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Addiction, Mental Health, Systemic Racism, and Expressive Arts Therapy: A Review of the
Literature
Capstone Thesis
Lesley University

May 5, 2020

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Expressive Arts Therapy

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Abstract

Systemic racism has plagued people of color for many years. The thought of advancing in this world has been cut down by systems put in place to advance the White agenda. One of those systems is the health care system. Addiction and mental health care are areas where identifying as a person of color can be a hinderance when seeking treatment. Addiction and mental health have also been stigmatized, and treatment for people of color is available but lacks affordability. This literature review addresses the layers of what systemic racism is and how it has affected the lives of multicultural populations. It will also reveal a gap in research on expressive arts therapy and addiction, mental health, and systemic racism. There is adequate research on the other modalities, but minimal in expressive arts. Because of the limited literature, non-minority clinicians do not have adequate evidence-based practices that can educate them on how to deal with the intersectionality of helping a client who is a person of color, with an addiction and/or managing their mental health. Through this journey I have learned that without a change in societal views there will always be disparities in treatment of any kind. This inquiry is important to the field because expressive arts therapy is still relatively new, and a good avenue for enhancing quality of life for people of color suffering from addiction. Also, there needs to be a way to allow maximum success in treating clients despite their race, ethnicity, or socioeconomic status.

Keywords: systemic racism, addiction, mental health, expressive arts

Addiction, Mental Health, Systemic Racism, and Expressive Arts Therapy: A Review of the
Literature

Introduction

Every time we invalidate someone else's struggle with mental health, we reinforce the idea that they should struggle in silence.

-Dr. Christina

Addiction, mental health, and systemic racism coincide more than the general public realizes. Addiction can cause mental health; mental health can cause someone to be addicted to a substance; and systemic racism is a hinderance in accessible care and can deepen someone's addiction and/or negatively affect their mental health. The current opioid crisis is a good example of the disparities of treatment between white and non-white minorities.

The Center for Disease Control and Prevention (CDC) categorized the rise in opioid use into three main "waves": the first wave started in the late 1990's, which attributed to a rise in prescription opioids for both acute and chronic pain management; the second wave started in 2010, attributed to increasing heroin use, often in conjunction with other synthetic opioid compounds; and the most recent and deadly wave started in 2013, attributed to the increasing access and the utilization of high-concentration synthetic opioids. (Santoro & Santoro, 2018, p. 2).

The research that has been done on addiction and treatment sheds some light on the lack of care, understanding, and accessibility of specialty treatments given to certain populations. What I have learned is that the research so far has covered the lack of accessibility due to people having a substance misuse disorder, and not having affordable health care or the providers not taking time to be educated on substance misuse (Romo, Ulbricht, Clark, & Lapane, 2018).

Romo et al. (2015) found in their qualitative study that due to socioeconomic barriers, clients suffer:

When all the data was entered into NVivo software the results shown [sic] that the barriers all surrounded the accessibility to primary care. The service provider was lacking knowledge, and were unwilling to discuss their situations, and the provider's overall attitude toward the client impacted their experience (p. 99).

There is a gap in research pertaining to expressive arts therapy and addiction, mental health, and systemic racism. This review is organized as follows: (a) it discusses addiction and systemic racism, society, and media, using the disparities between the crack epidemic versus the opioid crisis as an example; (b) it discusses the connection between systemic racism and health care, treatment, and mental health; (c) it defines expressive arts therapy and how it addresses systemic racism; and (d) it seeks to identify how the expressive arts can address issues of substance use.

Literature Review

Addiction and Systemic Racism

It is important to define the terms that will be discussed throughout the paper. I use the following definitions provided by Matsuzaka and Knapp (2019)

- “Race is defined as a social construct assigned to groups based on their perceived phenotypic characteristics within categorical organizations (Helms, Jernigan, & Mascher, 2005)” (p.2).
- “ Racism has been described as a system of oppression manifested within internalized, interpersonal, and institutionalized levels based on racial categorizations that privilege whites as the dominant group (p. 3).

- “Systemic racism involves the maintenance of racial privilege and subjugation within institutional structures” (p. 3).

According to the *DSM-5 Made Easy* (Morrison, 2014), addiction/substance use disorder is diagnosed when a user has taken a substance frequently enough to produce clinically important distress or impaired functioning, and results in certain behavioral characteristics. Substance use disorder (SUD) can develop accidentally, especially from the use of medicine to treat chronic pain (p. 393).

Society and Stigma

Ideology is “the broadly accepted set of values, beliefs, myths, explanations, and justifications that appear self-evidently true, empirically accurate, personally relevant, and morally desirable to the majority of the populace” (Brookfield, 2005, p. 41). Ideology defines the connection between how and why people are treated in certain ways. Those mindsets are further embedded into cultures and societies which normalizes stigma and white privilege. Ideology refers to “repressive trains of thought that makes it possible for subordinates to accept their social positions as ‘natural’ or ‘inevitable’” (Stige, 2002, p. 323). Ideology is hard to recognize because it is “embedded in language, social habits, and cultural forms” and because it appears “as common sense, as givens, rather than as beliefs that are deliberately skewed to support interests of a powerful minority... while appearing to advance the interests of all” (Brookfield, 2005, p. 41).

Stigma defined by Weiss, Ramakrishna, and Somma (as cited in Mora-Rios, Ortega-Ortega, & Medina-Mora, 2017) is “a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgement about a person or group” (p. 1). “Social rejection of drug use is greater than that directed at other psychiatric conditions, like depression and anxiety.” (Schomerus, Lucht, Holzinger, Matschinger, Carta & Angermeyer, 2011). The drug users are deemed as outcasts and not

having enough will power to change. I had a distant relative that constantly stole from the family to support his habits. At the time, his immediate family did not understand what he was going through or how and when it started. He was treated like an outcast by his family. “Drug users are socially perceived as persons incapable of self-control, who are responsible for their own behavior (Corrigan, Kuwabara, & O’Shaughnessy, 2009); and this perception could affect their recovery process and emotional well-being” (Mora-Ríos et al., 2017, p. 1).

Stigma plays a big part in how people are viewed and act. Stigma is a complex and multifaceted concept (Goffman, 1963; Link & Phelan, 2001). When stigma is enacted, an individual’s attitude toward a particular stigmatized condition (e.g., alcohol or drug addiction) is based largely on stereotypes and labeling, which often create an “us” versus “them” view of individuals affected by the condition (Link & Phelan, 2001).

Mackert, Mabry, Hubbard, Grahovac, and Holleran Steiker (2014) collected data from two different collegiate subpopulations to explore potential variations in stigmatized beliefs about addiction. The results showed a significant difference between the advertising and social work students, with the advertising students holding the greater stigmatized beliefs. Consistent with previous mental health literature (Couture & Penn, 2003; Mann & Himelein, 2008) this study indicates students with more exposure to the complex issues surrounding substance misuse and recovery held fewer stigmatized beliefs about someone struggling with substance misuse. The more removed a person is from the problem, the less aware they are, and the less action will be taken to change bad habits.

In the early 1900’s the mindset of the progressive reformer viewed drug use differently than what was actually occurring at the time (Herzberg, 2017, p. 594). In the middle class, drug dependency was seen as accidental. They believed honest labeling would be a solution to the addiction. They believed that once the consumer knew all the information they would be able to

make a rational decision and stay away from dangerous drugs (p. 594). According to Harvey W. Wiley (as cited in Herzberg, 2017), an early pioneer of food chemistry, food toxicology, and food safety, “there was no need to prohibit product” (p. 594). In 1906, the Food and Drug Act required truthful labeling of medication to help the middle-class with drug dependency, proving they were victims instead of perpetrators (p. 594).

Reformers did not consider “poorer, urban drug users” (Herzberg, 2017, p. 594). These populations were deemed as “pleasure seekers with undeveloped moral compasses” (p. 594). Their drug dependence could only be controlled through prohibition and strict policing of the criminals. The tactics taken to disrupt and create more of a divide between the races, were already done earlier, restricting of alcohol to Native Americans and later sales of narcotics to Africa and the Philippines (p. 594).

In the 1920’s the new Narcotics Division of the Treasury Department was empowered to arrest and incarcerate drug sellers and users they deemed “nonmedical”; this type of drug user came to be known as a “dope fiend” or junkie” (Herzberg, 2017, p. 595). As with many cultural binaries, the terms did not hold true to the innocent consumer: “rational drug users were those who were not junkies. Through this backdoor cultural logic, the concept of “medicines,” like that of “drugs,” acquired a social component” (p. 595). For decades, before the neurobiological discovery of addiction and how it can be caused by genetics, race and addiction had a face. It was not the face of the Caucasian housewife who was being dosed with medications or the Caucasian man who misused the very drugs non-white minorities were being incarcerated for. It was the face of the Black and/or Latinx male trying to maintain and sustain. “As the twentieth century wore on, race became an increasingly central ingredient in that social component” (p. 595).

It was not until the 1940’s that the FDA even began to investigate “over the counter” (Herzberg, 2017, p. 607) sales by druggists, and even then it was extremely undermanned. Relatively

weak policing meant limits on sales, and white markets for pharmaceuticals sedatives and stimulants quickly grew to become the nation's largest sources of psychoactive substances (pp. 607-608). With "harsh 'drug war' policies," they

have reproduced social inequalities, intensified urban crises, and more recently, contributed to a racialized carceral state. Meanwhile, insufficient pharmaceutical regulations have encouraged a boom-bust cycle in addictive medicines, enabling a series of preventable public health crises including an early twenty-first century epidemic of prescription-opioid-related deaths. (p. 592)

The focus of the Omnibus Anti-Drug Abuse act was on the users, abusers, and distributors and the differences between rock cocaine and the powder (Santoro & Santoro, 2018, p. 4). Both drugs have similar chemical makeups, but have been penalized differently. Substance misusers of these drugs were not offered medical treatment options instead of incarceration like the current opioid crisis victims. This has "intensified the public perspective that these individuals had a moral failing" (p. 4) rather than a neurobiological causation. It has been shown that some drug users internalize these social stereotypes, which can lead them to experience feelings of insecurity, guilt, and low self-esteem (Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008).

Other research has shown that "in the nineteenth century opiates and cocaine were essential therapeutic tools, ... mainly because physicians relied on them" (Herzberg, 2017, p. 593). This action produced addiction among the white, middle-class, especially women who could afford doctor visits. American historical class distinctions were associated with racial differences in the use of these substances.

Nonprescribed cocaine use for example, which first spread among manual and industrial laborers was widely understood to be common among African Americans workers....

Opiate users, on the other hand, were white, but many were immigrants from Southern and Eastern Europe or their American-born children. (p. 593)

When Perdue Pharmaceuticals first released oxycodone hydrochloride to the market in the mid 1990's, their marketing strategy targeted specific providers in the rural and suburban areas (Santoro & Santoro, 2018, p. 5). During this time oxycodone became known as the "hillbilly" (p. 5) drug because of the areas it was being used in. Oxycodone was promoted for the treatment of moderate pain with minimal side effects. The findings submitted to the FDA, were not consistent (p. 5). Years after the Food and Drug Act, medication was still being distributed with misguided information.

In 2016, 64,070 Americans died from drug overdoses with 66% of those deaths involving opioid compounds....the rate of Caucasians who died from an opioid-related overdose was 79%, but only 10% for non-white minorities, identifying an alarming discrepant racial profile of opioid users in the United States. (Santoro & Santoro, 2018, p. 2)

According to Alexander et al. (2019), the past 35 years have seen a shift "from relatively low heroin mortality, to a prescription problem in the white population, and more recently to a heroin/fentanyl epidemic affecting both the black and white populations" (p. 713).

Media

The viewpoint of the people has shaped the stigma surrounding addiction. Throughout American history, race, ethnicity, and class have influenced the public's opinion of drug use and addiction (Santoro & Santoro, 2018, p. 3). During the U.S. crack cocaine epidemic of the 1980's, "in the U.S. the political campaign, known as the 'War on Drug,' was used as a response to counteract the increasing rates of use and abuse of [opioids] (p. 3). Media coverage depicted African Americans and Latinx as criminals and addicts, while Caucasian Americans were portrayed as "victims" (p. 4).

The 1986 Anti-Drug Abuse Act signed by President Reagan pushed for incarceration as a means to handle the increasing prevalence in use of crack cocaine (Santoro & Santoro, 2018). This act came with harsher sentencing for distributors of crack cocaine versus powder cocaine. “In 1988, the Omnibus Anti-Drug Abuse Act expanded the law to allow harsher criminalization of the crack cocaine users” (pp. 3-4).

The media has always played an enormous part in the way different populations are viewed. Currently, the term *fake news* has been floating around and causes a societal uproar and consciousness that makes the viewer curious, disturbed, or proves a stereotype. In regard to the opioid epidemic news stories involving the white and or middle-class persons with substance use or misuse disorders more frequently “include a narrative with clear reasoning to their abuse of opioids. Attributing to the external factors rather than an inherent moral failing or neurobiological disorder” (Santoro & Santoro, 2018, p. 4). The representation of persons with substance use and or misuse disorders in this way allows the viewer to empathize with their own while overlooking the misuse that may or may not be related with their cognitive schema of substance use disorders. “Conversely, media coverage coming from minority communities were more frequently short where a name, an arrest, and criminal charges are being displayed” (p. 4).

Back in the early 20th century portrayals of crack cocaine use have been racially profiled, which has been constructed as an issue of people of color (POC) compared to cocaine use, which has been constructed as an issue of White individuals (Netherland & Hanson, 2016). Media around substance misuse by race have broadcasted stereotypes of POC as developing substance use disorders (SUD) based on personal deficits (e.g. mortality and criminality), compared to White individuals as developing SUD based on contextual influences (e.g. social and environmental factors; Matsuzaka & Knapp, 2019, p. 6).

At a time when authorities were cracking down on prescription drugs, sales went down causing an increase in the smuggling of illicit drugs (Herzberg, 2017). Studies at this time reported fewer white, native-born, middle-class Americans claiming addiction. These developments helped to create expert consensus around the problem with addiction to see where the problem lay.

Authorities increasingly agreed that addiction was a problem of street-hustling urban “junkies” and heroin, not of patients and their medicines. The result was what historians call the “classic era of narcotic control” characterized by punitive policies justified by a steady drumbeat of antinarcotic propaganda (p. 596).

The constant acts and policies that were created in the past have not taken care of the issue but perpetuate the drug use of Caucasians. The lack of awareness and the focus on self-preservation, has created a preventable crisis. The underreporting of non-white minorities means that those people were not treated or were refused treatment due to the societal viewpoint on addiction and racial discrimination (Alexander et al., 2019, p. 713). Alexander et al. further state the lack of reporting in southern states where there are large black populations. “Recent research has indicated that opioid mortality is underreported by about 24% nationally and that the extent of underreporting varies by geography” (p. 713). Furthermore, classifying black opioid deaths as an ‘unspecified drug’ would make the ratio higher (p. 713).

Systemic Racism and Health Care

Health care is one system where racial inequalities have persisted

Systemic racism theory is firmly grounded in race-critical literature created since the 1960’s Black civil rights movement and first articulated for health care system” by Kwame Ture and Charles Hamilton (1967: 3-4). They argued that “racism” involves “predication of decisions and policies on considerations of race for the purpose of subordinating a racial group.”

(Feagin & Bennefield, 2014, p. 7)

The majority of the decisionmakers in the healthcare system are Caucasian. Those positions consist of “public health researchers, and policymakers, medical educators and officials, hospital administrators, and insurance and pharmaceutical executives, as well as important medical personnel” (Feagin & Bennefield, 2014, p. 8).

There is evidence that POC enter into substance use treatment with greater severity of substance misuse issues than white individuals (Lowman & LeFauve, 2003). Results come from a tendency to delay seeking services (Schmidt et al., 2007) because of economic barriers (Griffith, Ober Allen, & Gunter, 2011; Shavers, Klein & Fagan, 2012). With the growing racial diversity in the United States and evidence of the association between racial discrimination and substance misuse among POC (Borell et al., 2010; Hurd, Varner, Caldwell, & Zimmerman, 2014; Yoo, Gee, Lowthrop, & Robertson, 2010), there is a need for providers to adopt an antiracist substance use treatment approach to working with POC.

Significant data strongly suggest the majority of white health care and public health personnel and researchers operate from white-framing which “includes normalized notions (e.g. stereotypes, images, narratives, ideologies) of biologically and culturally distinct racial groups, and it links to discriminatory practices accounting for institutionalized inequalities in health care and health” (Feagin & Bennefield, 2014, p. 8).

The higher rates of unemployment among POC, particularly Black and Latinx individuals, may correspond with the lack of access to employee-based private health insurance (Barnett & Vornovitsky, 2016). Roman, Ducharme, and Knudsen (as cited in Matsuzaka & Knapp, 2019), stated that “POC without private health insurance or the ability to self-pay may not gain access to private substance use treatment programs, which are found to have more expansive evidence-based service offerings compared to public substance use treatment programs” (p. 6). Inequalities in pay based on race and gender have plagued many families. People are expected to manage with unlivable wages

and once they seek help, they are deemed burdened with stereotypes, such as “welfare queens,” for trying to provide. “Socioeconomic fundamentals, many generated by racist practices in institutions other than health care, significantly shape public health, but so do practices of medical and other health decisionmakers” (Feagin & Bennefield, 2014, p. 9). Health disparities involve both individual and institutional actions generating oppressive systems (Krieger, 2003). The treatment of Blacks in the medical field outside of affordability has deterred black people from seeking treatment (Feagin & Bennefield, 2014). People like Anarcha, Fannie Lou Hamer and Harriet Lacks, and many more have been experimented on and the white population have been profiting from it.

According to Feagin and Bennefield (2014), understanding systemic racism and how it shapes health and health care requires going beyond a conceptualization of individual racial biases disconnected from a broad white racial framing and associated structural power inequalities. Systemic discrimination has been long reproduced by well-institutionalized white framing-through recurring racial stereotypes and prejudices, but also through racist ideologies. (p. 11)

Systemic Racism and Treatment

“Feagin’s (2000) concept of systemic racism is useful in understanding the institutional causes of racial disparities over centuries of subjugation”. It “involves maintaining privilege of White groups through” institutional dominance. . .SUD and substance use treatment operate within the systemic context of institutions with historical racist practices” (Matsuzaka & Knapp, 2019, p. 5). There is inconsistent research in racial factors and substance use treatment outcomes in relation to reduction in misuse. There are studies indicating that Black and Latinx clients treatment has been unequal or worse than white clients. Treatment retention has been defined as “the number of days spent in treatment from the date of admittance to the last date of service” (Roberts & Nishimoto, 2006, p. 60). Retention is one way to measure outcomes in substance use treatment. If the records

show Black and Latinx clients leaving treatment before receiving full treatment, can shine a light on inefficient treatment based on personnel or stereotypes based on clients' unwillingness to fix their moral failings.

The therapeutic relationship is found to have a more significant impact on treatment outcomes than any other factor (Lambert & Barley, 2002; Lewis, 2004). A positive experience in treatment can outweigh the multilayer factors that can exist within the therapeutic relationship. The treatment starts with the foundation principles the treatment center was founded on. From there the staff will uphold those values with the clients. If those views and values are from a historical systemic racist white framing point of view, the counselor-client relationship will not flourish causing negative outcomes in treatment.

Another treatment used is Naloxone, "a drug designed to rapidly reverse the effects of opioid overdose" (Alexander et al., 2019, p. 713). My question is, what population is receiving the naloxone? Is it insurance based? What if there are socioeconomic factors preventing treatment, does the person overdose? Or, is it a situation where if sent to the emergency room they are still treated, but have to deal with a medical bill? There are so many unanswered questions. Naloxone has been given to law enforcement officers, schools, and libraries. I am curious to know if the people administering the drug to the public have racial biases, will they give the drug or not? Giving the power to the people is not thought out. If there is no psychoeducation given about addiction and how prejudices play a part, then the people hold the power of life and death.

In 2006, Massachusetts implemented the Overdose Education and Nasal Naloxone Distribution (OEND) programs (Walley et al., 2013). The Massachusetts Department of Public Health expanded the program to four other organizations in 2007 and two more in 2009. The sites provided OEND to potential overdose bystanders through trained non-medical public health workers under a standing order from the OEND medical director. Potential overdose bystanders

were opioid users at risk for overdose, as well as “social service agency staff, family, and friends of opioid users” (Walley et al., 2013, p. 13). Sites also offered addiction programs, and community meetings, such as groups for family of opioid users. Due to the naloxone and its effect on the prevention of overdose; there are over 188 community-based opioid overdose prevention programs (OOPPs) operating across the United States in various service venues (Wheeler et al., 2012). With all these programs helping out the community, the articles do not state which communities are being serviced. Can the communities turn away people at will? What is the cost of treatment?

Systemic Racism and Mental Health

Rollock and Gordon (2000) state that:

Racism represents a challenge to the mental health establishment. Racism connotes a disturbance in human relationships that leads to differentially negative outcomes for the victims (and ultimately the perpetrators). Mental health is concerned with appropriate and effective adjustment to social reality. As racism persists in its traditional forms in American society, it retains the potential to disrupt individual mental health, confound the societal systems designed to promote psychological well-being, and distort the process of psychopathology and mental health. (p. 5)

“Racism can erode the mental health status of its individual victims and dominate the institutional and cultural mechanisms through which it operates” (Rollock & Gordon, 2000, p. 6). Experiencing racism on an institutional level has the possibility to effect proper coping mechanisms necessary to function in society as a whole. Where does the hurting end and the healing begin? Racism can take root and create a lens in the victim that can create psychiatric disorders and go untreated, the individual remains stuck in another stereotype. “Perceptions of institutionalized racist practices, among other community problems, have been linked to mental health functioning in both dominant and subordinate social groups” (Hendryx & Ahern, 1997; Jackson & Volckens, 1998).

Race, Addiction, and Mental Health

Carliner, Delker, Fink, Keyes, and Hasin (2006) conceptualize racial discrimination “as both an acute and chronic stressor that adversely affects physical and mental health. As a source of stress, discrimination may, therefore, increase the risk for substance use and misuse, as has been demonstrated in prior studies” (p. 1). Drug and alcohol users are a diverse group with specific needs that complicate treatment, especially if they have multiple conditions that are vulnerable to stigmatization. Hartwell (2004) reveals that people with dual diagnosis face multiple stigmas, especially those who have more than one psychiatric illness, have committed a crime, or show high-risk behaviors associated with impulsiveness and seeking immediate gratification. The fear of being properly taken care of appropriately, alongside familial beliefs, perpetuates the illnesses. Williams (1998) reported,

- There may also be higher levels of severity of illness among black patients;
- Blacks may be more likely than whites to refuse procedures recommended by their physicians; and,
- Whites may be more aggressive in pursuing medical care (p. 312).

The reason addiction and mental health are closely related is because of pain management. The misuse of opioid pain medication is one source of the upsurge in the current opioid crisis. “Intersectionality is a framework for understanding how multiple social identities interact to influence health conditions among members of multiply-disadvantaged groups such as race, class, gender, sexual orientation, or disability” (Carliner et al., 2016, p. 1). According to Santoro and Santoro (2018), “pain management is a significant problem in American healthcare” (p. 1). From the stereotypes and folkloric tales of Black bodies being stronger and more durable from slavery until now, reported pain is not taken as seriously.

Physician practice, alongside with other systemic problems, has created disparity in the race/ethnicity of prescription opioid users and more gravely in opioid overdoses and deaths. This inequality begins with pain management practices and extends to treatment responses and the availability of addiction resources. (Santoro & Santoro, 2018, p. 2)

Previous studies suggest that adults with mental health disorders (i.e. mood and anxiety disorders) are more likely to be prescribed opioids and remain taking them long-term (Davis, Lin, Liu & Sites, 2017, p. 407). Among the 239.4 million U.S. adults, the literature estimates that 38.6 million had a mental health disorder (p. 410). Of the adults with mental health disorders, 18.7 % were opioid users. Approximately 115 million opioid prescriptions are distributed each year in the U.S., 51.4% of which are received by adults who have mental health disorders (p. 410).

Expressive Arts Therapy

Shaun McNiff (2015) explained, “creativity is the ability to take what exists and change it into something new through unique responsive acts. It puts imagination into action” (p. 1).

According to Ellen Levine (as cited in Levine & Levine, 1999),

As practitioners of expressive arts therapy our work uses play and art-making to broaden and deepen imaginative activity. The imagination is implicitly therapeutic. Yet in therapy, clinicians are creating a special context for playing and art-making. Carrying out these activities in an intentional way within a relationship that makes use of transitional experiences. When we heighten the efficacy of the transitional space by firming up the frame within the relationship, we allow imagination to flower (p. 272).

Racism and Expressive Arts Therapy

In August 2016 there were questions about a passage of Tennessee HB 1840 allowing the refusal of services to clients if their beliefs do not align with the counselors’ (Kaiser, 2017). The article explained, since the Trump/Pence administration, the American Art Therapy Association

(AATA) made a decision to agree to Karen Pence's initiative HeART. That initiative has further perpetuated white privilege, systemic racism, and classism. With the division in the country against, immigrants, people of color, and the LGBTQIA community, revoking access to treatment is controversial.

“When institutions, laws, public policies, and the systems in which art therapists work, enact trauma on those who receive services meant to ensure safety, mental health, and well-being, what is the profession to do?” (Kaiser, 2017, p. 154). To allow counselors to pick who they want to work with is further pushing the white agenda. It is only treating those people who the counselors deem worthy of care and wellness. Art is a way of expression and it may be the only outlet non-white minorities experience. To remove that is to cause harm, which is the antithesis of the cardinal rule of doing this, or any healing, work. If the HeART initiative is enhancing the viewpoint of discrimination, would the codes of ethics change and what would that conversation look like for the other modalities (e.g. music, drama, dance, expressive)?

Expressive arts is a mental health treatment given to clients who are open to the experience. It may seem like a specialty treatment, but technically it is not, as “specialty treatment refers to formal programs specifically designed to treat SUD (e.g., rehabilitation, in/out patient services). However, specialty treatment services are severely underutilized by those with SUD” (Pinedo, 2019, p. 162). After the passage of the Affordable Care Act in 2010, the expansion of “coverage for substance abuse treatment services” (p. 163) was available for more than 62 million Americans. A study was conducted “using 2008-2014 data from the National Survey on Drug Test Use and Health (NSDUH)” that showed people “with opioid use disorder utilized treatment services, reported that their insurance paid for treatment, less likely to report financial barriers after the act was passed. The study also did not take into account race/ethnicity” (Pinedo, 2019, p. 163).

Art therapists have started the work of acknowledging the effort that is needed to dismantle white supremacy and racism in the field. “Dominant whiteness in art therapy negatively affects white art therapists by limiting their social skills, self-awareness, and ability to engage in productive dialogue about race and other structures of oppression with clients and peers” (Hamrick & Byma, 2017, p. 107). According to Sue and Sue (2016) there is an urgency for helping professionals to recognize personal resistance to encountering information that might challenge beliefs about one’s self and one’s own internalized bias. To disrupt and dismantle racist, heteronormative, and Eurocentric teachings of art therapy or any other modality, there needs to be a willingness to face a level of uncomfortability with the norm of white privilege to achieve social justice. Gipson (2015) suggests:

If we intend to make a larger impact on social issues, art therapy should seek out the leadership of communities who disrupt normative spaces. Multicultural committees should be comprised of self-identified special interest groups that receive institutional support to publish, recruit, mentor, and rebuild the field. (p. 145)

Once such group is the Black Art Therapists Collective (n.d.), which is “an organized network of Black art therapists committed to diversifying and improving the field of art therapy by increasing the participation and visibility of Blacks throughout the profession worldwide” (“About”). There are also those in the field trying to change structural racism, and teach current generations from perpetuating whiteness and white fragility (Gipson, 2015; Hadley, 2016; Hamrick & Byma, 2017; Kaiser, 2017).

Substance Use and Expressive Arts Therapy

When considering the arts, the thought that typically comes to mind is child-like. The concept of allowing oneself to explore in different mediums to grasp a better understanding of self, can be uncomfortable. Paired with substance use, the lack of understanding of the two is typical. In

most research (Ross et al., 2015, p.7), it is not the user of the substance, but the personnel that needs the empathy to treat this population. The lack of empathy and understanding health care professionals have has caused studies to be done to show why patients stay or leave treatment. There have been successful studies conducted showing the power of the expressive arts. One study showed that people who have used methadone as a way to reduce the use of opioids and attended EAT “required less methadone” (“Expressive therapy and drug rehab,” n.d., para. 9). Supportive-expressive therapy coupled with drug counseling can be a good way to help people with co-occurring psychiatric problems (“Supportive-expressive therapy can help treat severe substance use,” n.d.).

Having the experience to facilitate substance use expressive groups, I found most clients were willing and open to the experience. If they did not like what was going on they had the opportunity to leave the groups. When asked why they left, the replies were that they do not see themselves as creatives. According to Shaun McNiff (2015), “commitment and attitude are everything. The most intractable obstacles and blocks are in the mind and in approaches to creativity that reinforce too much thinking and not enough practice and play” (p. 2). Preparation for those groups consisted of allowing the clients to have physical takeaways that can remind them of progress made in recovery or something that helped with triggers. We had to work together as a group, breaking out of comfortability to enjoy the process and the product.

Discussion

There needs to be anti-racist framework to counteract the years of historical institutional racism that has permeated the society. The work will be hard because people are so used to operating in certain systems, or unaware of their prejudices. The first step is “substance use counselors should seek to build awareness of their beliefs and attitudes about race, related to both others and themselves, as part of a process of racial consciousness development” (Matsuzaka &

Knapp, 2019, p. 14). If the focus is to help and enhance quality of life, curiosity and education should be foundations of the counselors work. As Alexander et al. (2019) state, “a better understanding of racial differences and how they relate to the use of other drugs, place of residence, and socioeconomic status is necessary to improve health interventions and rehabilitation programs across the country” (p. 713).

In regards to how expressive arts ties into systemic racism, addiction, and mental health, it does not—not specifically. The research addresses individual modalities and how they tackle the individual issues of addiction, mental health, addiction, and systemic racism. The research does not cover the intermodal transfer through the liminal space that creates and defines what expressive arts is as a separate unique modality. In the article, “Dominant Narratives: Complicity and the Need for Vigilance in the Creative Arts Therapies” (Hadley, 2013), the author discussed the need for authenticity, power, and privilege shifts, and how she acknowledges her whiteness in a predominantly white world. Whiteness, and the status one carries when being white, need to be discussed. Because whiteness is the majority in this field, there is not enough discussion about what whiteness is and how privilege bleeds into it regardless of social standing. Expressive arts being a relatively new form of therapy can help clients embrace themselves, and the world without losing to the injustices of the world. This field should be used to educate, not only about each modality, but about the clients who seek guidance and acceptance.

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THESIS APPROVAL FORM

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Type of Project: Thesis

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

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