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The Opioid Epidemic and the Need for Arts in Community-Based Treatment Options:

A Literature Review

Capstone Thesis

Lesley University

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Art Therapy

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Abstract

Over the past three decades, a public health crisis, the opioid epidemic, has ravaged the lives of individuals, families, as well as entire communities across the US. The prevalence and complexities of substance use disorder (SUD) and opioid use disorder (OUD) continue to challenge clinicians to find effective treatment options for clients. The focus of this literature is to develop support for using art therapy (AT) as a form of treatment for those with SUD, to distinguish the benefits that community-based AT could provide, and propose the need for further research that explores the use of community-based AT with those with SUD. The literature was drawn from areas of inquiry such as art therapy, neurobiology, substance use disorder, and community-based art therapy. The research has shown that art therapy provides numerous benefits for those with SUD as well as communities. Art therapy offers an alternative form of expressive communication that can enable personal growth and healing. The literature identifies that the benefits that art therapy provides match many of the unique needs of the SUD population. Additionally, research has shown that art therapy positively affects similar neuropathways that are negatively impacted by prolonged substance use. This research demonstrates that art therapy is a useful form of treatment that could counteract the negative neurological effects of SUD.

Keywords: art therapy, community-based art therapy, substance use disorder, opioid use disorder, opioid epidemic, gap in the research

Author Statement: The author identifies as a white, cisgender female of mixed European ancestry from rural New England.

Introduction

Over the past three decades, the United States has seen the devastating effects of the opioid epidemic, a public health crisis that has swept across the nation. The current opioid epidemic has affected the lives of individuals, families, and communities across the US (Sharma, Bruner, Barnett, & Fishman, 2016). The opioid epidemic has caused suffering and death across the country, from large metropolitan areas to small rural communities (American Society of Addiction Medicine, n.d.; National Institute on Drug Abuse, 2019; Noonan, 2017; Scholl et al., 2018; Van Zee, 2009).

Research indicates that art therapy (AT) has been used in the treatment of substance use disorders (SUD) in many clinical treatment settings for more than six decades (Feen-Calligan et al., 2008; Holt & Kaiser, 2009; Schmanke, 2017). The literature also indicates that the use of AT with this population has been shown to be beneficial in ways that traditional talk therapy sometimes is unable to. Some of these benefits include helping to promote self-expression, nurturing creativity, encouraging creative problem solving, providing aesthetic distance, providing a safe means of engaging in self-reflection and providing more profound insight, supporting a form of nonverbal communication, and developing a supportive community of peers (Casey & Webb, 2019; Halužan, 2012; Olsen & Sharfstein, 2019). The literature provides additional evidence that engaging in community-based art therapy provides a means of building community; unites the group to work towards a common cause; provides a useful technique to process the thoughts and emotions tied to a shared experience; provides a means of telling the story of an issue, group, or community. Community-based art therapy may also allow the community to reclaim their identity; serve as an avenue for confronting stigmas, stereotypes, and

discrimination; and it serves as a tool for facilitating social change; among other benefits (Berman, 2017; Klorer, 2014; Milbrandt, 2010).

While the use of AT in some treatment centers is not uncommon, there is no literature that discusses the use of AT with individuals in recovery from SUD outside of a clinical treatment setting, including community-based settings. Furthermore, there is no literature that has explored the use of community-based AT in response to the current opioid epidemic. This indicates a gap in the literature regarding the use of AT with this population in community-based settings, as well as the use of art therapy with those who have been affected by the ongoing opioid epidemic.

This thesis was initially intended to be a community engagement project. However, as the final preparations were being made to start the project, it was shut down by the emergence of the worldwide coronavirus pandemic. Because conducting the project was rendered impossible, this thesis became a literature review. The first section of the literature review will provide a detailed examination of the historical origins of the crisis as well as what contributing factors led to the current opioid epidemic. The next section will investigate SUD. The following section will explore the neurological effects of SUD. The next section will provide a brief overview of AT, and then explore how AT has been used in the treatment of SUD and its benefits for this population. The following section will explore the use and benefits of AT in community-based settings. Next, the neurological effects of AT will be presented, followed by the proposal for the need for further research on the potential benefits of community-based AT for individuals in recovery and those affected by the opioid epidemic.

My thesis will stress the need to provide multimodal supportive resources that maintain the continuation of treatment for those in recovery beyond their allotted time in clinical treatment

programs. Furthermore, the current research will argue for the importance of involving the community in addressing the opioid epidemic. Additionally, the research will demonstrate how the use of AT can help those in recovery from SUD and be used as a vehicle for creating meaningful social change. The importance of this work has only increased due to the current coronavirus pandemic, which has seen a significant increase in overdoses and subsequent deaths due to isolation, lack of access to treatment centers and recovery meetings, and the stress and depression that this pandemic has brought about (Kamp & Campo-Flores, 2020; Mann, 2020; Weiner, 2020).

Method

Research for this literature was collected using the Lesley University online database to find peer reviewed scholarly articles using search terms including art therapy, community-based art therapy, substance use disorder, art therapy in the treatment of substance use disorder, communities affected by the opioid epidemic, history of the opioid epidemic, and art therapy and the opioid epidemic. Other research was conducted using google search engine to find relevant news articles and information that discussed the opioid epidemic, its history, and political factors that contributed to the epidemic. The data was organized chronologically and by subject. These subjects comprised of the history of the opioid epidemic; current events concerning the opioid epidemic; neurobiological effects of substance use and art therapy; art therapy and substance use disorder; art therapy use in clinical substance use disorder treatment; and community-based art therapy. Articles and other data were organized and stored into the appropriate subject folder.

Literature Review

This literature review begins with an exploration of the history of the opioid epidemic from the Civil War to 1970. Next, the history from the War on Drugs to the present time was investigated. The following section briefly discussed SUD, then the neurobiological effects of SUD and art therapy was explored. The next section provided a brief overview of art therapy. Next the use of AT as a treatment method for SUD in clinical settings as well as the use of AT in community-based settings was investigated. The literature concludes with the discussion section.

History of the Opioid Epidemic: Civil War to 1970

The current opioid epidemic has had a remarkable effect on communities across the entire nation. But how, when, and why did this crisis start? To understand how the current opioid epidemic came to be, it is essential to investigate the historical origins that led up to this crisis. Opioids have been used as a treatment for pain for centuries (Bernard et al., 2018; Buchman et al., 2017; Jones et al., 2018; Olsen & Sharfstein, 2019; Rummans et al., 2018). Opioids such as opium and heroin, as well as other highly addictive substances such as cocaine, were once readily available to the public and found in many over-the-counter treatments for everyday afflictions such as menstrual cramps, toothaches, and indigestion (Buchman et al., 2017; Jones et al., 2018; Olsen & Sharfstein, 2019). The use of these substances was quite common during the nineteenth and twentieth centuries, not only for their medicinal use but also for recreational use. The recreational use of these substances was seen as a simple personal vice, much like alcohol or cigarettes (Buchman et al., 2017; Olsen & Sharfstein, 2019). It was not until much later that the highly addictive nature of these substances and the deadly consequences of their continued use were fully realized.

Morphine was one of the early opioid pain treatments that were used medically during a pinnacle event in US history (Bernard et al., 2018; Buchman et al., 2017; Olsen & Sharfstein, 2019). Morphine was used to treat soldiers and civilians that were injured during the American Civil War, one of the country's most prolific wars (Bernard et al., 2018; Buchman et al., 2017; Olsen & Sharfstein, 2019; Unick et al., 2013). The medical benefits of morphine were profound, as its therapeutic use provided relief from debilitating pain for injuries suffered by many soldiers and civilians (Bernard et al., 2018; Olsen & Sharfstein, 2019; Rummans et al., 2018). However, after the war had ended, numerous individuals who were treated with morphine during the war still relied on these narcotics. The continued use of these opioids led many of those who were treated with them to develop a dependence on opioids and subsequently develop higher levels of tolerance. The increase in individuals' tolerance of opioid doses led to a higher demand for opioids with increased potency. (Bernard et al., 2018; Buchman et al., 2017; Olsen & Sharfstein, 2019; Rummans et al., 2018).

During the nineteenth century, opioids were available with many over-the-counter treatments and through prescriptions. Many white individuals from middle- and upper-socioeconomic statuses used these treatments both medically and recreationally (Buchman et al., 2017; Olsen & Sharfstein, 2019). The individuals who would use these narcotics habitually would eventually become dependent on these narcotics, which would later be known as opioid use disorder (OUD). Everyday citizens faced the same problematic opioid use disorders as the civil war soldiers who were given morphine during and after the war years (Buchman et al., 2017; Olsen & Sharfstein, 2019).

As time progressed into the early 20th century, there was a significant increase in the number of individuals who had developed substance use disorders (Buchman et al., 2017; Olsen

& Sharfstein, 2019). These narcotics' non-medicinal and medicinal use crossed both racial, ethnic, cultural, and socioeconomic lines (Buchman et al., 2017; Olsen & Sharfstein, 2019; Rummans et al., 2018). Even though narcotics were used by many groups of people, when these narcotics became criminalized, these substances and the use of these narcotics became stigmatized and unjustly associated with racial and ethnic minorities and other oppressed and marginalized groups (Buchman et al., 2017; Olsen & Sharfstein, 2019; Rummans et al., 2018). These marginalized groups were discriminated against because they were viewed as lower-class citizens by the dominant white, Christian, middle to upper-class society (Buchman et al., 2017; Olsen & Sharfstein, 2019; Rummans et al., 2018).

Issues created by using these narcotics were only acknowledged as a public health issue after the number of white, Christian, working-class individuals who developed opioid use disorders could no longer be ignored. It was at this point that both medical and legislative action was taken to try and mitigate this problem (Buchman et al., 2017; Olsen & Sharfstein, 2019). The steps taken to try and control the public health issue led to the development, passing, and implementation of the 1914 Harrison Narcotic Control Act (HNCA). According to Olsen & Sharfstein (2019), “the 1914 Harrison Act not only turned many users into criminals, but it also forbade physicians from prescribing the most effective form of treatment” (p. 154). This act designated that the consequences for prescribing opioids in a manner deemed irresponsible could result in a physician losing their medical license or serving jail time (Buchman et al., 2017, Jones, et al., 2018; Olsen & Sharfstein., 2019). As a result, the general public’s attitude towards opioids in medicinal and non-medicinal use was drastically changed. According to Olsen & Sharfstein (2019), “in the early 20th century, when drug use became illegal across the United States and much of the world, people who used drugs became criminals incarcerated rather than

cared for” (p. 15). The use of opioids went from being seen as a “personal vice” to criminal activity (Barry et al., 2014; Buchman et al., 2017; Olsen & Sharfstein, 2019). Following this act, both patients and physicians alike began to avoid prescribing or using opioids to treat medical conditions. The medical prohibition of opioids continued throughout most of the 20th century (Buchman et al., 2017; Olsen & Sharfstein, 2019).

History of Opioid Epidemic: The War on Drugs to Present

In 1971, then-President Richard Nixon declared his War on Drugs initiative in response to the rise of the drug counterculture and protests the war in Vietnam that arose throughout the 1960s and 1970s (Olsen & Sharfstein, 2019). This initiative created a new department of law enforcement that was charged to manage what was considered the escalating drug problem in the US. This new department was named the Drug Enforcement Agency (DEA). The DEA department was created because of this initiative, which placed the DEA operatives as crucial players in the United States’ domestic drug policy (Buchman et al., 2017; Olsen & Sharfstein, 2019). The War on Drugs, as well as the HNCA, worked to criminalize those who used opioids and other substances as well as the manufacturers of these illegal substances (Olsen & Sharfstein, 2019). However, no action was taken to focus on helping those who struggled with substance use (i.e., providing effective treatment options for those who used these opioids either illicitly or prescribed). However, it is imperative to note that prescribed opioids are just as addictive as illicit opioids, which have and continue to be misused just like illicit opioids (Buchman et al., 2017; Olsen & Sharfstein, 2019).

The 1914 HNCA, the 1956 Narcotic Control Act, Nixon’s War on Drugs in 1971, Reagan’s Anti-Drug Abuse Act in 1986, which included mandatory minimum sentences for drug possession, Clinton’s crime bill of 1994, as well as Trump’s racist and xenophobic propaganda

blaming individuals from Mexico for the importation of drugs into the US and his promise of a “border wall” to create a barrier on the US/Mexico border, have all helped to fuel the mass incarceration of people from marginalized groups for nonviolent drug offenses (Olsen & Sharfstein, 2019). These marginalized groups continue to be disproportionately targeted by these policies, which were created because of the aforementioned initiatives (Bernard et al., 2018; Buchman et al., 2017; Jones et al., 2018; Lyapustina & Alexander, 2015; Olsen & Sharfstein, 2019). The targeting and stigmatizing of these oppressed and marginalized groups demonstrate how stigmas associated with substance use were initiated by narratives created by the dominant white supremacist society (Olsen & Sharfstein, 2019). Even though these narratives were created long ago, they continue to prevail in our current society (Bernard et al., 2018; Buchman et al., 2017; Olsen & Sharfstein, 2019).

Prior to the late 20th century, opioids were generally reserved only for the treatment of severe traumatic pain, end of life care, and pain related to the treatment of cancer (Bernard et al., 2018; Brand, 2018; Buchman et al., 2017; Jones et al., 2018; Olsen & Sharfstein, 2019; Rummans et al., 2018; Van Zee, 2009) This began to change when the prohibition of opioids began to shift during the 1980s. Much of the research regarding the history of the current opioid epidemic cite a specific source that was cited frequently and used as a significant influencing factor behind this change. This source is a short, one-paragraph letter entitled, “Addiction Rare in Patients Treated with Narcotics,” written by Jane Porter and Boston University professor Hershel Jick (1980). This letter was published on January 10th, 1980, in the popular medical journal *The New England Journal of Medicine* (Bernard, et al, 2018; Buchman et al., 2017; Jones, et al, 2018; Olsen & Sharfstein, 2019; Porter & Jick, 1989; Rummans, et al., 2018; Van Zee, 2009). The Porter and Jick (1980) letter stated that out of 11,882 hospitalized patients who

were treated over a short term, under medical supervision, with opioid narcotics for acute pain, only four had developed an opioid use disorder (Bernard, et al, 2018; Buchman et al., 2017; Jones, et al, 2018; Rummans et al., 2018; Van Zee, 2009). This letter did not provide further evidence that the use of opioids over an extended period for chronic pain and/or non-cancer-related pain was either safe or effective (Bernard et al., 2018; Buchman et al., 2017; Jones et al., 2018; Olsen & Sharfstein, 2019; Rummans et al., 2018). Despite this, the letter became a widely used resource to support the long-term use of opioids for chronic pain. Since the Porter & Jick (1980) letter was published, it has been cited more than 600 times to support the crusade which promoted the long-term use of opioids for treating chronic pain (Buchman et al., 2017; Olsen & Sharfstein, 2019; Rummans et al., 2018). According to Olsen & Sharfstein (2019), “Hershel Jick would later state that he was ‘mortified’ about his letter’s legacy, as his research related to hospitalized patients, not patients with chronic pain” (p. 137). This further exemplifies how this letter, and its research were taken out of context and touted as evidence to support the cause of this crusade.

Many advocates, scientists, and special interest groups campaigned for the long-term use of opioids in the treatment of chronic, non-cancer-related pain (Buchman et al., 2017; Olsen & Sharfstein, 2019; Rummans et al., 2018). These groups often used invalid sources such as the Porter and Jick (1980) letter, as well as other such sources to support their claims that pain was undertreated, and their promotion of less restricted use of opioids in the management of chronic and non-cancer related pain (Bernard et al., 2018; Buchman et al., 2017; Jones et al., 2018; Mularski et al., 2006; Olsen & Sharfstein, 2019; Rummans et al., 2017).

This crusade was further promoted by The American Pain Society (APS) which began its campaign in 1995 declaring that pain need to be viewed and treated similarly to vital signs. This

campaign indicated that pain was drastically undertreated and needed to be evaluated and managed by clinicians in a similar manner to the way that they evaluate and manage a patient's vital signs (Bernard, et al, 2018; Buchman et al., 2017; Lyapustina & Alexander, 2015; Mularski et al., 2006; Olsen & Sharfstein, 2019; Rummans et al., 2018). This campaign was supported by the Veteran's Health Administration (VHA) who in 1998 introduced a form of documentation where hospital patients would designate their level of pain on a scale from 0-to 10. This initiative became known as the 'Pain as the 5th vital sign' (Bernard et al., 2018; Buchman et al., 2017; Lyapustina & Alexander, 2015; Mularski et al., 2006; Olsen & Sharfstein, 2019; Rummans et al., 2018). This initiative led the Center for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality to create a 25-question survey entitled the Hospital Consumer of Healthcare Providers and Systems (HCAHPS) (Bernard et al., 2018; Olsen & Sharfstein, 2019; Rummans et al., 2018). The HCAHPS survey included information about patient's reported level of satisfaction regarding the care they received while in the hospital (Bernard et al., 2018; Buchman et al., 2017; Jones et al., 2018; Olsen & Sharfstein, 2019; Rummans et al., 2018). This survey became a representation of a hospital's quality of care given to patients. The surveys were required to be submitted or the hospital would incur a penalty fine (Bernard et al., 2018; Jones et al., 2018; Olsen & Sharfstein, 2019; Rummans et al., 2018). A hospital's overall survey score would be used to determine if and how much federal healthcare funding a hospital would receive. Out of the 25 questions on this survey, three were designated to a patient's reported level of satisfaction regarding the treatment of their pain management. The patient satisfaction section of the survey made up 30% of the overall score. As a result, clinicians were pushed to either prescribe more opiates to appease patients or risk losing their funding and

incurring a fine (Bernard et al., 2018; Buchman et al., 2017; Jones et al., 2018; Lyapustina & Alexander, 2015; Olsen & Sharfstein, 2019; Rummans et al., 2018).

As a result of the campaigns that advocated for the use of opioids for chronic and non-cancer related pain, the number of opioids being prescribed in the US began to greatly increase (Bernard et al., 2018; Buchman et al., 2017; Jones et al., 2018; Lyapustina & Alexander, 2015; Olsen & Sharfstein, 2019; Rummans et al., 2018). According to Olsen & Sharfstein (2019) “the cultural change in prescribing opioids for pain touched every corner of medical practice - from cardiology to neurology, from dentistry to emergency medicine, from nurse practitioners to physician assistants, from surgery to primary care” (p. 144). The number of opiate prescriptions increased dramatically not only because of these initiatives, but also because of aggressive marketing done by big pharmaceutical corporations, specifically, Purdue Pharmaceutical (Bernard et al., 2018; Buchman et al., 2018; Olsen & Sharfstein, 2019). In 1995 Purdue Pharmaceuticals developed and released the extended-release opiate medication OxyContin® on the market (Bernard et al., 2018; Buchman et al., 2017; Jones et al., 2018; Lyapustina & Alexander, 2015; Olsen & Sharfstein, 2019; Rummans et al., 2018). Purdue Pharmaceuticals used sources lacking sufficient scientific evidence, such as the Porter and Jick (1980) letter, to promote the use of their medication for long-term chronic pain. Purdue created advertisements that stated that opioids, specifically their opioid medication OxyContin®, were safe for treating chronic and non-cancer related pain over an extended period and it was less addictive than traditional opioid medications (Bernard et al., 2018; Buchman et al., 2017; Olsen & Sharfstein, 2019; Rummans et al., 2018).

Purdue additionally sent physicians and hospitals across the nation a training video called “OxyContin® Got My Life Back” which deceptively identified OxyContin® as a safe

medication and detailed that this medication was formulated in a way that addiction was much less likely to occur (Bernard et al., 2018; Buchman et al., 2017; Jones et al., 2018; Olsen & Sharfstein, 2019; Rummans et al., 2018). Purdue also exceedingly used data out of context to support their claims about the safety of the use of their product. These claims and misuse of data were all used successfully to reassure doctors and the public about the safety of using OxyContin® as a long-term treatment method (Bernard et al., 2018; Buchman et al., 2017; Jones et al., 2018; Olsen & Sharfstein, 2019; Rummans et al., 2018). The efforts of the crusade in supporting the use of opioids for chronic pain as well as the aggressive marketing performed by Purdue Pharmaceuticals were successful and proved to be profitable for the company (Bernard et al., 2018; Buchman et al., 2017; Olsen & Sharfstein, 2019). By the year 2016, the United States had 62 million people prescribed at least one form of opioid medication, and the US was consuming 80% of the world's prescription opioids (Olsen & Sharfstein, 2019; Rummans et al., 2018).

In 2004, Purdue was arraigned by the West Virginia attorney general for downplaying the dangers of addiction to their product OxyContin®, which the company settled the case for 10 million dollars. In 2007 Purdue Pharmaceuticals was taken to court by the US Department of Justice, pled guilty to criminal charges and fined 6 hundred million dollars for knowingly advertising their product with deceptive information which downplayed the addictiveness of their product (Bernard et al., 2018; Buchman et al., 2017; Jones et al., 2018; Olsen & Sharfstein, 2019; Rummans et al., 2018). The lies and misdirection of Purdue Pharmaceuticals had finally been revealed after over a decade of deceit. Despite the charges and fines that Purdue Pharmaceutical incurred, the damage was already done. The United States is amid a full-blown opioid epidemic (Bernard et al., 2018; Olsen & Sharfstein, 2019; Rummans et al., 2018).

The opioid epidemic has had a severe and disturbing impact on countless communities and families throughout the US including in the state of Massachusetts. In the year 2019 alone, the state of Massachusetts had over 1,500 confirmed deaths resulting from opioid-related overdoses (Massachusetts Department of Public Health, 2019a, 2019b, 2020). In the same year, Massachusetts was listed as one of the top ten states in the nation with the highest number of deaths resulting from opioid-related overdoses (National Institute on Drug Abuse, 2019). The reluctance of the US government to formally address this crisis earlier is believed to have contributed to the widespread impact of this epidemic which did not just affect large metropolitan cities but also suburban and rural communities (Olsen & Sharfstein, 2019).

Between the years of 1999 and 2017, over 700,000 people died of drug overdoses in the United States. Over 56% or nearly 400,000 of these deaths were confirmed to be from opioid related overdoses (Jones, et al., 2018; Rummans et al., 2018; Scholl, et al., 2018). In the year 2017, 1,913 people died of confirmed opioid related overdoses in Massachusetts (Jones, et al., 2018; National Institute on Drug Abuse, 2019). In October of 2017, the United States Government officially acknowledged the opioid epidemic as a public health emergency (Bernard, et al., 2018; Buchman et al., 2017; Jones, et al., 2018; Olsen & Sharfstein, 2019). The history of the use of opioids in the United States has shown that this is not the first time that this country has dealt with an opioid epidemic. In fact, the events of the past epidemics are uncannily like the events the country is facing today with the current opioid epidemic (Bernard et al., 2018; Buchman et al., 2017; Olsen & Sharfstein, 2019). The current opioid epidemic is the result of multiple contributing factors that for over a century have created the appropriate circumstances which permitted this crisis to grow and eventually spread across the nation (Bernard et al., 2018; Buchman et al., 2017; Jones, et al., 2018; Olsen & Sharfstein, 2019; Rummans et al., 2018).

Substance Use Disorder/Opioid Use Disorder

SUDs are characterized by an obsessive craving for substances and both impulsive and compulsive behaviors that compel someone to continue using a substance or substances despite negative consequences (Buchman et al., 2017; Olsen & Sharfstein, 2019; Volkow et al., 2016; Volkow & Morales, 2015). People with SUD continue to use a substance despite the often severe negative consequences that can impact their health, relationships, and day to day life (Buchman et al., 2017; Olsen & Sharfstein, 2019; Volkow et al., 2016; Volkow & Morales, 2015). The worst of these consequences is of course death (Matto, 2002; Megranahan & Lynskey, 2018; Olsen & Sharfstein, 2019; Volkow et al., 2016). For those suffering from OUD, the substance that is causing these severe cravings and compulsions is opioids. Both prescription and illicit opioids can be addictive and can be extremely dangerous. (Bernard et al., 2018; Buchman et al., 2017; Olsen & Sharfstein, 2019; Rummans et al., 2017).

SUD, which includes OUD, is a largely misunderstood medical condition (Olsen & Sharfstein, 2019; Volkow et al., 2016). Those who suffer from SUD/ OUD are often referred to as ‘addicts’ (Barry et al., 2014; Jones et al., 2018; Olsen & Sharfstein, 2019; Schmanke, 2017). Research has shown that there is a significant stigma associated with this label as well as other commonly used labels that are often placed upon those suffering from these disorders. The common use of labels such as these is shown to have caused widespread discrimination and bias against those suffering from SUD. This discrimination only further impacts their already difficult recovery journeys (Bernard et al., 2018; Buchman et al., 2017; Olsen & Sharfstein, 2019; Rummans et al., 2018).

The discrimination and bias against those with SUD inhibit their access to jobs, their access to safe housing, and contribute greatly to the lack of social support that is needed during

this difficult and vulnerable period of their lives (Barry et al., 2014; Matto, 2002; Megranahan et al., 2018; Olsen & Sharfstein, 2019). It is understandable that the discrimination and lack of access to essential needs and supports would only intensify any feelings of anger, inferiority, guilt, shame, remorse, and hopelessness that those struggling with SUD/ODU often suffer from (Buchman et al., 2017; Olsen & Sharfstein, 2019; Rummans et al., 2017; Schmanke, 2017; Skeffington & Browne, 2014). These negative emotions coupled with lacking access to the necessary support and basic needs often make the already difficult recovery journey even harder and would likely severely deter these individuals' ability to continue with their recovery journeys (Buchman et al., 2017; Matto, 2002; Olsen & Sharfstein, 2019; Rummans et al., 2018).

Treating SUD, the same way as other medical disorders, is important for reducing the stigma surrounding it (Barry et al., 2014; Buchman et al., 2017; Olsen & Sharfstein, 2019; Rummans et al., 2018; Volkow et al., 2016). According to the American Society of Addiction Medicine (ASAM), addiction is “a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual’s life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences” (2019). This definition provides an example of how addiction is seen and understood through the lens of the medical model. This helps to clarify that SUD is a medical disease. By identifying SUD as a real disease, ASAM is addressing some of the associated stigmas and misconceptions that are often associated with SUD/ODU (Jones et al., 2018; Olsen & Sharfstein, 2019; Schmanke, 2017; Skeffington & Browne, 2014).

SUD can be influenced by numerous bio-psycho-social factors including an individual’s familial genetics, direct or indirect exposure to traumatic events, a lack of access to affordable mental health treatment, as well as environments where they grew up, and geography (Buchman

et al., 2017; Olsen & Sharfstein, 2019; Schmanke, 2017; Skeffington & Browne, 2014).

Definitions such as the one provided by the ASAM, help to clarify that SUDs are not a choice and are not the result of having a weak moral compass (Olsen & Sharfstein, 2019; Skeffington & Browne, 2014; Volkow et al., 2016; Volkow & Morales, 2015). Using this definition helps confront stigma because it specifies that this disorder is a medical condition that should be regarded and treated the same way as any other medical condition (Barry et al., 2014; Buchman et al., 2017; Olsen & Sharfstein, 2019).

According to the National Institute on Drug Abuse (NIDA), “addiction is a lot like other diseases, such as heart disease. Both disrupt normal, healthy functioning... have serious harmful effects, that in many cases, are preventable and treatable...can last a lifetime and... lead to death” (2020). While many consider SUD to be a choice or a result of moral failure, they fail to recognize the bio-psycho-social aspects of SUD and its neurological effects (Olsen & Sharfstein, 2019; Schmanke, 2017; Skeffington & Browne, 2014; Volkow et al., 2016; Volkow & Morales, 2015).

Neurobiological effects of SUD

Volkow et al. (2016) identified that SUD affects the brain of those who struggle with this disorder. The authors explained that SUD critically manipulates an individual’s way of thinking, behaviors, and ability to control specific actions such as impulses (Matto, 2002; Olsen & Sharfstein, 2019; Schmanke, 2017; Volkow & Morales, 2015). Volkow et al. (2016) asserted that addictive substances, such as opioids, stimulate the brain’s reward center by releasing intense dopamine surges. When the brain’s reward center is stimulated after recurrent occurrences, the brain learns to associate the sense of reward with those specific stimuli, which can include people, places, objects, and sensory-related stimuli (Olsen & Sharfstein, 2019; Volkow et al.,

2016). When these external stimuli have become associated with the sense of reward, dopamine begins to be released by experiencing the associated stimuli. The dopamine is being released as an anticipatory response to the stimuli instead of for the reward. These releases of dopamine in response to stimuli are what create triggers and subsequent cravings for individuals with SUD (Matto, 2002; Olsen & Sharfstein, 2019; Schmanke, 2017; Volkow et al., 2016).

These conditioned responses become profoundly embedded and can cause the individual to experience cravings even after the person has stopped using the substance long ago.

According to Volkow & Morales (2015) repeated substance use “triggers neuroplastic changes in the glutamatergic inputs to the striatum and midbrain dopamine neurons, enhancing the brain’s reactivity to drug cues, reducing the sensitivity to non-drug rewards, weakening self-regulation, and increasing the sensitivity to stressful stimuli and dysphoria” (p. 712). Therefore, as stated by Volkow & Morales (2015) “interventions designed to counteract dysphoria or strengthen executive control... may improve long-term success and recovery from addiction” (p. 720). Art therapy research has shown that AT counteracts dysphoria and can strengthen the executive control functioning in the brain that is affected by prolonged SUD, which makes it an ideal treatment option for supporting those in recovery from SUD (Schmanke, 2017).

Treatment of SUD

According to Olsen & Sharfstein (2019), there are several components involved in the effective treatment of SUD/OD. These components include medication, mental health counseling, and social support. Research indicates that a multimodal approach to SUD treatment, which includes therapy, is the most effective treatment method (Matto, 2002; Olsen & Sharfstein, 2019; Schmanke, 2017; Volkow et al, 2016; Volkow & Morales, 2015). Medication is often involved when treating individuals with OUD. Olsen & Sharfstein (2019) have identified

that the United States Food and Drug Administration (FDA) has approved the following medications for OUD treatment: buprenorphine, methadone, and naltrexone. These medications have been tested and shown to effectively help reduce illicit opioid use by satiating the parts of the brain that cue cravings for substances while also inhibiting the sensation of pleasure and reward related to the substance use (Olsen & Sharfstein, 2019). Over time, these medications help to reduce cravings. By gradually diminishing cravings, these medications also help to reduce the actions or behaviors that an individual would engage in to obtain the substances (Olsen & Sharfstein, 2019; Volkow et al., 2016).

Along with medication, psychotherapy is a vital part of SUD treatment (Olsen & Sharfstein, 2019). A major objective of SUD counseling is supporting people to learn how to identify their triggers and how to effectively react to them (Olsen & Sharfstein, 2019; Schmanke, 2017). Counseling can reveal underlying psychological features and needed supportive social services, which may be contributing to the SUD. With this knowledge, counselors can provide better support and resources to those they serve, as they can help them learn how to manage their SUD as well as any other contributing bio-psycho-social factors (Matto, 2002; Olsen & Sharfstein, 2019; Schmanke, 2017; Skeffington & Browne, 2014). It is also important to screen clients with SUD/OUD for other underlying conditions, as they may be using substances to self-medicate. A few of the other conditions that are often diagnosed in individuals suffering from SUD include depression, bipolar disorder, and post-traumatic stress disorder (PTSD) (Olsen & Sharfstein, 2019). According to Olsen & Sharfstein (2019), “all people with addiction need social support, including healthy friendships and access to nutritious food, safe housing, and, for many people, employment” (p. 18). Without access to these important social supports, those with

SUD would likely find maintaining their recovery incredibly difficult, if not impossible (Barry et al., 2014; Buchman et al., 2017; Olsen & Sharfstein, 2019).

Art Therapy

Art therapy (AT) is a form of psychotherapy that utilizes the creative process of artmaking to facilitate therapeutic growth, healing, and transformation. As a therapeutic modality, AT goes beyond traditional talk therapy by incorporating the cognitive and physical processes involved in creating artwork to expand on what can be expressed through verbal communication alone (Feen-Calligan et al., 2008; Malchiodi, 2011; Schmanke, 2017). AT is a practice that exercises the creative process as a means of expressing emotions and thoughts in a manner that facilitates reparation, insight, motivation, and recovery (Feen-Calligan et al., 2008; Hanes, 2017; Malchiodi, 2011; Schmanke, 2017). AT is a creative therapeutic modality that is shown to be beneficial for people of all ages. Using the therapeutic creative process, clients can gain insight, create meaning in their lives, express and find relief from difficult and traumatic experiences, express and clarify overpowering and unconscious emotions, enhance overall sense of wellbeing, and improve ones' everyday life (Malchiodi, 2011).

Art Therapy in the Treatment of SUD

The first mention of art therapy being used as a treatment modality for individuals with SUD was in an article featured in the psychiatric journal *Psychiatry* in the early 1950s (Feen-Calligan, 2007; Hanes, 2017; Schmanke, 2017). The 1953 article was authored by art therapy pioneer Elinor Ulman. In the article, Ulman elaborated on her time working at the Alcoholic Rehabilitation Program of the District of Columbia (Schmanke, 2017). The first article which described the use of art therapy with the SUD population was written nearly 70 years ago; since then, several studies and literature that explores art therapy as a treatment modality with this

population has been published (Feen-Calligan, 2007; Laurer & Van der Vennet, 2015; Megrarahan & Lynskey, 2018; Schmanke, 2017). Of these studies that have been done, art therapy has been shown to be highly useful in treating those with SUD (Adedoyin et al., 2014; Feen-Calligan et al., 2008; Horay, 2006; Schmanke, 2017).

The literature will focus on three of the benefits that art therapy provides for those in recovery. The first of these benefits is the use of art therapy as a form of nonverbal, expressive, and symbolic communication (Hanes, 2017; Holt & Kaiser, 2009; Schmanke, 2017). Hanes's (2017) conducted a qualitative study with women in a residential substance use treatment facility which discovered that the client's road drawing artwork served as a metaphor for their potential and motivation for change. Another study conducted by Holt & Kaiser (2009) explored the use of an art therapy protocol involving five directives with clients in the early stages of SUD treatment. This research found that the creative process helped clients to express conscious and uncover unconscious feelings, thoughts, and experiences. Revealing these feelings, thoughts, and experiences allowed for the examination of both known and previously unknown information yielding for implicit knowledge to convert into explicit knowledge. The authors further identified that self-expression provided clients with a subsequent sense of emotional relief.

The second benefit art therapy can offer those in recovery is a valuable method to identify, explore, and process difficult emotions, thoughts, and experiences through the creative process (Feen-Calligan et al., 2008; Hanes, 2017; Schmanke, 2017; Skeffington & Browne, 2014). A qualitative study conducted by Feen-Calligan et al. (2008) investigated the effects of using famous art reproductions in group therapy with minority women in residential inpatient SUD treatment facilities. This study established that clients were able to find links between their thoughts, feelings, and behaviors, plus recognize the effect that these attitudes and perceptions

had on their recovery process. The researchers discovered that clients were able to interpret and relate to the mood conveyed from the artwork. By relating to the art on an emotional level, the artwork provided a platform that allowed the clients to feel safe disclosing about difficult experiences, including traumatic experiences, that they associated with the feeling expressed in the artwork. A case study with a female client in an Australian substance use treatment facility conducted by Skeffington & Browne (2014) found that artwork produced in group art therapy sessions provided a meaningful opportunity for the client to safely face and explore their past traumatic experiences in a way that was not overwhelming. Additionally, this case study found that addressing these experiences in this way also helped to facilitate therapeutic transformation for the client that awakened their internal motivation to change their maladaptive lifestyle.

The third benefit art therapy provides for those in recovery is a process that allows for enhanced self-awareness, an opportunity to gain insight, explore possible options, identify needs, and acknowledge the need to change (Feen-Calligan et al., 2008; Hanes, 2017; Schmanke, 2017; Skeffington & Browne, 2014). A review conducted by Adedoyin et al., (2014) explored whether expressive therapy interventions improved the efficacy of conventional outpatient substance use treatment approaches. Through their research, the authors found evidence that “art therapy can facilitate new insights, expression of emotions and conflicts, and formulating new perspectives that encourage positive growth and healing” (p. 542). The authors elaborated that art therapy is a holistic process that utilizes all the senses and provides clients an opportunity to separate themselves from their troubles, via the creative process. This in turn offers a meaningful way for the clients to gain an objective perception of the issue. With this newfound perception, clients along with their therapist, can uncover useful solutions for the troubles they are facing (Feen-

Calligan et al., 2008; Hanes, 2017; Kapitan et al., 2011; Matto, 2002; Schmanke, 2017; Skeffington & Browne, 2014).

Community Art Therapy

Art therapy is a practice that is not strictly limited to private or clinical treatment settings. Other sites where AT is used include community-based settings (Kapitan et al., 2011; Potash & Vance, 2022; Slayton, 2012; Talwar, 2015). Community-based AT uses healing or transformative arts interventions focused on organizational and community needs versus interventions designed to meet individual clients or group needs within clinical or private practice settings (Kapitan et al., 2011; Slayton, 2012). It is typical for community-based AT to form cooperative affiliations with organizations based in the community that identifies social advocacy as a primary objective (Kapitan et al., 2011; Nolan, 2019; Slayton, 2012).

Research has shown that community-based art therapy can provide many advantages (Golub, 2005; Nolan, 2019; Potash & Vance, 2022; Slayton, 2012). For the purposes of this literature review, two of the advantages that meet the needs of those with SUD will be investigated. The first advantage that will be explored is how community-based art therapy helps to bring people together to build a community of healing and work towards a common goal (Nolan, 2019; Potash & Vance, 2022; Slayton, 2012). The second advantage is how community-based art therapy can empower a community to work together to create social change (Golub, 2005; Nolan, 2019; Potash & Vance, 2022; Slayton, 2012).

The first advantage of bringing a community together to heal and work towards a common goal is demonstrated in a qualitative study conducted by DelliCarpini (2020). The author facilitated a community-based mural making project in New York City with youths involved in the city's justice system. The study's objective was to boost social connection and

facilitate “social power shifts within a collective community” (p. 185). The study revealed that the participants were able to enhance their communal connections, and through the mural project found a creative and meaningful way to critique the misrepresentation that is imposed on them by a dominant society that actively rejects their sense of agency.

The second benefit is how community-based art therapy can be used to empower a community and create social change. This advantage is demonstrated in a qualitative thematic analysis conducted by Potash & Vance (2022). This analysis investigated protest artwork displayed during a Black Lives Matter protest at the White House in response to the murder of George Floyd by police (Egan et al., 2020). Potash & Vance’s analysis results found that the artwork signage and the protest itself “offered a collective vision for social change and building cross-racial solidarity” (p. 126). The authors found that the artwork served to identify and communicate systemic problems, upheld and celebrated Black cultural identity, communicated the dignity of the Black community in their resistance against oppression, and the artwork served to memorialize those who had been killed. Kapitan et al. (2011) supports this evidence by indicating that “a traumatized community may turn to the arts to help its members move from personal tragedy towards shared experiences that restore collective identity” (p. 65). Potash & Vance (2022) additionally discovered that the protestors’ artwork contained both explicit messages asserting the need for social change as well as serving as a container for holding and sharing the complex emotions held by the protestors and a significant portion of the US population (Potash & Vance, 2022).

Discussion

Art therapy in specific clinical settings devoted to SUD treatment within the US has been practiced since at least the 1950s. Despite the significant history of the use of art therapy in clinical SUD treatment, there is no literature is available that investigates the use of art therapy in community-based treatment settings as a form of ongoing treatment option for those with SUD. The lack of research that explores the use of art therapy outside of clinical settings for those with SUD illustrates a major gap in the present art therapy literature. This gap is particularly relevant as it demonstrates the lack of available ongoing community-based treatment options (Olsen & Sharfstein, 2019) that utilize the healing power of the arts for those individuals and communities that have and continue to be affected by the current opioid epidemic.

Community-based AT for those with SUD can provide vital community and social support for those in recovery (Kapitan et al., 2011; Potash & Vance, 2022; Talwar, 2015). After completing a clinical treatment program, those in recovery are often sent home. For many of those in recovery, their home communities are the same communities where they were active in their substance use before treatment. By returning to the same environments, those in recovery are essentially being forced to face unavoidable triggers that induce powerful cravings alone while they are still very vulnerable in the early stages of their recovery process (Olsen & Sharfstein, 2019; Schmanke, 2017). This places those in recovery in situations that could endanger their recovery as well as their lives. When those in recovery come across the same places and people that they historically associate with their substance use, they may be triggered and once again experience cravings (Matto, 2002; Olsen & Sharfstein, 2019; Volkow et al., 2016). Although they may have abstained from substance use throughout their time in clinical treatment and possibly beyond, cravings pose a threat to anyone in recovery, regardless of how

long it's been since they last used. This is especially true when there is a lack of available resources where they can access the type of support that they need (Olsen & Sharfstein, 2019).

While the strategies and skills that they developed while in treatment may help to some degree, with repeated exposure to triggers, the likelihood that they may relapse increases (Matto, 2002; Olsen & Sharfstein, 2019; Schmanke, 2017; Skeffington & Browne, 2014; Volkow et al., 2016; Volkow & Morales, 2015). Financial instability is an issue that often affects those with SUD/ODU (Olsen & Sharfstein, 2019; Schmanke, 2017; Skeffington & Browne, 2014). Because of this, most people in recovery don't have the ability to just move to a new community and start a whole new life. Since most people do not have this type of privilege, those in recovery may feel stuck in an environment where they are faced with unavoidable people, places, and things that trigger cravings which further compounds the difficult recovery journey (Matto, 2002; Olsen & Sharfstein, 2019; Schmanke, 2017; Skeffington & Browne, 2014; Volkow et al., 2016; Volkow & Morales, 2015). This is especially relevant for those who live in communities that have been extensively affected by the current opioid epidemic (Olsen & Sharfstein, 2019).

Without access to appropriate community-based AT programs that provide the support that those in recovery need in their day to day lives, the likelihood of relapse, overdose, and death is significantly increased (Casey & Webb, 2019; Kapitan et al., 2011; Matto, 2002; Olsen & Sharfstein, 2019; Volkow et al., 2016). While specific resources such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) meetings are generally available, they may not necessarily be appropriate or provide the support needed for everyone in recovery. Not everyone in recovery finds that AA or NA meetings are helpful to their circumstance, and there is no one-size-fits-all treatment for SUD (Dickson, 2007; Hanes, 2017; Olsen & Sharfstein, 2019; Schmanke, 2017). The literature maintains that multimodal approaches to SUD treatment

are the most effective (Olsen & Sharfstein, 2019; Schmanke, 2017; Skeffington & Browne, 2014; Volkow et al., 2016; Volkow & Morales, 2015). Therefore, providing alternative resources such as community-based AT programs for those in SUD recovery could provide invaluable support to not only individuals in recovery but also to the wider communities affected by the opioid epidemic (Casey & Webb, 2019; Kapitan et al., 2011; Klorer, 2014; Olsen & Sharfstein, 2019).

The current opioid epidemic has had a devastating effect on individuals, families, and communities across the US. While some clinical treatment options are available for individuals with SUD/ODU that utilize AT within their programs, supportive community-based treatment options that use art therapy outside of clinical SUD treatment settings, are scarce to non-existent. Literature discussing the use of AT with those with SUD in clinical settings has shown that it can be a highly beneficial form of treatment for this population (Feen- Calligan, 2007; Feen- Caligan et al., 2008; Hanes, 2017; Holt & Kaiser, 2009; Skeffington & Browne, 2014). Due to the advantages that art therapy can provide for this population within clinical settings, it can be assumed that art therapy would also be beneficial as a form of ongoing treatment. This treatment option would be particularly valuable to those who have completed inpatient clinical treatment programs and those who do not have access to clinical treatment options. Furthermore, community-based therapeutic interventions could provide a more extensive scale resource to whole communities affected by the opioid epidemic (Olsen & Sharfstein, 2019). Based on the research that identifies the many benefits that art therapy provides those within treatment for SUD, it is surmisable that community-based art therapy interventions would be especially valuable for communities confronting the devastating effects of the opioid epidemic.

Due to the current COVID-19 pandemic, I could not pursue the community engagement project that I had initially planned to do. However, it is my goal that my research will illuminate this gap within the art therapy literature and illustrate the need for further investigation. I also hope that my research may provide a stepping-off point for future studies in examining the possible benefits of using community-based art therapy with both individuals and communities struggling with or affected by SUD/OD. The ongoing opioid epidemic has increased the need for diverse treatment options, as well as treatment providers available to those within communities who are affected by OUD (Olsen & Sharfstein, 2019; Volkow et al., 2016). Community-based art therapy has the potential to provide a valuable resource for both the individuals and communities affected by this epidemic. This type of resource could prove useful to those who have found that they cannot access traditional clinical treatment resources or the available services within their community are lacking the type of support they need (Olsen & Sharfstein, 2019). Community-based art therapy can provide an accessible, supportive, and healing form of treatment to those in need, especially those who are struggling to maintain their recovery after completing their clinical treatment program (Hanes, 2017; Kapitan et al., 2011; Schmanke, 2019; Skeffington & Browne, 2014).

Limitations for this review include the small number of participants involved in the studies. Because of this the results for any of the research cannot be generalized. Not all the research used concluded that AT would be the most beneficial treatment modality to use with the SUD population. Research conducted by Megrnahan et al. (2018) identified music therapy to be the most beneficial modality to use with this population. The literature used was all English language articles which limits the scope of this review. Much of the research was conducted in clinical inpatient SUD treatment settings in the US which is not accessible for many

marginalized communities. Lastly, I recognize that my worldview has been shaped by my heritage, culture, privilege, environment, relationships, and education which influences the perspective and possible bias of this review. Unfortunately, there is no literature available that discusses the use of community-based AT with those in recovery from SUD, or as a response to the effects of the opioid epidemic. As mentioned earlier, the need for community-based supports and resources plays an important role in helping those with SUD/ODU to maintain their recovery (Olsen & Sharfstein, 2019; Schmanke, 2017; Volkow et al., 2016). Having treatment resources that utilize AT in community-based settings would fill a much-needed gap in the available treatment options to individuals in recovery and provide a valuable resource for the wider community effected by the opioid epidemic.

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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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