, 2007). Traditional "talk therapies" that rely on the client's conscious awareness of internal processes might be less effective for substance abuse than modalities like the creative arts therapies which have the ability to access the subconscious and non-verbal parts.

Art therapy has much to offer in the treatment of addiction, as either an alternate or adjunct to the more traditional treatments available. Several of the aforementioned addictions treatment models have also been adapted to fit within an art therapy framework (see Wilson, 2003). While substance-abusing individuals may use chemical substances to blunt affect, art has the capacity to enhance emotional awareness and facilitate emotional expression (Waller & Mahony, 1999; Horay, 2006). Art can bypass intellectual defences, directly tapping into raw emotion and pain in a non-verbal or meta-verbal way (Wilson, 2003). This process may be painful but it is not threatening, as transposing images from mind to paper can work to simultaneously contain the emotions

and distance the addict from the intense feelings of shame, anguish, and rage that often emerge (Waller & Mahony, 1999). Like story-telling, art-making offers the client a safe method of communicating via metaphor. Additionally, substance-abusing individuals can begin to learn to regulate their emotions when faced with the challenges of impatience, frustration, or a lack of confidence that occasionally surfaces when one is inexperienced with art materials (Matto, 2002). Gradually building up skill with the art materials helps a client to develop self-esteem and a sense of mastery while accepting personal limitations.

Art therapy has been found to be particularly helpful with traumatized individuals. Although telling one's story is an important step to recovering from trauma (Johnson, 2009), verbalizing traumatic experiences is occasionally re-traumatizing. Art therapy, as a non-verbal mode of expression, has an advantage over traditional "talk therapies" in that a traumatic experience may be more safely expressed through images rather than words. Furthermore, traumatized individuals may have difficulty remembering their experiences in words. Traumatic memories are typically stored in implicit memory and are sensori-motor or affective in nature (van der Kolk, 1994). These memories cannot be expressed semantically, thus a modality like art therapy that works on both a sensor-motor and visual level is posited as being uniquely effective for the treatment of trauma.

Visualizing a traumatic experience on paper helps an individual to process that experience and further acts to empower her. Merriam (1998) notes that the formulation of images made in art therapy provides traumatized women with a voice. Empowerment is additionally fostered by choice and the sense of agency afforded by creating one's own art product in art therapy. A sense of agency is particularly important when in an

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institutional setting, such as a restricted rehabilitation centre, where the routine of one's day is controlled by others (Merriam, 1998). Art production offers substance-abusing mothers a safe and acceptable way of revealing and liberating rage, a feeling which is often difficult for women to express in their gendered roles as nurturers. This is in accordance with White and Epston's (1990) assertion that physical documents and the printed word hold a power that the ephemeral spoken word does not have.

Art therapy to support attachment. Children also tend to find the art process appealing, while the safe therapeutic environment created by a supportive therapist creates a reparative re-parenting experience (Henley, 2005). The playful nature of art-making is also restorative and life-affirming, giving substance-abusers the opportunity to play and to re-experience their childhood. Wilson (2003) calls this the process of "healing the inner child" (p. 291). Proulx (2003) pioneered an approach to dyad art therapy for attachment difficulties. She stresses the importance of the child and parent creating artwork together in therapy, but at the developmental level of the child, with the goals of developing reciprocity and empathy. She also notes that attachment problems in parents may have begun early in life, at a pre-verbal age, therefore the use of non-verbal modalities like art therapy work well to unearth deep conflicts. Furthermore, the art therapy process can be utilized with very young children, who may not yet be capable of verbalizing their emotions.

Story-making in art therapy. Story-making is well-suited to art therapy in a group for substance-abusing mothers and their children. Both story-making and art-making are creative processes which, by working at a metaphorical level, are non-threatening and can bypass defences (Neill, 2008). A few therapists have discussed the

application of story-making in therapy, with some making recommendations for story structures, and others guiding the symbolic content. For example, Neill (2008) utilizes an educational approach when facilitating story-making sessions, teaching people the very basics of story-writing and telling. These include the use of a beginning, in which characters and settings are introduced, middle in which characters are developed and their motives are elucidated, and an end in which a conflict is resolved.

Lahad (1992) developed a story-making model to assess individual differences in coping responses. Although his model was initially designed for use in crisis intervention or acute stress, the model might also be used as a longer intervention to facilitate coping with chronic stress. Chronic stress is useful to address in substance abuse treatments as the self-medication hypothesis suggests that individuals may use and abuse drugs as a maladaptive way of coping. Lahad's six-part model asks the client: "(1) Think of a main character…(2) What is your hero's mission?...(3) Who or what can help the main character?...(4) Who or what obstacles stand in the way…(5) How will he/she cope with this obstacle?...(6) Then what happened?" (p. 157). These six elements are noted as being common to most fairytales and mythological stories told around the world. Jungian theory suggests that fairytales are a form of archetypal story with which everyone can identify, as they are rooted in individual experience (Lahad 1992; Neill, 2008). In Lahad's model, clients may choose to create imaginary heroes, however he finds that these are typically projected images of the self. The oral tradition of telling stories was seemingly intended for educational purposes – to instruct and guide people through the moral dilemmas of life (Neill, 2008). While the oral tradition is less prevalent in Western culture today, there are numerous published books designed for educative purposes. For

example, there are several children's books designed to explain the recovery process to children, such as *Mommy's gone to treatment*, or the colouring book *My dad is an alcoholic* (see www.parentbooks.ca for a complete list of children's-help books). Consistent with May's (2005) findings, an unscripted story, however, told by the child's own mother is the best kind of medicine. As such, a story-making art therapy group program in which substance-abusing mothers have the opportunity to create their own stories was envisioned as a therapeutic means of addressing attachment. The following sections describe the process of creating such a program, complete with a session-by-session description of results.

Methodology

One of Winnicott's (1988) most cherished ideas was that the mother is the expert of her family, and the health professional's job is to learn from rather than teach her about mothering. He says, "the scientist, if he cares to do so, may look with awe at the mother's intuitive understanding, which makes her able to care for her infant without learning" (p. 16). As I am neither a mother myself, nor have I been a substance-abuser, I thought it best to seek out the substance-abusing mother's "specialist knowledge" in order to design a program to suit her specialized needs. With its post-modern philosophical viewpoint, qualitative research seeks to discover the individual's unique experience, relying on the client's rich descriptive accounts and naturalistic observations as data (Marshall & Rossman, 2006). As such, a qualitative and exploratory method was thought to be the best way to respond to the research question, "How can story-making in an art therapy group program be used to support attachment between substance-abusing mothers and their children?"

The research process consisted of an 8-week long exploratory trial program at a residential rehabilitation centre for substance-abusing mothers and their children. My own field observations converged with feedback from the 7 participants, as well as theory drawn from the aforementioned literature, resulting in the subsequent creation of a more structured story-making art therapy program. This convergence of data, termed *triangulation*, is important as qualitative research is particularly prey to subjectivity if the researcher is not reflexive, or self-critical (Carolan, 2001). Triangulation, or the idea of "finding multiple perspectives for knowing the social world" by using multiple data sets or sources, is used to replace the numerical checks for validity and reliability common to quantitative research (Marshall & Rossman, 2006, p. 204). By soliciting others' viewpoints – in this case participant feedback and what others have described in the literature – I ensure that the following program is both valid and reliable. The following sections describe in greater detail the participants and data solicited for this project resulting in the final construction of a therapeutic story-making program.

Participants

A small, non-randomized sample of 7 participants, including 3 mothers and 4 preschool aged children, were involved in this study. These included Kay, and her 5-year-old daughter Issie; Sue, and her 3-year-old son Phillip; and Lucy, and her 2 sons, 3-year-old James, and 5-year-old Barry (note that all names have been changed to ensure confidentiality). There were originally an additional 3 participants, however these dropped out of the rehabilitation centre shortly after this study began. The participants were recruited from a residential drug rehabilitation centre where I had been completing my practicum requirements for 4 months prior to the start of this study. Participants

were already familiar with me and art therapy from a weekly drop-in group which I facilitated. At a centre-wide group meeting, I described the aims of the story-making program. I invited any women who were interested in the program to sign-up for further information at a private meeting. I sought between three and four pairs of mothers and children, as a relatively small group size was thought to foster intimacy, leading to further exploration and therapeutic benefit. Inclusion criteria included mothers with children over the age of 3 who were thought to be developmentally able to verbally and symbolically communicate ideas through art and story. Additional criteria included those who were able to commit to attending at least 6 of the 8 sessions in order to provide adequate time to complete the story-books, as well as to ensure that on any given day a minimum of 2 participants were present.

Setting. The residential drug rehabilitation centre where this research took place is part of a larger organization in a downtown urban core, with multiple centres for specialized populations. The specialized population at this particular site is chemically-dependent mothers with children from infancy to 6 years of age, who choose to enter treatment of their own volition. The mother-child pairs live in dorm-rooms with shared kitchens. Consistent with the therapeutic community "self-help" model which the centre endorses, the mothers take turns with chores such as cooking meals for each other, cleaning, and looking after each others' children in the nursery and daycare while the remainder are in counselling throughout the duration of their year-long stay. Residents cycle through graduated phases of the recovery program with corresponding increases in authority and responsibility within the community. It is one of few residential treatment centres where children reside with their mothers, rather than staying with extended

relatives or in foster care. Children attend daycare or school while the mothers attend daily group therapy, peer support groups, and psycho-educational parental competence training. While this model keeps the family unit together, ensuring the continued bond between mother and child, the substance-abusing mother must face the dual burden of recovering from her addiction whilst raising her (and other people's) children. This is particularly tiring for women who must learn new coping skills to handle the chronic stress for which they may have previously turned to drugs.

Data

Participant feedback. Primary source material was collected from the participants in the form of short questionnaires. The mothers were invited to fill out the questionnaires themselves, and were also requested to read the questionnaires to their children and then to record their oral responses. 4 of the participants completed the questionnaires, including the 3 mothers and one child. Questions were open-ended, and intended to elicit information on the experience of the program, aspects of the program that were effective and ineffective, and practical suggestions for further programming. The questionnaires were intended to be distributed at both the middle and end of the program in order to track any possible changes in the participants' experiences, however due to absenteeism each participant only completed one questionnaire towards the end of the program. Using Patton's (2002) method of inductive analysis, the text on the questionnaires was then analyzed for common themes and ideas in order to develop categories to consider when designing a program such as this. Tape-recorded group discussions of the program, with similar focus questions as written on the questionnaires, were planned at the middle and final sessions immediately following completion of the

questionnaires in order to determine if participants' opinions changed at all as a result of group discussion, as group discussion is thought to be influential and occasionally thought-provoking. Unfortunately, the group discussions did not transpire as a result of absenteeism.   Prior to the commencement of the program, ethics approval was obtained and university-approved informed consent letters were distributed and signed during private meetings where it was emphasized that participants' identities would be kept confidential through the use of pseudonyms. It was expressly stated that facsimiles of participants' stories and artwork would not be collected, as these were considered to be personal and confidential. Generalized descriptions of their stories and artwork are recorded below.

Therapist observations. Additional data was collected in the form of personal observations. Therapist process notes and group progress notes were recorded upon the completion of each session. Process notes included information on counter-transference and other interpersonal relations between the participants and the facilitator. Group progress notes included information on attendance, materials, art activities, verbal comments, and interpersonal relations between participants and among each mother-child pair.

Numerous ethical considerations arose throughout the duration of this research process, specifically concerning my conduct as a therapist-researcher, the collection of data, and the legal implications of how data was stored and managed. Every effort was taken to ensure that the process was ethical and that data was secure. Client information and my therapist notes were kept secure by keeping all data under lock and key, to which only I had access. A transcript of selected portions of the feedback questionnaires, with

pseudonyms, was shared only with my research advisor. Feedback questionnaires were typed up without identifying information, and then locked in the aforementioned filing cabinet.

Literature. The literature review (above) summarizes the data collected from secondary sources including published essays, studies, and articles in books and peer-reviewed journals in the mental health field, including psychology, psychiatry, social work, and the creative arts therapies, as well as unpublished student theses. These were perused for their practical clinical application to the development of an art therapy group program working within a narrative and attachment theory framework. The following program is constructed with consideration to Luthar and Walsh's (1995) post-modern relation-based conception of the treatment needs of substance-abusing mothers and their children.

Process

An exploratory method was used to determine how story-making could be useful to substance-abusing mothers and children in an art therapy program. Given a relatively unstructured environment, an empty sketchbook, a wide choice of art materials (including oil and chalk pastels, felt-tip markers, tempera and watercolour paint, water-colour crayons, pencils, collage materials – magazine images, glitter, and glue – stickers, and stencils) and the simple directive to "make a story," I closely observed how these mothers made use of the time, space, and materials. As I was acting in the dual role of therapist and researcher-observer, I also provided structure and gave directives where it seemed necessary in order to increase the therapeutic benefit of the trial program.

Participant feedback and my personal session notes have been qualitatively coded according to the broad ideas that converged. The common themes that emerged related primarily to session structure, including duration of the sessions, time spent solely for mothers' work, and day of the week, as well as to particular art interventions, including more practical instruction on story-creation. Participants' and my own observations are distributed throughout the resulting structured program, described in detail in the subsequent section.

Results

This section consists of a program overview and session-by-session description of the revised treatment program complete with participants' feedback and personal observations where appropriate. For complete transcripts of the participants' written feedback, see Appendix A.

Program Design

Structural overview. The following consists of an 8-week program made up of 2-hour long sessions in which both mothers and children have the opportunity to make their own personal stories. The ideal group size for a program such as this is between 4 and 6 dyads, or between 8 and 12 participants in total. This program has gone through a few phases of development. Proulx (2003) recommends collaborative parent-child art interventions at the developmental level of the child to promote bonding. Hall too recommends collaborative art-making to strengthen relationships (as cited in Hosea, 2006). It was thus originally proposed that the creation of a single "family" story would provide the best kind of positive interaction between mother and child. Upon commencement of the trial program, however, it became apparent that the mothers

desired to make their own stories. The mothers' creative needs overwhelmed their ability to focus only on working with their kids. Thus it was suggested that they each create their own story, however attempting to do so simultaneously meant that there was not enough time for both groups to complete their stories as the children required a great amount of assistance from their mothers.   Sessions consisting of two consecutive hour-long periods, in which first mothers and children create together, and then the mothers create their own stories in the second hour, was finally devised as a solution to this dilemma.

Program goals. These goals are considered to be realistic aspirations given the brief, 8-week-long time-frame. Goals here relate primarily to the mother-child relationship, as it is recognized that a program such as this would most likely be used as an adjunctive treatment, in conjunction with addictions-related treatment groups in a residential or outpatient setting. Group and dyad goals include:

- *Bonding*: developing a sense of empathy and appreciation between mother and child; forming new, adaptive ways of communicating, and relating to the other; and dealing with disciplinary issues and parenting skills as problems arise.

- *Relationship-building*: creating trusting friendships between participants with the further goal of creating a social support network among mothers.

- *Empowerment*: voicing one's story and opinions towards the creation of something of which one can feel proud; developing a sense of self-efficacy.

- *Self-awareness*: exploring oneself through artwork; working towards the goals of developing self-esteem and a greater sense of personal identity.

- *Relaxation & pleasure*: reducing stress and having fun!

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Group frame. Participant feedback on the questionnaires related primarily to scheduling and the group frame (see Appendix A). The primary complaint, which corresponded with my own observations, was that the mothers had difficulty juggling the creation of their own artwork alongside that of helping their children make art. Only Kay, mother of mature, 5-year-old Issie, was able to complete her storybook whilst simultaneously helping her child, indicating that the original set-up might have worked better given a group of slightly older children (e.g. ages 6 –10). Art-making was easier when the mothers were engaged in developmentally-appropriate collaborative activity with their children, such as play-dough making, however the mothers then seemed to be both less stimulated and less committed to attending the group. This message was clearly conveyed by absenteeism, or by mothers sending their children alone or with another mother. Thus the aforementioned solution was devised in which the first hour of the session is devoted to collaborative family time, with the second hour devoted to the mothers' creations. This set-up would be facilitated by having one mother volunteering each week to look after children in an adjoining play area – common practice at the residential rehabilitation center already – or, if available, a co-therapist or assistant to supervise the children. The structure of a shared mother-child hour followed by a second hour of parenting skills or counselling expressly for primary caregivers is common-practice at various facilities for dyads with relationship difficulties (Proulx, 2003). This format ensures that the activities are interesting and inviting to both parties so that all group members will want to participate, as everyone deserves a chance to play and express themselves creatively. The final, eighth session is joint, allowing for sufficient time to wrap-up and engage in a special sharing ceremony.

The structure of a "children's hour" followed by a "mothers' hour" not only ensures that the children receive adequate help and attention from their mothers, but it also allows the mothers to do deep therapeutic work at different levels: as mothers and as women; as children themselves and as adults; both subconsciously and consciously. Proulx (2003) notes the advantages of parents engaging in "infantile expression" along with their children as it allows them to express their own subconscious fears and unresolved conflicts without inhibition (p. 27). They may regress, and their own experiences of being children may surface, allowing them to address these deeply-rooted emotions (Proulx, 2003). Indeed, it was observed in the sessions that the mothers enjoyed finger-painting with their children, even talking in "baby" voices with them, however became visibly anxious when the creative work became too messy or chaotic. Hosea (2006) has observed similar fears in a painting group for mothers and young children, suggesting that it is a fear of being overwhelmed and losing one's sense of self in the mess that makes the therapist's containing role vital to dyad work. The notion of a loss of control or sense of self is particularly pertinent to substance-abusers who flirt with chaos whenever they plunge into the highs and lows of drug-use. It is therefore important to neither infantilize these women nor to allow them to leave in a regressed and highly vulnerable state, thus an hour of "adult work" at the end of a session ensures that the mothers feel mature and act responsibly.

One final note on the group frame must address the relationship between therapist and the group members. The therapeutic relationship, a blend of the real, human relationship between the therapist and client, and *transference*, the client's unconscious projections of previous relationships onto the therapist, is a major factor that is highly

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associated with change in therapy (Yalom, 2005). This change factor is particularly pertinent when relationship-building is the primary goal of therapy, as Harris (2004) suggests that the transference relationship has the power to alter one's "internal working model of relationships", or attachment patterns (p. 147). In psychotherapy with poorly attached children, a therapist typically creates a reparative parenting experience, however, in a group for children and mothers, to whom does the therapist ally herself?

Parashak (2008) describes the struggles of balancing the needs of mothers and children in art therapy groups that she facilitates for at-risk adolescent mothers and their children. She notes the importance of allying with the mothers as she has observed that when the mothers' needs are met, they become more emotionally available to their children. As Fraiberg and others (1975) noted early on, "when this mother's own cries are heard, she will hear her child's cries" (p. 109). Thus, within a therapy group for substance-abusing mothers and their children, the therapist's role is to create a secure relationship with the mothers by offering safety, trust, empathy, and helpful parenting tips. This would then hopefully alter a mother's patterns of relating, producing parallel changes in her relationship with her children. As Byng-Hall (2001) says, "a family therapist is rather like a good grandparent who is there to support the parent/child relationship, not to take sides or take over" (p. 33). Stern echoes these sentiments with the notion of "good grandmother-transference" (as cited in Hosea, 2006). In a group for mother-child dyads, the therapist's role is to provide safety and security, while it is the mothers' primary responsibility to care for their children.

The Story-Making Program: "Children's Hour"

Weekly routine. The children's hour of the story-making program consists of the same weekly routine, as ritualistic repetition fosters a sense of trust and predictability for any clients in therapy, but especially for children (Proulx, 2003). The routine proceeds in the play room, or art room if available, as follows:

- *Check-in*: children choose a toy animal (therapist may choose to vary this with different objects such as stones, coloured scarves, etc.) from a basket to represent how they are feeling today. Children may describe their feelings with words, sounds, or physical actions.

- *Story-time*: mothers take turns reading a children's story that is loosely related to the day's activity.

- *Art activity*: each day a different activity is completed in the workbook. It is recommended that group members complete the art directives together as a group and in a consecutive fashion, however the workbook format does allow clients to work at their own pace, going back to missed/unfinished activities.

- *Clean-up*: mothers and children work together to clean up the art materials and the tables, facilitating closure of the activity and ensuring that members adopt responsibility for their actions. Music may be put on to accompany this routine to help make it more enjoyable and to facilitate times of transition.

- *Snack & sharing*: mothers and children enjoy a healthy snack (e.g. fruit slices, cheese and crackers, fruit juice etc.) while each dyad takes turns presenting and describing their art project to the group.

Snack-time is an important part of any children's group. Snack-time helps mark the end of the session and will be a familiar transitional routine to children in any organized

group like preschool or daycare (Proulx, 2003). Furthermore, snacks are symbolic of feeding and nurturing and should help to make the group feel comfortable. Winnicott (1988) notes that feeding marks the very beginning of the human relationship between a mother and her child. When the baby is at the mother's breast (or when she is holding him with a bottle) they share a unique and communicative gaze. In the exploratory trial program, I usually brought the snacks to the group, highlighting my role in the group as "mother hen." One session, one of the mothers spontaneously decided to bring the snacks for the day, and was rewarded with appreciation from the other mothers, which clearly made her feel good about herself and her position within the group. Thus it is recommended that mothers take turns (perhaps signing up beforehand) bringing snacks from the communal canteen for the whole group each session. This would ensure participation and commitment, and would further highlight group members' roles as nurturing mothers. The sharing component of the group serves to reinforce the day's activity, helps the children verbalize their actions and feelings, and serves as a point of pride for each mother-child pair, as other mothers typically comment on the children's work. Ideally, the mothers would then leave to go to a second art room, with the collaborative artwork left to dry on the wall/table for the duration of the "mother's hour" to remind the children of their relationship and her impending return (Proulx, 2003).

Children's Workbooks

The following session-by-session description of art interventions would be compiled into a special workbook that the children may complete throughout the duration of the 8-week-long program. In the exploratory trial program, it was found that even the older children had difficulty attending to a sustained project that lasted for more than two

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sessions, as in the story-making project, and so different activities are thus recommended here. Indeed, one other resident at the centre declined participation in this group as she did not believe that her children were capable of handling a sustained project, nor did she wish to commit to attending consecutive weekly sessions. The workbook format thus preserves continuity, ensuring that group members may complete all projects despite inconsistent attendance. The discrete activities presented here can also loosely be formed into a familiar narrative. At the end of each session children may take their workbooks home with them, to both remind them of their time in therapy and to allow them to complete unfinished activities.

Session 1: *My name* (introduction of the main character). Mothers describe to their children how they acquired their names, and together they decorate the front of the book with the child's name. They may use markers, pencils, crayons, stencils, and/or collage materials (images, sequins, etc.). This activity serves to introduce the names of all members to each other and to the therapist, and furthermore clearly demarcates possession. In a residential centre like the one in which I worked, children tend to become fiercely possessive of their toys as they have little space to call their own, and things are habitually shared and then later lost. The loss of possessions and personal space may be particularly difficult at a time when the mother-child dyad is in a state of transition.

Art therapist Stack (2006) recommends using "name designs" as an ice-breaker activity as it works to build self-confidence. Creating a work of one's name is a strong assertion of one's presence and agency. Telling the story of one's name is also a good opening activity recommended by Neill (2008) for group therapy as it is non-threatening.

It also helps to build group cohesion, as it simultaneously unites the group – for everyone

has a name – and yet highlights people's individuality. The story of one's name is a form

of the basic "home story" described by Barton (as cited in Neill, 2008). These consist of

stories that we are told from a very young age or that which we tell ourselves, that form

our sense of personal identity. Home stories are important to explore in therapy as they

shape our worldview and our fundamental beliefs.

It is also useful to come up with collective group rules in the first session. The

trial group came up with three main rules: "respect, speak nicely to others, and no

fighting." Group rules that keep the group safe should be encouraged here. When asked

what they thought the group goals should be, the trial group suggested "self-confidence

and rapport" as the two primary goals. We then made a large poster of the rules, and

each participant agreed to follow them by tracing around their hands to "sign" the paper –

this act was performed mainly for the children who did not yet necessarily know how to

sign their own names. The mothers, however, enjoyed the hand-tracing as well.

Session 2. *Handprints and footprints* (character development). Mothers and

children each choose a colour (or combination of colours) and create handprints and

footprints in washable tempera paint. This was a favourite activity in the trial group, as it

is fun and easy to do, requires no artistic skill, and provides a tangible record of a

particular point in the child's life. In addition, the feeling of the wet, squishy paint

provides a stimulating tactile-sensory introduction to art materials and art-making for

young children (Proulx, 2003). Older children may use the hands/footprints as a starting

point to create funny creatures by adding small squiggles and lines overtop with markers.

Finger-painting is another variation of this activity.

The addition of small lines to the prints in order to make creatures is a variation of Stack's (2006) "foot-in-the-mouth faces" where the client is asked to make funny faces out of a tracing of their feet. She says that this activity works well to stimulate the imagination, particularly with those new to art, as it guides the artist slowly through the creative process. This activity is also noted to encourage body awareness, non-verbal expression, development of abstraction (as one is creating something whole from a part), and has the added benefit of being a fun activity as the results are typically quite humorous.

It is important to provide smocks and cleaning supplies (moist towelettes are particularly helpful!) for this and other art activities. As mentioned before, some mothers and children have a difficult time finger-painting as they are worried about becoming dirty and losing control. This activity can be helpful to assess issues relating to rigidity and discipline (Proulx, 2003). Depending on the client, this activity may serve as an impetus for later discussion or an opportunity for containment and trust-building on the part of the therapist. If this activity is still too difficult or anxiety-provoking, simple modifications may be made, such as using long brushes or toys to paint with instead. It is also important to note that some young or regressed children are liable to taste the paint when they finger-paint, thus edible paints made of cornstarch and food-safe dyes or condiments, like mustard and ketchup, may be used to paint with instead.

Session 3. *Self-collage* (more character development). Mothers and children search for images to represent the child and his/her interests, such as preferred activities, foods, movies, colours, etc. to glue onto the page. Images may be pre-selected and cut and placed in a collage-box ahead of time by the therapist in order to reduce the amount

of time spent looking for images. Knowing the clients' interests can help the therapist to "prime" the box with images that she knows the clients will enjoy. The glue used in collage can also serve as an interesting metaphor for attachment (Proulx, 2003). This metaphor for "sticking together," or bonding, may be explored in a parental discussion later if the time seems appropriate.

Session 4. *Mandala drawing* (the journey). A circle is used as the starting point for a drawing with crayons, markers or pastels. This is a relatively unstructured activity, allowing for more individualized imagination to come through. Children should take the lead in this activity, although the mothers can help prompt children who are stuck by making suggestions or asking guiding questions like, "think about the circle as a telescope or camera lens…Imagine you could go anywhere you wanted – where would you go? What would you want to take a picture of?" Circles are one of the most basic and universal geometric shapes, and a common starting point for drawing in art therapy exercises. In the context of parent-child interactions, Proulx (2003) describes the circle as a womb-like space, where feelings of protection may be explored, as the boundaries of the circle help to contain the space of the drawing.

Session 5. *Play-dough blob-monsters* (obstacles). Mothers and children take turns pouring cups of flour, salt, water, and food colouring into a large mixing bowl to make play-dough (flour to salt ratio is 2:1). Once the play-dough is thoroughly mixed, and kneaded until it is a pleasing doughy consistency, it is cut into equal portions for all participants to play with. Participants may enjoy simply playing with the play-dough, enjoying its sensory-tactile qualities, or they may be encouraged to create blob monsters

out of the play-dough. These are then photographed, and the pictures are pasted into the

workbook in order to preserve the creations.

Play-dough making was a favourite activity of the trial group at the residential

centre, and was re-created several times. Children enjoyed the play-dough's tactile

qualities, while the mothers routinely expressed nostalgia for their own childhoods. This

is an art therapy intervention recommended by Proulx (2003) and is especially helpful in

supporting attachment. She says:

> The flour and food colouring, which represent feeding, are familiar and
>
> non-threatening, and help the parent to return to that early period of the
>
> child's life…for many parents, kneading the dough is a new experience;
>
> for others, it reminds them of their childhood…   (p. 39)

Turn-taking is also worked through in this session, allowing for control issues to surface

and be addressed (Proulx, 2003).

Session 6. *Dress-up portraits* (friends/supports). Mothers and children have fun

dressing up in costumes/props (these may be collected by the participants ahead of time

or brought in by the therapist) and pose for a photograph together in front of a backdrop

of their choosing. The backdrop can be made of paper or cloth or even a collaborative

painted mural created earlier. A copy of the photograph is then inserted into the

workbook to serve as a memento for later.   The costumes may be related to a theme or

respond to a question like, "who do you want to be when you grow up?" Future-oriented

questions like this one might provide the basis for a discussion on impending termination

and what happens after the end of treatment. This session is based on a highly successful

Halloween activity at the residential centre in which participants were photographed wearing their Halloween costumes.

This activity draws on theory from phototherapy. Photography is a popular tool in art therapy as it is noted as being a "user-friendly" medium, as many people have had experience with cameras through family snapshots (Weiser, 2004). Photographic results are both rewarding and require minimal effort and artistic experience. Self-portraiture in phototherapy provides an interesting starting point for self-reflection (Alter-Muri, 2007). The use of dress-up in self-portraiture adds an element of humour and role-play to the therapeutic intervention, in that clients can play with different aspects of their self-identity.

Session 7. *Picture frames* (returning home; resolution). Using ready-made or hand-crafted cardboard frames, mothers and children work together to fashion a frame for the photograph that was taken in the previous session. These can be decorated with paint, collage images, fabric, glitter, etc. The creation of frames for the photographs serves to symbolically protect or shelter the pair featured in the photograph. This metaphor may be accentuated by providing cardboard frames in the shape of a house or they may be simple and rectangular in shape. This was an activity attempted in the trial group which proved to be especially meaningful for one dyad who asked for additional copies of their photographs as they possessed no other family photos. They hung these photographs, complete with hand-made frames, in their otherwise bare rooms, allowing them to decorate and symbolically claim their institutionally-allotted space.

Session 8. *Cookie-making* (closure). This final session is a joint session. In the first hour, mothers and children create and decorate sugar-cookies together. This activity

provides a repetition of the sharing skills learned during play-dough making. In the

second hour, mothers and children enjoy eating the cookies, whilst participating in a

closing ritual in which each participant shares their "story" from their workbook with the

rest of the group. A final telling of one's story is an important concluding step in

narrative therapy, in which the story is typically read to an "outside witness" to affirm

and validate the voice of the story (Payne, 2006).

Closing ceremonies are common to narrative therapy. In this session, upon

reading their books aloud, each mother-child pair then participates in a ceremonial book

exchange in which mothers give a copy of their books to their children, and children give

a copy of their workbooks to their mothers.   Mothers and children each keep their

original books, and present a coloured copy of their books to the other as a gift or legacy.

It was originally proposed that the mothers and children would simply perform an

exchange, but in the trial group, it seemed that both Kay and Lucy expressly wanted to

keep their books, while Sue, having created her book with her son's interests in mind,

was quite happy to give her book away. A copy of each book, then, provides both the

mothers and their children with a memento of their time together, or, in the words of

Hosea (2006), "embodied tokens of affection." This is especially pertinent in the event of

unforeseen separation, as chemically-dependent mothers lose their children to foster care

more frequently than others (Harmer et al., 1999; Suchman et al., 2005).

In the event of separation, the book may even become a kind of *transitional*

object – described by Winnicott (1988) as an object which symbolically represents the

mother when she is not immediately available to the child for comfort. Common

transitional objects include blankets, teddy bears, and dolls. Proulx (2003) notes the

value of the art product as a transitional object in dyad therapy with mothers and children, particularly if the artwork was created together, as in the case of the children's books here. This ceremonial book exchange is also similar to Matto's (2002) "recovery-related gift exchange" in which adult substance-abusing clients are paired and asked to create a gift for each other based on what they think the other will need to take with them when they leave treatment (p. 79).

The Story-Making Program: "Mothers' Hour"

Weekly routine. In this, the second hour of the weekly session, mothers leave their children in the playroom, and then return to the art room, or go to a second art room if available. The routine of the "mothers' hour" roughly parallels to the children's hour and would proceed as follows:

- *Check-in*: a verbal check-in focused on the here-and-now, in which the therapist inquires how it was to be working with their children in the previous hour. This check-in may function more like a discussion, in which mothers commiserate about their various joys and struggles, providing each other with parenting tips.

- *Physical relaxation and warm-up exercise:* mothers take turns guiding simple movements to loosen muscles and relax tension.

- *Art warm-up exercise*: a simple and quick drawing exercise, such as the squiggle game, scribble drawing, or round-robin drawing, is done to loosen creative energy and help get participants ready for the long-term art project.

- *Long-term project:* mothers work at their own pace, following the steps in the story-making workbooks until complete.

- *Clean-up*

- *Sharing*: mothers return to the children's playroom before sharing their day's

  work, so that the children may see what their mothers have been working on.

The initial check-in is an important part of the mother's group. In the trial group,

it was helpful having group members at different stages of their recovery who could share

tips and offer hope to other members. In keeping with the therapeutic community model

of the residential centre, with some group members further along in their recovery to act

as positive role models for the new residents, the group helps each other rather than

relying on the therapist. The physical relaxation exercises induce positive feelings by

releasing endorphins in the bloodstream. As chemical dependence involves

dysregulation in the MDS, it has been found that body-based exercises and relaxation

techniques that evoke the same neurotransmitters involved in the drug's function can

serve to de-couple or counter-condition the substance-abuser (Brown, 2009).

Mothers' Workbooks

The quest story. The daily activities in the mother's workbooks form the basic

elements of the common *quest* or hero story. First described by Campbell (1988) as the

"hero's journey", this archetypal narrative involves the main character, or hero, who sets

out on some kind of journey or mission, encounters various obstacles along the way, and

eventually overcomes them. In narrative therapy, White and Epston (1990) refer to this

type of story as a "success story," and they are posited in sharp contrast to the "sad tales"

typical to traditional psychotherapy (p. 163). Success stories externalize the problem,

and help to change negative perceptions relating to one's ability to overcome similar

problems (White & Epston, 1990; May, 2005).   In his discussion of the narratives told by

those recovering from illness, Frank (1995) describes three patterns of stories that

typically emerge: narratives of restitution, chaos, and the quest. Of the three patterns,

Frank finds the hero quests to be the most distinctive, enlightening, and healing. Of the

narrative forms categorized by May (2005) in her Family Attachment Narrative Therapy

model, described earlier, the "successful child narrative" is most similar to that of the

quest story.   The journey travelled in the quest story helps the hero to find meaning and a

sense of purpose in her battle with illness, trauma, or hardship. Although she may

initially have been reluctant to embark on this journey, upon her return she sees herself in

a new light and with newly discovered inner resources. As Frank (1995) notes, "illness is

the occasion of a journey that becomes a quest" (p.115). Like battling any medical

illness, overcoming addiction is indeed an arduous journey with many obstacles.

The quest story is an archetypal narrative that resurfaces in fairy tales, folk lore,

and mythologies around the world. Archetypal stories like this one serve a universal

need and, through oral telling and publication, offer a mode of connecting with others to

share common experiences (Neill, 2008). While the basic steps of a hero quest are laid

out in the mothers' workbooks, the mothers in the story-making group have a choice in

how they realize their narratives. The mothers may choose to make themselves the main

characters, thus creating personal life stories, or they may choose to provide some

metaphorical distance by creating fictional tales; they may even choose to use common

fairy tales as their inspiration. In the trial group, each of the 3 mothers instinctively

created their own version of a quest story with very different results. Kay made an

autobiographical story that was true to her own life; Sue created a purely fictional

narrative with dinosaurs as the primary characters, as dinosaurs were her son's favourite

animals; and Lucy created a blend of fiction and fact, creating a heroine who was loosely based on herself but who had special "super powers."

Workbook format. The use of a workbook to facilitate story-making was devised as a method of reducing anxiety. In the trial group, when I gave out blank sketchbooks to the participants, there was a great deal of anxiety and uncertainty as to how they would go about making a story, as this was a new task for all of them. When working with substance-abusing adults, Matto (2002) recommends challenging them with "healthy risk-taking." The workbook is non-threatening, and yet also encourages clients to try new things. The workbook format is a concept borrowed from narrative and cognitive-behavioural therapies, modalities which commonly use written documents or workbooks to sustain clients throughout the week, so that the work done in a single weekly hour-long session is not forgotten (Payne, 2006). While therapeutic "homework" is not usually relished by clients, I found that, because the stories were fun to make, the mothers in the trial group frequently requested to work on their stories during the week. This showed investment in the therapeutic process, and helped to de-mystify myself as an omniscient therapist, locating the force of change within the client herself.

Finally, the workbook format allows for different styles of working. By having all the steps laid out in front of them, mothers may choose to first plan their story and then create it, or they may follow their character's journey organically as it emerges, page-by-page. In the trial group, for example, Kay asked if she should create the "pictures first and then write the words," or if she should write the story before making the pictures. I responded that it was her decision, and in the end she created the pictures first but never wrote out her narrative, thus having a workbook in which all of the

elements of a quest story are expressly elucidated will help the mothers to structure their story. In the trial group, many of the participants did not know how to begin to write a story, and so on the first day we discussed elements of a typical story, such as a beginning, middle, and end; main characters; and conflict and resolution. Neill (2008) also recommends teaching the pacing of a typical story by dividing a simple story into four parts: first establish characters, second and third build tension and develop characters, and finally, resolve the conflict. The proceeding steps are loosely based on Lahad's (1992) 6-part story model, and roughly correspond to the sessions in the children's hour in order to preserve continuity.

Session 1. *Title, cover page, and name.* As in the first session of the children's hour, mothers reflect on where their own names are from and relate their current experiences of parenting back to their own experiences of being parented. In this activity, the mothers may also decorate the covers of their story-books to facilitate identification. Mothers may use a variety of materials which will be accessible every session. These include: oil and chalk pastels, crayons, pencils, felt-tip markers, acrylic and watercolour paints, and collage materials. Other options might include family photographs (if a client is writing an autobiographical tale), or the opportunity to create scenes with props, simple sets, and a digital camera to easily record and print out images.

Session 2. *Introduction of the setting.* The story opens with an introduction of the setting. If stuck, the group can brainstorm common opening lines for stories (e.g. "Once upon a time in a faraway land…"); the therapist may also prompt the group with guiding questions for inspiration, such as "where would this story take place? In what

country? In a house? In a fantasy world?" A collection of fairy tales and mythologies might also be made available for perusal in the first few sessions.

Session 3. *Introduction of the hero/main character(s).* Mothers are directed to create a main character or characters. They are encouraged to describe these with images, descriptive words, etc. Guiding questions might include: "What is her/his name? What does she look like? What does she do? Describe her, both her inner and outer qualities."

Session 4. *The character sets off on a journey or mission.* Mothers are encouraged to create a situation in which the main character must fulfill a mission or leave home to find or achieve something. If stuck, clients can be helped to come up with ideas by first playing a round-robin story game; by creating imaginary scenarios for the characters in magazine images; or by taking turns writing a few places/goals on a piece of paper to be placed in a hat, and then selecting a different one from the hat.

Session 5. *The character encounters obstacles/conflicts along the way.* Mothers are encouraged to create a situation in which the character encounters unexpected obstacles. At this point, if the group feels safe, the mothers may first be prompted to consciously think about and/or discuss their own obstacles before writing about their character's. Lahad (1992) recognizes that, even if writing a fictional tale, a client will nonetheless unconsciously project some of her own experiences into the story. Therapy can work at this unconscious level, or it may be expedited by making issues conscious.

Session 6. *Supports: who or what helps them along the way?* Mothers are encouraged to develop or think of friends or tools that might help their main character to

face his/her obstacles. Again, if it feels safe, the therapist might apply this question to the mothers' own lives, or may choose to keep it in the metaphorical realm.

Session 7. *Resolution.* Mothers are encouraged to come up with an ending for their story. The conflict may be resolved, the mission completed, or the journey ended. Mothers are encouraged to finish their story-book between sessions if there is not enough time during the session, so that these may be colour-copied for the final session and book exchange.

Session 8. *Story-exchange, cookies and tea.* In this joint session, mothers and children share their stories with each other over tea (or other warm beverage) and cookies made in the first hour. The women are empowered by voicing their stories, and by helping others through their narrative guidance and shared understanding. Frank (1995) describes the power of the tale told by the wounded story-teller: "through their stories, the ill create empathic bonds between themselves and their listeners…the circle of shared experience widens" (p. xii). This is akin to the ancient tradition of oral story-telling, which serves the dual purpose of empathic connection and vicarious learning (Neill, 2008). If participants wish, they may widen the audience by bringing in other family members, such as grandmothers, to hear their stories.

Role of the Therapist

One final note on this story-making program concerns the role of the therapist. In a short-term group program such as this, there is not enough time to address deep conflicts as in long-term psychotherapy, thus it is advised that the therapist work on a more supportive and arts-focused level. As group facilitator, the art therapist's main responsibility is to create and hold the space, providing materials and offering simple

artistic advice, keeping the group safe, and offering a supportive and non-judgemental ear

that is open to listening to participants' stories. This supportive approach has been found

to be particularly effective with this client population, who may have difficulty forming

attachments, especially in a short-term group (Janzen et al., 2010). The art therapist

shares in the client's experience of art-making by watching and holding the space, much

like a mother does with her child (Parashak, 2008). In line with the basic tenets of

narrative therapy, the therapist is open to learning from her clients as they are considered

to be the experts of their own lives. The therapist may offer parenting tips, and intervene

on disciplinary matters when necessary or when asked to by participants, but otherwise

encourages the mothers to help each other in offering tips and solutions. Substance-

abusing mothers tend to be highly sensitive to critical feedback and help on parenting

skills (Luther & Walsh, 1995). A supportive environment will be a welcome change to

the typically harsh, "tough-love" approach advocated by many rehabilitation centres.

The experience of a genuine empathic connection with a therapist and other group

members can help put a mother with substance abuse on the first step toward recovery

and toward building a stronger emotional bond with her child.

Summary

In sum, the story-making program is an 8-week-long group art therapy program

for substance-abusing mothers and their children. Data drawn from the pertinent

literature, my own observations of an exploratory trial program, and participant feedback,

suggests that the creation of archetypal quest-type stories is the best approach to

promoting personal exploration, empowerment, and for building social relationships.

Mothers and children each make their own personalized versions of these stories, so that

they may have a tangible record of their collaborative process, of their time spent in therapy, and of their own personal agency.

Discussion

There were several points of interest that arose during the process of constructing the program, including limitations of the study, and avenues for future research. These points are discussed below.

Limitations

The primary limitations of this study relate to methodology. For one, due to the small size and non-randomized sample of this study, there is a little generalizability. This program would ideally be tested further, and with more participants, in order to determine its wider applicability. Also, as a method of investigation, questionnaires are generally limited to what the participant is willing or able to report (Carolan, 2001). In this case, it seemed apparent that some of the participants were less comfortable with writing, and so chose to write as little as possible. Audio-taping group discussions, as originally planned, would have been fruitful in obtaining more data. Participants also knew that I would be reading the questionnaires, as such it is possible that they were affected by the phenomenon of *social desirability* or the bias towards saying what the researcher wants to hear (Carolan, 2001).

Participants may have been more honest had a blind researcher been conducting the feedback questionnaires. Indeed, I had difficulty in playing both the role of researcher and the therapist. It is likely that my observations were biased as a result of my role as therapist. As this was not merely an exploratory research program but also a therapy group, ethical issues arose relating to my action and inaction in the group. For

example, there may have been instances where I might have intervened as a therapist, however chose to simple observe participant responses in order to obtain data for this research. It is possible that the less structured, exploratory approach may have in some way actually limited participation as the women may have felt less supported. As was noted previously, absenteeism was a major problem, resulting in a lack of participant feedback. The lack of attendance, despite the fact that participants had agreed to attending 6 of 8 sessions before signing up for this study, made it difficult to obtain any oral group feedback. It is assumed that a change in structure and timing of the program (e.g. on a more convenient day or time for members) would have resulted in greater attendance, however this was not possible due to logistics. Also, a more directive approach as therapist might have resulted in greater attendance. As a student therapist, it should be noted that the practice of playing the dual roles of both researcher and therapist is quite common, however, ideally a second, impartial researcher would be solicited to observe a trial program such as this.

Future Directions

It would be beneficial to try out this more structured program with another group of mothers and children in order to determine if the changes made to the structure of the program were helpful. Additionally this program might prove to be effective for other groups of mothers and children with attachment difficulties, or even with groups of fathers and children as a tool for relationship-building. It would be illuminating to compare this group treatment program to other programs with similar treatment goals, such as psycho-educational behavioural parenting groups, in order to determine if there is a difference, or particular benefit, to the use of story-making and art therapy. Perhaps

elements from the other creative arts therapy modalities could be incorporated and explored further in this program, including music and drama. It would have been informative to further examine the women's stories, however due to their vulnerable positions it was deemed insensitive and perhaps even unethical to explore their personal stories and artwork in greater detail. One final consideration for the use of story-making in a group program with clients such as this is variation in literacy levels. Given the high incidence of low education/socio-economic status to substance abuse (Hans, 2000), it is possible that a therapist might encounter clients who do not read and write, thus the use of written directions in a workbook as impetus for story-making would need to be reconsidered.

Conclusions

The use of story-making in a group art therapy program for substance-abusing mothers and their preschool-aged children offers exciting new possibilities for supporting attachment. If early caregiving relationships affect not only the development of one child, but children in subsequent generations, then supporting attachment early in life has the potential to better our collective future. With love, care, dedication, and support, it can be "happily ever after" for substance-abusing mothers and their children.

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Transcripts of questionnaires

In the spirit of full disclosure, the following are verbatim transcripts of the questionnaires that were filled out or answered orally by the participants. Participant responses are grouped together for ease of comparison. In some cases, the answers are translated from the original French. Every effort was made to translate these answers according to the original meaning. Only one of the children chose to participate in answering the questionnaires.

QUESTIONNAIRE

Stories of substance: Story-making in art therapy for mothers and children

Please answer the following questions. These comments will be used for educational purposes only in order to construct a model of a story-making program. Your identity will be kept confidential, and, if used in the final research report, will be used along with a pseudonym.

1) What was your experience of this story-making program?

- *Lucy*: I discovered that I have a lot of imagination.

- *Issie*: Good.

- *Sue*: Fun. I found it very interesting and enriching. I will finish it [the story] to make up for all the lost time.

- *Kay*: Awesome. Well, generally good, but not all of the time – longer sessions, and maybe during the week would be nice.

2) **What did you like most about it?**

- *Lucy*: Making drawings and images.

- *Issie*: I liked a lot about it. My storybook is on the magazine.

- *Sue*: Creating – cutting and pasting, imagining, and colouring.

- *Kay*: I like that art is not on the surface. It's like we have a bubble, and we can go deep into our bubble. A bubble is like what's going on in my head – I don't know how to explain it – it's my personal space. I also like that there's no expectations; because me, when I feel pressure from some one, I usually distance myself from them. Like the psychiatrist here – she gave me homework to do and I didn't do it, so I felt ashamed and I pushed away from her.

3) **What did you like least?**

- *Lucy*: Writing.

- *Issie*: When you miss a class when we're not here.

- *Sue*: The fact that the people [other participants] were not constant in their participation. And once again – there was not enough time.

- *Kay*: The time – it was too short.

4) **What could be improved?**

- *Lucy*: Nope – it is fun and inspiring.

- *Issie*: More food! Maybe hamburgers, chicken nuggets, and French fries.

- *Sue*: A longer program.

- *Kay*: The schedule – during the week would be nice, so that we can work on our own, without our children beside us.

5) Is there anything else you would like to add (in words or pictures)?

- *Lucy*: Thank you.

- *Issie*: *(drew a picture of a "male-y sheep")*

- *Sue*: I found it cool that some one would take the time to come here and do these kinds of special activities with us. Happy Easter, and THANK YOU! *(drew a picture of a big smiley face)*

- *Kay*: Solutions to the scheduling: put it during the week; it could even be during our parental competence groups or the mornings when we don't have anything else to do.