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Development of an Art Therapy Protocol for Reducing Shame in Forensic Offenders

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Abstract

This research follows the development and implementation of the *Shame Reduction for Offenders (SRO)* art therapy protocol. The protocol is carried out in a group format with twelve participants with forensic backgrounds on an inpatient unit at a psychiatric state hospital. Using art therapy, the patients directly and indirectly address feelings of shame as well as fear of losing control. Due to the nature of art therapy, the non-verbal aspects of this protocol allow participants to confront these feelings in a less threatening space. This protocol allows participants to gain insight and communicate about the topics of shame and control more confidently during and after these sessions than in previous treatment, as reported by the treatment teams of the participating individuals as well as observations by the group co-leaders.

Introduction

Patients with a forensic history often show fear of losing control, as discovered by personal observation as well as through the shared experiences of others working with this population. This fear of potential recidivism, and often shame about the original loss of control, leads to self-sabotage as a patient approaches a potential path to discharge. Fear of losing control is at the center of the shame that many of these patients exhibit surrounding their offenses. Based on this understanding, I developed the *Shame Reduction for Offenders (SRO)* art therapy protocol. The SRO protocol directly addresses the observed experience of shame as well as fear of losing control, and is intended for use with any participants who have a forensic history. For the purposes of this primary research and further development of the SRO protocol, this protocol was administered in a group format on an in-patient psychiatric unit with patients who had been charged not guilty for reasons of mental illness (NGRI) or incompetent to stand trial (IST). This inquiry examines the use of this art therapy protocol as a tool to engage participants in insight, psychoeducation, and self-acceptance concerning the emotions of shame and fear of losing control in patients with a forensic history who have also been diagnosed with mental illness.

Through literature, this paper addresses the areas of forensic psychiatry and treatment in forensic hospitals, forensic art therapy, art therapy in psychiatric hospitals, psychiatry and shame, and art therapy and shame. There is substantial support that the level of experiencing shame directly correlates with depressive symptoms as shown by multiple studies using the Internalized Shame Scale (Cook, 2001) and The Experience of Shame Scale (Andrews, Qian, & Valentine, 2002). There have also been studies linking the suppression of shame with the expression of hostility and aggression in a maladaptive manner (Jakupcak, Tull, & Roemer, 2005). Understanding shame and how it relates to other behaviors that are commonly treated allows for

a greater consideration of how shame may need to be addressed in treatment as well. This understanding is shown throughout this paper as the SRO protocol focuses treatment directly on reducing shame.

Art therapy has been used with forensic clients for a variety of purposes with success, including decreasing depressive symptoms (Gussak, 2007), fostering hope (Kim, Kim, & Kim, 2017), increasing insight and decreasing recidivism (Smeijesters & Cleven, 2006). Art therapy has also been shown to effectively reduce feelings of shame such as in Mills & Kellington's work with children who had witnessed domestic violence (2012) as well as Marie Wilson's work with those recovering from a sex or substance addiction (2000; 2012).

The development of the SRO art therapy protocol has been heavily influenced by forensic art therapy research such as how to address aggression using art therapy (Smeijsters & Cleven, 2006), and art therapy and shame protocols such as those written by Wilson (2000). Additionally, art therapy directives have been inspired by treatment tools used in forensic psychiatry (Linhorst & Turner, 1999).

Literature Review

This review will highlight the current literature as it pertains to the current treatment of forensic patients and clients as well as how art therapy uniquely addresses reducing feelings of shame.

Forensic Psychology Treatment

Linhorst & Turner (1999) review the literature surrounding current forensic treatment in hospitals. They find that multiple studies have established the existing treatments to be insufficient, focusing on only medication and evaluation rather than offering appropriate psychotherapy treatment when needed. The main study discussed in this article examines this

finding further, following the medical treatment in four long-term psychiatric public hospitals serving patients with either a legally sectioned or voluntary status. This study focused mostly on patients found Not Guilty for Reasons of Mental Illness (NGRI) due to their long lengths of hospitalization. Linhorst & Turner (1999) found significant differences when comparing the results of which mental illnesses NGRI patients were diagnosed with versus those of voluntary patients. Patients who were found NGRI had a higher percentage of co-occurring substance use disorder and personality disorders than voluntary patients. They also found that NGRI patients, on average, were higher functioning than those who were on a voluntary status and that NGRI patients were less likely to require restraints or commit assault on hospital grounds. Linhorst & Turner (1999) attributed these differences to not be due to differences in the nature of these populations, but to the different standards used for discharge from the hospital, as those who are found NGRI are held to a higher standard of functioning before being released from the hospital. In the past, insufficient treatment of NGRI patients has been attributed to that status being a small percentage of the hospital population. However, NGRI patients now are often the majority at public state hospitals, calling for new treatment standards and rehabilitation offerings to be required for successful community reintegration (Linhorst & Turner, 1999).

Forensic offenders and shame. Tangney, Stuewig, Mashek, & Hastings (2011) examine the extent to which 550 jail inmates are prone to guilt and shame. The research found that the incarcerated offenders were prone to shame and guilt to the same degree, and experienced these emotions to serve the same functions, as the general community samples. Among other specifics in the application of their findings, Tangney, et al. (2011) found that proneness to shame was likely connected to impulsivity, "criminogenic patterns of thinking," and substance use. These associations are all aspects of patients' lives as observed in an inpatient psychiatric unit that may

increase as a form of self-sabotage as one approaches a path to discharge. Tangney, et al. (2011)

found these findings to have a high level of generalizability across gender and race. However,

these findings were reported based on findings with inmates charged with felonies and may not

apply to those with misdemeanor offenses.

Forensic Art Therapy

In Chapter 1 of his edited book, Drawing Time: Art Therapy in Prisons and Other

Correctional Settings, Gussak (1997) describes the use of art therapy for prison populations as

invaluable due to its nonverbal nature. This allows for access to nonverbal responses and content

unavailable through talk therapy alone, as well as the expression of complex material in a

simplified way. In an already threatening environment, nonverbal expression allows for

disclosure of information without a requirement to discuss the vulnerable material. A trained art

therapist is able to guide these patients through the emotional process of working through his or

her problems revealed by these disclosures, sometimes never even leaving the metaphorical

plane to allow distance from the intimidating subject matter. Through a case study, Gussak

(1997) demonstrates how art therapy can be used to break through the defenses of a prisoner to

work through their problems within the art process without destroying the defenses needed to

stay safe in the limited and vulnerable environment of a prison. This aspect of art therapy

applies to many vulnerable environments and situations, including that of a psychiatric hospital.

Residing on a unit with many patients learning how to best function while living with a variety

of mental health diagnoses is difficult environmentally. Due to this, it is important that patients

in this setting are able to keep the defenses needed for daily functioning in this difficult situation

while treatment is being provided.

In his article, The Effectiveness of Art Therapy in Reducing Depression in Prison Populations, Gussak (2007) evaluates the effect of art therapy in prisons on inmates' depressive symptoms. He specifies eight benefits that are particular to art therapy in a correctional setting: non-verbal communication may be preferred due to common low educational levels and disabilities in this population; a simple form of expression for complex material; no required direct disclosure; art promotes disclosure in a non-threatening way; art can bypass common defenses; art can "diminish pathological symptoms without verbal interpretation" (Gussak, 2007, p.446); art allows for a diversion and emotional escape; and art allows for a form of expression that is socially acceptable.

Smeijsters & Cleven (2006) find evidence that arts therapies can help to decrease recidivism. Art therapy in particular is mainly used as a coping mechanism or as a part of cognitive-behavioral psychotherapy in their patients' treatment. Art therapy also has been shown to allow patients to increase personal insight as well as understanding of the behaviors of others (Smeijsters & Cleven, 2006). The particular materials and techniques chosen for expression in art therapy can allow for a release of aggression. It also allows the patient to reflect on an image related to their crime without directly addressing the crime itself. Of all the arts therapies, art was found to be the best selection in order to reach insight and decrease cognitive distortion. With this, the SRO protocol uses art therapy techniques to both directly and indirectly address cognitions and emotions surrounding a participant's offense(s).

Day & Onorato (1997) address the subjects of empowerment, containment, reaching out, transformation of shame, and resolution through their group art therapy process with inmates who have experienced trauma. Day & Onorato (1997) found through their group case study an ability to work through these subjects using art therapy despite the prison setting. They note the

importance of increasing services directed at self-improvement in forensic settings. These

subjects are not the only areas that those who have experienced trauma go through. Addressing

empowerment, containment, reaching out, transformation of shame and resolution could be

beneficial to all offenders who have experienced a sense of victimization, including those with a

mental illness.

Aulich (1994) examines how various types of treatment of sex offenders affects the

deeper motivation behind the offending behavior, such as knowledge about sexuality, insight into

feelings, and the development of healthy behavior patterns. Aulich approaches the sense of

control in art therapy sessions and how control (either a lack thereof or overuse of it) with the art

materials and within the therapeutic relationship can parallel how the patient uses control in their

daily interactions. This provides the opportunity to work on this sense of interpersonal control

with some distance. The patient and therapist can work on this in an indirect way, addressing the

control of the art materials, or a direct way, addressing the interactions between patient and

therapist during the art making process. Through a case study, Aulich found one client had an

intense need to gain and maintain control, which he was able to do in the art therapy sessions.

Aulich (1994) also looks at the concept of self-image in her clients who have committed sex

offenses.

Working with clients who are on probation, Liebmann (1994) used her skills as an art

therapist in her job as a probation officer. Through individual case studies, Liebmann describes

how she used her role as a healer rather than a punisher, using art therapy and her unique

position to help her clients with both practical and emotional problems. These case studies

demonstrate the clients' ability to identify events leading to their offenses through art therapy.

Liebmann found this gained insight enhanced the clients' sense of control and improved their decision making skills.

Art Therapy in Psychiatric Hospitals

Kim, Kim & Kim (2017) looks at the effects of art therapy, particularly the use of mandalas, on psychiatric inpatients. The researchers studied patients with a variety of mental health diagnoses, including schizophrenia, bipolar disorder, and major depressive disorder. Assessing both before and after the art therapy sessions, the researchers measured differences in subjective well-being, resilience, and hope. The results showed that this form of group art therapy increased hope for the subjects, though no significant difference in markers of well-being or resilience were discovered. This increase in hope, as well as a sense of empowerment and achievement, was also found by George and Kasinathan (2015) in their work doing mural art therapy with young offenders with a mental illness diagnosis. Many living situations that offenders may find themselves in, whether it be a prison setting or a hospital setting, are difficult settings in which to maintain hope. One must be able to have a sense of hope in order to have the drive to work on him or herself. The research of Kim, et al. (2017) demonstrates how the use of art therapy as a modality can increase hope in these settings, preparing patients or clients to have the motivation to work on themselves.

The findings of Kim, et al. (2017) were also supported by the qualitative description of participants in De Vecchi, Kenny, & Kidd (2015). In this research analyzing the use of art therapy in rehabilitation programing in a psychiatric facility, the participants identified that the art therapy differed from other rehabilitation programing due to its ability to serve as a space for self-expression and building confidence.

Treatment Surrounding Shame

Psychiatry and shame. Andrews, Qian, & Valentine (2002) test the accuracy of the Experience of Shame Scale (ESS) questionnaire compared to the already established shame scale of Test of Self-Conscious Affect (TOSCA) in relation to patients' depressive symptoms. The study concluded that ESS assessed specific areas of shame such as self and performance whereas TOSCA assessed general shame. In explaining their rationale behind the creation of the ESS, Andrews, et al. (2002) note that many tools assessing a specific emotion avoid directly asking about the particular emotion, such as shame, whereas others only directly address it.   Both indicate a correlation between shame and depressive symptoms. Andrews, et al. (2002) use this study to analyze if shame is able to be used as a predictor of these depressive symptoms. Tools such as the ESS, TOSCA, and Cook's (2001) Internalized Shame Scale provide an overview of what types of questions are being asked in order to measure the experience of shame. Andrews, et al.'s (2002) ESS assessed characterological shame, behavioral shame, and bodily shame. Areas within these types of shame are broken up and addressed with an experiential component, a cognitive component, and a behavioral component. For the research and creation of the SRO protocol, characterological shame and behavioral shame were the primary shame components focused on**.**

Ashby, Rice, & Martin (2006) used regression analysis to examine how shame mediates the relationship between maladaptive perfectionism and depression. This article provides an example of how the Internalized Shame Scale (ISS) is used in practice. For Ashby, Rice, & Martin's (2006) study, the ISS is used in combination with the Beck Depression Inventory (BDI) and the Rosenberg Self-Esteem Inventory (RSI). The study concluded that maladaptive perfectionism is likely to be one cause of increasing depressive symptoms, low self-esteem, and/or shame. The concepts of maladaptive perfectionism as well as learning to forgive oneself

for mistakes are shown by Ashby, et al. (2006) to be crucial in reducing internalized shame. The SRO includes specific interventions that address improving self-esteem, increasing self-confidence, and embracing self-affirmations in order to address these concepts.

Jakupak, Tull, & Roemer (2005), evaluate the link between shame and hostility or aggression, observing that many men use hostility as a way to eliminate emotions such as shame or fear. Jakupcak, et al. discuss not only that there is a connection between hostility and shame, but that the suppression of shame, as well as fear of loss of control which furthers the shame, may lead to the expression of aggression. While there is not yet proof of causation, the results of the study found men's fear of vulnerability to be a predictor of anger expression. As the SRO is focused on the population of those who have a history of forensic offenses, the link between expression of anger and hostility, and shame and fear of emotions, is an important one. Jakupcak, Tull, & Roemer (2005) note, "A number of clinical observations suggest that men may express hostility and aggression to terminate vulnerable emotions, such as shame" (p.276). This link between hostility and shame is an important one to note when pursing treatment to minimize recidivism. In order to work with this, the SRO protocol directly addresses shame, normalizing the emotion and using psychoeducation to create a greater understanding around the feared emotion. Jakupcak, et al. discuss not only that there is a connection between hostility and shame, but that the suppression of shame, as well as fear of loss of control which furthers the shame, may lead to the expression of aggression. However, it is important to note that there is not yet proof of causation. In looking at this, the SRO protocol addresses understanding and accepting shame as well as re-gaining confidence in one's own sense of self-control in order to minimize acts of aggression and hostility.

Art therapy and shame. Art can be used to manage difficult topics, allowing the participant to have a sense of control as well as containment of what they are creating and expressing. Mills & Kellington (2012) use group art therapy "to witness—in a very concrete, as well as metaphorical way—the truth of the children's experiences" (p.10). This witnessing allows for a space to address the shame children feel in regard to having witnessed domestic violence. The researchers found that addressing the experiences that the shame surrounds through art allowed the subjects to increase their sense of self-worth (Mills & Kellington, 2012).

Similarly, Wilson (2012) discusses her use of art therapy focused on reducing shame in addictions treatment in her chapter in Malchioti's *Handbook to Art Therapy*. Reviewing the literature surrounding shame theory, shame and addiction, art therapy in addictions treatment, and art therapy and shame reduction, Wilson develops a protocol for shame reduction art therapy treatment directly addressing aspects of addiction that relate to shame. Wilson (2000) also adjusts her art therapy shame reduction treatment to specifically address sex addiction. In both of these shame reduction treatments, Wilson notes the importance of establishing safety within a group and with oneself, understanding various aspects of addiction, breaking through denial, recognizing the process of recovery, and addressing the origins of shame. Wilson used the participants' recognition of their shame and the labeling of it to distance their feelings from it, allowing these participants to then address the cognitive dissonance surrounding the feeling of shame.

Methods

The Stress Reduction for Offenders (SRO) was created using a combination of my observations from clinical experience and research of those working with forensics (Tangney, et al., 2011; Liebman, 1994), art therapy (Gussak, 1997, 2007; Smeijsters & Cleven, 2006; Aulich,

1994), and shame (Andrews, et al., 2002; Ashby, et al. 2006; Jakupacak, et al., 2005; Wilson, 2000, 2012). The SRO art therapy protocol, discussed throughout this research, was implemented with adults with a forensic history and mental health diagnosis.

Participants

The SRO protocol was initially carried out on a locked psychiatric in-patient hospital unit with patients who have a history of committing at least one felony and have been sectioned to the hospital having been found either incompetent to stand trial (IST) or not guilty for reasons of mental illness (NGRI). The art therapy protocol was carried out in a 45-minute weekly group therapy setting with twelve adult participants over the span of six weeks.

Participants for this research were originally selected by the rehabilitation treatment team on one particular unit of an inpatient psychiatric unit. Of the twelve participants selected, each were invited to participate in the session every week. Though asked to participate in all six sessions, participants selected week by week if they would like to attend that day. Each of these participants fully attended at least one session of this group.

Procedure and Materials

The SRO protocol can be adjusted to use a variety of materials that can be made regularly available. In this use of the protocol, model magic, colored pencils, and markers were made available each week for the participants to select from. For the group sessions at the in-patient unit, each session began with each participant summarizing in one word how they felt about the previous 48 hours. This process helped establish a routine and allowed each client to acknowledge the feelings they had in that moment while moving into the group space. At the end of each session, each participant set an intention for themselves for the upcoming week. This

helped establish a routine while also encouraging participants to come back to the present

moment before returning to their life outside of the group.

Protocol Breakdown

The protocol consists of six themed sessions: establishing safety with the group and self;

art as container; understanding, defining, and normalizing shame; taking control; self-

affirmation; and empowerment. These sessions work together to form group connection and a

safe space to explore and work through emotional subject matter.

Establishing safety with the group and self. It is important to begin a group by

recognizing the need to establish a safe space within the closed group. This session begins with

working together as a group to establish ongoing group guidelines. The participants are then

directed to create art about how they want to introduce themselves to the group. Each participant

is then asked to share their name and something they want the group to know about them, with

the option of sharing their art during this process.

Art as container. Understanding the art as a container for difficult emotions allows for

participants to feel comfortable expressing themselves through the artwork. This also

demonstrates to the participant that it is safe to explore those difficult emotions. Using premade

paper boxes or wooden boxes (paper bags will also work if boxes are unavailable), participants

are instructed to create a representation of themselves. Using drawing and collage materials, on

the outside of the box, participants create a representation of what they want others to see about

themselves. On the inside of the box, participants represent emotions that they prefer to keep

inside and not allow others to see.

Understanding, defining, and normalizing shame. In this session, a combination of art

therapy and psychoeducation is used, working towards allowing for comfortable conversation

around a topic that is often not verbally acknowledged. This session also supports the goal of

linking among group members through sharing of this common emotion: shame. The session

begins with a psychoeducation session on shame, discussing how common shame is as well as

presenting the participants with a summary of current research related to shame. Using an air

dry clay such as model magic, participants are instructed to create a creature that represents the

emotion of shame. Participants are then given the opportunity to do what they feel they need to

this creature, whether it is to comfort it, crush it, or tear it apart.

      Taking control. At the core of the *SRO* is the 4th session surrounding the concept of

taking control, whether this takes the form of gaining control or re-gaining control that has been

lost. This session addresses what has been observed to be the source of the shame for many of

these individuals: the loss of control while committing an offense. The fear of potentially losing

this control has been observed by myself and my peers as a crucial roadblock to accepting

transition out of the hospital. In this session, participants are instructed to "draw an image of the

situation that led you to legal trouble." This directive can be adjusted to various materials such as

a sculpture or diorama. Upon the completion of this drawing, participants are encouraged to use

additional paper and collage materials to adjust the image to show "how you would handle the

situation differently if you were there right now." Again, the materials can be adjusted to what

the therapist feels is appropriate for the clients participating. The participants are then offered the

opportunity to share their emotional reaction to the experience.

      Self-affirmation. In order to reinforce the confidence in one's own self-control, the fifth

session is focused on recognizing one's strengths. Using a lamp to create a shadow on a wall

that a large piece of paper is hung on, participants are instructed to take turns tracing the shadow

of each person's profile of their head. If this is unavailable, an alternative is to have each

participant trace their own hand on a piece of paper. Once everyone has a tracing, they are instructed to fill the hand or head silhouette outline with words and images describing their areas of strengths and interests using drawing and collage materials. The participants will then share at least one strength they feel most connected to, vocally recognizing this aspect of themselves, as well as allowing others to hear potential strengths with which they may identify.

Empowerment. Preparing for the conclusion of the group, participants are reminded of their ability to self-comfort. In this final session, participants are asked to make a puppet or doll representation of the vulnerable part of themselves. The participants are then asked to create an environment of safety for the puppet or doll. If time is of concern, a variety of toys and stuffed animals may be provided for participants to select one as a representation of the vulnerable part of themselves. Participants are then instructed to create a safe environment for the selected toy.

Data Collection and Analysis

Throughout the study, I created reflection artwork of the experience of each session after administering the SRO protocol to the group. For each session, a reflective art piece was made, reflecting what I observed of the the emotional experiences of the participants in the session. Additionally, upon the completion of each session, I noted statements and behaviors that were evidence of characterological shame, behavioral shame, or bodily shame expressed during the session.

To analyze this data, further processing through art, journaling, and creating charts took place. I connected observations of each session to look at the protocol as a whole and noted differences and similarities throughout the process. I also reflected upon what it felt like for me to engage in the process of this protocol with the group.

Expectations

From personal observations and research from which this protocol was created, I went into this study expecting participants to experience a loss of shame and find comfort in addressing the topic of shame. Once this had occurred, my further expectations included increasing the participants' confidence in the sense of control. Initial limitations included unknown group size and lack of mandatory attendance, causing some participants to skip important steps within the protocol.

Results

This section will describe the sessions and my observations. Through my experience of the participants exhibiting shame as well as my art reflections, I analyze what it was like to facilitate this protocol. The participants of this group were diverse in age, nature of criminal history, length of stay, mental illness diagnosis, and affect. Ages ranged from 22-74. One participant was in the hospital for a set 40 days and another has been at the hospital for 8 years. Some participants already had significant insight into the areas they wished to improve upon whereas others could not understand why they belonged in this treatment setting.

Session 1: Establishing safety with the group and self

Observations. Attended by five participants, members were introduced to the group and asked to work together to create group rules and standards. Participants were hesitant to speak, but a majority of them were open to art making. All participants eventually spoke when introducing themselves through their art. Resistance to speak lessened as the group went on. One member was hyper-verbal, but this appeared to be to the relief of others who were timid about speaking. Body language indicated comfort in silently art making and allowing one member to continue speaking. Four out of five participants appeared reserved at beginning. Two out of five participants appeared reserved at end. Concern about personal art making ability was

vocalized by one and evident by asking others to guess subject of artwork by one. It was also

evident by avoidance by one. Shame of possibly saying something they could not take back was

evident by one who avoided talking as much as possible while still participating to a minimal

degree. The types of shame observed during this session were the cognitive and behavioral

component of characterological shame with respect to personal ability, as well as the cognitive

component of behavioral shame with regard to doing something wrong or saying something the

speaker worried would appear stupid.

Art response. In session one, the goal of the session was to create a sense of safety

within the group. In my expressive reflection, as seen in Figure 1 in Appendix A, the unique

paths each participant took as each became more expressive in their own way stood out during

this session. While using art to introduce themselves to the group, some members used the art

created as a primary form of focus when introducing themselves to the group, while others used

verbal communication as their comfort zone. Introducing themselves in this way allowed

participants to select whichever form of communication they were more comfortable with

sharing with the group, whether it be verbal or non-verbal. As time went on throughout the

session, each participant became more open to sharing themselves with the group.

Session 2: Art as container

Observations. Attended by two participants, the group was invited to create an artistic

expression of what parts of themselves they allow others to see on the outside of a box and

express what parts of themselves they hide from others on the inside of the box. One participant,

who was new to the group, was consistently hyper-verbal with pressured speech. The other

participant did not want to talk or share, but also made audible noises expressing frustration with

how much the other group member spoke. While the manifest content of the verbalizations

appeared unrelated to the art making, the two participants related to each other through the art making, expressing common symbols and themes as they interacted through tangential and loosely related topics of conversation. Both participants shared what was on the outside of their box as the more reserved group member expressed frustration through body language and inappropriate laughter at the more vocal group member. The quiet group member then shared aspects of the inside of his box, including a resistance to show others his heart and psychotic symptoms which were similar to those currently being presented by the other group member. He expressed how he works hard to hide and suppress these symptoms and bodily reactions. The types of shame observed during this session were the behavioral component of characterological shame with regard to shame of personal habits and manner with others.

Art response. In session two, the interactions between the participants is what stood out in my art reflection, as seen in Figure 2, found in Appendix A. In this session, participants were encouraged to depict aspects of themselves that they share with those around them on the outside of their box and express aspects of themselves they do not show to others on the inside of their box. During this session, one participant was displaying symptoms of hyper-verbal and rushed speech and delusional thinking. The other participant had a unique reaction to the display of these symptoms, showing verbal and non-verbal discomfort. These are symptoms this participant also struggled with in the past and expressed feeling shame for, having them on the inside of his box. For this participant, addressing the parts of himself on the inside of his box about which he reported feeling shame was a confronting experience.

Session 3: Understanding, defining, and normalizing shame.

Observations. Attended by four participants, this session began with psychoeducation surrounding shame, with participants taking turns reading segments of the provided reading

material addressing the definition of shame and common aspects of shame. After each segment was read, participants had the opportunity to express any aspects of their experience where he or she related to the reading material. Participants were receptive to this material in different ways. Some related it to their life currently, one denied the existence of shame in his life, reacting to each part of the reading with deep explanations as to why this aspect of shame existed yet did not apply to him, others had reactions in body movement and inaudible noises, but declined verbal reflection. Each participant was invited to create a creature representing "shame." The person who had previously denied the existence of shame in his life decided to instead make a representation of how he feels he overcomes shame. When asked to describe this object, he went into detail about his history and connection to groups that others may feel ashamed to be a part of, such as hate groups. He noted aspects of shame within these groups, again noting that this shame did not apply to him. Another member depicted a combination of animals that he felt had the ability to hide. He declined speaking about his work, but would use little clay blocks he had created to build forms around the creature. When another member was speaking about a hate group, this participant turned his back to the member speaking and used the clay blocks to create a wall between the speaking member and his creature. When asked what he felt this creature needed to help him with, the member refused to speak, but began to create a maze with the blocks in front of the creature, eventually describing it as obstacles for the creature to get through. A third participant created a human face representing shame. She also created clay glasses, which she reported hid the creature's shame from the world. When asked what the creature needed, she put the glasses on the creature, explaining that the creature felt comforted by the knowledge that others could not see the shame. When asked if there was anything that might help the creature work through the shame, she replied, "not yet." Following

the completion of the session, this participant reported her connection to the project, stating that

she recognized how this applied to her and hoped to explore the subject further. The types of

shame observed during this session included the experiential, cognitive, and behavioral

component of characterological shame concerning the sort of person one is, as well as behavioral

shame concerning shame about doing something wrong.

 Art Response. In session three, the group directly addressed the concept of shame. In my

reflection of this session, Figure 3, Appendix A, the defense and coping mechanisms that various

group members displayed while discussing the topic of shame was eminent. Observations of

these defense mechanisms began upon the beginning of the group with the psychoeducation

portion, before members were asked to think about the concept of shame with respect to their

own lives. Some of the observed defense mechanisms included denial, compartmentalization,

repression, displacement, and rationalization. However, many of the participants were able to

recognize these defense mechanisms and project them onto their art, allowing themselves to

create adjustments to their creatures to help their creatures feel strong. Some of these included a

mouth to speak up, spikes to protect, lining around a vulnerable area, and healthy coping

mechanisms such as listening to comforting music.

Session 4: Taking control.

 Observations. The fourth session began with the room full with six participants and two

co-leaders. This was the maximum number of people that fit around the table without moving to

chairs that did not provide a surface to lean on. The group began with introductions, each

participant saying their name and a one word or phrase summary of their past day. One

participant with pressured speech had trouble limiting how long he was talking and staying on

topic, but was reminded to give all a turn to speak. This participant had to be reminded of this

throughout the session. After the warm-up, participants were invited to create a drawing, either

literal or representing the emotions, about what led them to legal trouble. At first, a few

participants were hesitant, and two respectfully asked to not participate in this section. These

two were invited to think about what they would put on paper. Both agreed. Participants were

then invited to consider things within their control that they would put in the situation or do

differently if they were in that situation at the present moment, and then put those things on

smaller pieces of paper and glue them where they saw fit on their scene. The same two

participants who declined the first directive declined this one as well. Again, they were asked to

do the exercise in their head, and both agreed. After this, participants were invited to share the

emotional experience of addressing this topic and taking control within the scene. One

participant began to share through metaphor about things about which he needs to feel in control.

Another participant shared directly what qualities he wished he had in his scene and that he had

pasted into his image. This participant, whose treatment team had reported that his legal issues

are often an area of resistance, elaborated into his insight of how he would act differently and

take control, should he find himself struggling to control his impulses. Another participant who

commonly denies his offense chose to not participate vocally in the discussion, but showed great

insight in his drawing and writing, which he chose to share with the co-leaders. This recognition

and acceptance of ability to have control in the situation was significant in this participant's

treatment. Throughout the session, this participant presented as calm and quiet. At the end of

the session, the participant thanked the co-leaders and presented with an expressive and happy

affect. To conclude the session, participants were asked to bring their mind back to the present,

checking in with how their physical body was feeling and setting an intention for the following

week. The shame observed in this session included the experiential, cognitive, and behavioral

component of characterological shame in terms of shame of personal habits as well as behavioral

shame concerning shame of doing something wrong.

      Art response. In my reflection of the fourth session, Figure 4, Appendix A, what stood

out the most was each patient's ability to navigate for themselves how deeply they could

comfortably go into the exercise regarding current emotional state. In a full group addressing a

difficult topic in a direct manner, some participants chose to sit out and observe, others used

metaphor to distance themselves, and others directly addressed their legal confrontations in a

broad way. Some participated only in artistic representation while others made solely verbal

contributions. In the conversation surrounding control, while many vocalized concerns, all

displayed evidence of control in action as they each participated to the degree that was

appropriate for them in that moment. With this recognition that partial participation was

acceptable, participants felt comfortable going deeper and more clearly into personal insight.

Session 5: Self-affirmations

      Observations. In the fifth session, six people attended, five of whom were returnees and

one who was new. Participants were asked to introduce themselves and select one word or phrase

to represent their past 24 hours. Participants then traced their own hand onto a piece of colored

or white paper with their choice of thin markers, colored pencils, or cray pas. Participants were

then invited to fill the hand with words and imagines representing aspects of themselves that they

are proud of and things they are good at. Participants then took turns sharing a few of the things

they put in their hand and related to each other on aspects they had in common. Participants also

shared how it felt to put onto paper aspects of themselves that they are proud of. Participants

were then asked to trace their other hand, either next to or on the back of the piece of paper. In

this hand, participants were invited to put ways that they could use the skills they are proud of in

their everyday coping. Participants then took turns sharing how they could use the things they are

good at in a coping manner. This included doing relaxing activities they enjoy when upset and

reminding themselves of good deeds when angry. This sharing turned into a brainstorming

session where participants, as well as the co-leaders, took some of the qualities multiple

participants had in common and discussed how they could be used for coping. All group

members participated, respected the time of others, and displayed personal insight. To close the

group, participants went around and set intentions for the following week. For broad intentions,

co-leaders encouraged participants to be more specific, which they were able to do. There was

evidence of the cognitive component of characterological shame; however, overall, there was

less observed evidence of shame than in previous sessions.

      Art response. In the fifth session, participants' willingness to self-evaluate and turn

strengths into coping skills stood out, as seen in Figure 5, Appendix A. Group members helped

each other, connecting with strengths that others identified. Group members also helped others

recognize how their strengths could be used as coping mechanisms, particularly in times of

frustration. Just as the participants were asked to draw and write their strengths and coping

mechanisms within a representation of themselves, in this case a tracing of their hands, my art

reflection took the form of strengths of the group as a whole, as well as how I have observed the

participants putting these strengths to use within hand tracings. Hands crossing over the top of

each other shows the helping hands between group members. The representation shows the

participants connecting to each other and assisting peers in turning strengths into actions.

Session 6: Empowerment.

      Observations. Session six opened with 11 clients in the room. Shortly thereafter, three

clients decided it was too crowded and by the time the working session actually began, eight

participants had decided to stay, the maximum amount that comfortably fit around the table with

the co-leaders standing or sitting to the side. One of these participants dismissed himself to go to

the bathroom halfway through the group and did not return. Participants went around saying their

names and selecting a word or phrase to symbolize their emotions over the previous 24-48

hours. Participants were then invited to select an image of an animal that they identified with.

Once selected, group members were asked to take colored paper, markers, colored pencils, and

precut magazine words and images to create a safe space for the selected animal. Some

participants decided to color in their animal to bring the animal to life. When asked, these

participants described their animal as already feeling safe in their strength. One participant had

selected a female lion and outlined strong features in the lion's face. She then surrounded the

lion with words and phrases that she described as comforting and encouraging to the lion. Other

participants selected a combination of drawing and adding collage materials to create a safe

space for their animal. Multiple participants even directly connected their own sources of

comfort to the aspects they added to their animal's surroundings. Upon completion, participants

took turns sharing about their relation to their animal as well as how the animal's surroundings

allowed that animal to feel safe. The session concluded with participants taking turns in sharing

an intention that they each had for the upcoming week. There were no observed aspects of

shame in this session.

Art response. As individuals within the group displayed evidence of empowerment, the

group as a whole showed further comfort and feelings of safety among one another. As seen in

Figure 6, Appendix A, this stood out to me as an unexpected result, as the participants were

asked to create a safe space. To find that several had established that comfort within themselves

was unanticipated and significant. Identifying the strengths and interests allowed participants to

use this knowledge as a superpower, keeping them safe from all of the difficult circumstances that come towards them. In the reflection art shown in Figure 6, I found comfort in space around the group. Just as participants were asked to select an animal that represented themselves, this stick figure represents not an individual participant, but the whole of the group. The group could clearly identify strengths within themselves and each other. Together, they formed a safe space within the group. The white space surrounding the stick figure represents the power the group has from recognizing their own strengths to keep the difficult aspects of their lives at bay until the group is ready to handle them.

Discussion

The SRO protocol was developed as a tool of recognizing and addressing shame and fear of losing control in those who have a history of committing an offense. The goal of this method is to allow each participant to confront their connection with feelings of shame and self-control. From this confrontation and recognition, participants are able to address what they need to feel confident in their self-control as they pursue further treatment. The use of art therapy, as opposed to talk therapy, with this method allows for participants to increase personal insight and empathize with others. (Smeijsters & Cleven, 2006) My observations of the twelve participants indicated that the protocol evoked thoughtful participation and insight from patients surrounding shame and control.

Four Major Themes of Observations

During the implementation of the SRO protocol, four major themes emerged: increased comfort and decreased hesitancy with artmaking, greater detail in artmaking, increased accountability, and an increased recognition of control.

Decreased hesitancy with art making. The more sessions a patient attended, the less time there was between the directive being introduced and the patient beginning to create. In the first couple of sessions, multiple participants would sit and look at their peers or at the materials for several minutes before beginning to create with the materials themselves. During some of these sessions, a couple of participants declined to participate in the art making altogether. By the last few sessions of the protocol, the rate of participation in material engagement increased to 100%. Additionally, the amount of time, on average, between the completion of the description of the art prompt and the beginning of patient engagement with materials decreased significantly. Part of this result is likely due to an increased sense of comfort as the group became knowledgeable about the structure of the group; however, I found there to be more aspects to this distinct change over time.

At the end of each session, multiple participants often expressed their satisfaction with the art therapy modality and reported an interest in returning to the group. It seemed to me that the self-soothing and distancing nature of art therapy allowed for the patients to address difficult topics without leaving the group consumed by those topics. Kim, et al. (2017) demonstrates that art therapy can increase hope and motivation. This increase of hope through the art therapy modality likely led participants to feel more motivated to work on their newfound insights.

Due to the fact that the sessions addressed shame and the experiences surrounding shame more as the protocol was implemented over time, the reduction of hesitancy correlated with the participants' addressing the concept of shame. This may not be simple coincidence. Mills and Kellington (2012) found that addressing an experience that is a source of shame through art allowed participants to feel assured in themselves and the containment of their expression.

Therefore, it is likely that the more they participated in the art therapy process, the more

participants' confidence in the ability of the art to hold large emotions for them grew.

       Greater detail in art making. As the participants attended more sessions, I observed

that they would go into further detail in their artwork, showing a greater comfort sharing

information within the space. One participant in particular, who attended 5 out of the 6 sessions,

began the group hesitant to embrace the art materials. Through encouragement, this participant

engaged with model magic in the first session, but was not interested in creating a product.

Participating in the prompt verbally, the patient used the art materials as a way to engage his

hands, but not as a tool of expression. Throughout the sessions, this participant engaged in the art

making process in a more concrete and product-oriented way. The first step for this participant

was creating symbols that inspired him to share verbally, while not sharing his artwork. This

form of personal processing was encouraged if the participant felt most comfortable with this.

However, the participant continued to put more of his expression onto the paper in both abstract

and concrete ways, ultimately using the art to confront emotions at a deeper level than he felt

comfortable sharing verbally.

      It seemed to me that part of this was due to the need to establish the art as a safe form of

expression, particularly since the inpatient environment may often be a threatening environment

that lacks privacy. Additionally, this patient's defenses are often activated when witnessing the

psychotic symptoms of others, which is common at an inpatient facility. Gussak (1997) found art

therapy to allow prisoners to break through some defenses enough to address problems while

maintaining the safety of personal defenses needed for survival in the threatening environment of

incarceration. Similarly, for this patient, art therapy likely allowed him to keep up defenses that

he needed to feel safe on the inpatient unit while allowing him to focus on his vulnerability through the art materials.

   Increased accountability. An unexpected result was that many patients who often have difficulty taking responsibility for how their actions affect their progress took accountability for what they needed to change in order to proceed in treatment. One concern I had with applying this protocol to those who had been found not guilty for reasons of mental illness (NGRI) or incompetent to stand trial (IST) was that some of the patients with this legal standing do not understand the crime they have committed. However, this research also showed participants who often reportedly denied responsibility of crimes in the past recognizing responsibility for actions, legal difficulties, and aggressive tendencies. These participants identified impulse control, taking the responsibility to maintain knowledge of laws, and asking for help. This showed not only in the directives that directly addressed accountability, but also through changes in the weekly intentions set by these participants at the end of each session. It appeared to me that by accepting making mistakes as a normality, shame surrounding these mistakes decreased enough for the patients to break through the denial of their existence.

   It is important for one to learn to forgive oneself for mistakes in the past. Ashby, Rice, & Martin (2006) find that if a patient is unable to accept mistakes, they become overcome by maladaptive perfectionism. The breaking down of maladaptive perfectionism comes with a decrease of low self-esteem, shame, and depressive symptoms. Having experienced mental illness and having, at some point, been confronted by the legal system, all of the participants in this study have likely experienced a sense of victimization, which can lead to the defense of denial. Day and Onorato (1997) found the importance of addressing empowerment, containment,

transformation of shame, and more in a group art therapy setting. Addressing these topics likely led to a validation of the participant's experience.

While I had previously observed a tendency to avoid a prolonged discussion on the topic of shame, it appeared that addressing this topic through psychoeducation and art therapy provided distance from the complex feeling of shame. Gussak (1997) notes that the non-verbal nature of art therapy allows for an outlet to confront these emotions in a non-threatening space. This new space allowed patients to withstand the discomfort of the subject long enough to work through the expression and acceptance of shame, which led to an ability to work through other emotions surrounding it.

Increased comfort in sense of control. Another result was an increase in confidence of maintaining self-control. With shame and imperfection normalized, participants showed evidence of accepting accountability of areas in which they lack impulse control. For example, one participant who has been noted to have difficulty with accepting responsibility in the past, showed linking through the art, adding words and images that he identified with to his own artwork. This later led to an expressed interested in taking steps to control impulses that had been identified by others for him in the past, but for which he had not previously taken responsibility. In this group, the patient noted actions he could take where in previous discussions of this topic, he had reported these things as out of his control. Through the artwork, it appeared that the combination of normalizing provided by the psychoeducation as well as linking with peers, and distance provided by the art media, led to an increase in personal insight. Smeijsters and Cleven (2006) found that art therapy allowed patients to understand behaviors in both themselves and others that previously had been difficult for those patients to understand.

I found that once patients felt comfortable identifying and naming areas in need of improvement for themselves, there was an increased effort in working to increase their control of these areas. Not only that, but it appeared that participants felt more confident in their ability to increase their impulse control in the identified areas, recognizing smaller steps and the need for change. This connection between shame and impulsivity is not a new concept. Tangney, et al. (2011) noted one of the areas connected to a proneness to shame in incarcerated offenders to be impulsivity. The connection of these two factors likely means that working on one would lead to work with the other. In fact, Jakupak, et. al. (2005) found that hostility is related to the suppression of shame and a fear of loss of control. Normalizing shame and accepting shame may allow for the ability to address any shame caused by impulsivity about which these clients may have previously been in denial. Allowing that to surface is the first step towards working on impulse control and decreasing the fear of loss of control.

Additionally, participants were able to gain comfort and confidence within themselves without further need for external support to create a safe space through metaphor. Having previously recognized personal strengths, multiple participants identified areas of their own strength that aided their ability to feel comfortable where they are. This ability to feel comfortable in their own ability to self soothe without outside help displayed an increased comfort in being able to act with intention without outside intervention. This was evident when participants were asked to select an image of an animal they identified with and create a safe and comforting space for that animal. Multiple participants, in response to this prompt, selected instead to create more detail inside of the animal. When sharing their artwork, these participants all described symbolism in what they created that were aspects within the animal that made it

feel comfortable. One participant directly said that he made the decision to not put anything in the animal's surroundings, as he did not feel the animal needed any additional outside comfort.

Art therapy provides the opportunity to address control in both direct and indirect ways to allow the participant to confront their sense of control. This is particularly important in working through the deeper motivation behind offending behaviors (Aulich, 1994). Offenders are also able to gain a sense of control and minimize recidivism by identifying what led up to their offenses and fine tuning their decision making skills (Liebmann, 1994).

Limitations of study

This study was not without its limitations. While initially intended to be a closed group, due to circumstantial factors including time and space limitations, the group ended up being an open group for a limited number of patients invited to participate. Having different members for each session did not allow for the sense of safety and community to grow as much as it may have in a closed group. With this, the number of participants that were present was different for each session. This inconsistency is important to note as a limitation as this may have affected the dynamic of the group within each session.

Another limitation was the size of the group room. While the room itself was large, only eight people could comfortably fit around the table. This led to some group members noting they wanted to join but leaving the room before the group began due to the comfort of people within the room. This also could have been avoided by the group being a closed referred group, as there would have been a cap to the number of people referred to the group.

It is also important to note the potential bias of this study. With any research, it is impossible to eliminate bias. As the data is subjective rather than objective, this leaves room for the possibility of bias within the observed results. While precautions were taken to prevent as

much researcher bias as possible, including allowing participant feedback and observations from

the co-leader of the group to influence the data, it is not possible to fully eliminate researcher

bias. My own expectations as the creator of this protocol were congruent with the results. Due to

the amount of literature read and my previous experiences that went into the creation of this

protocol, there is a possibility of bias leaning data toward the expected results.

Additionally, the patients came from a wide variety of ethnic and cultural backgrounds,

many of which were quite different than that of my own. This is another limitation and area for

potential bias, as these differences could lead to misinterpretations. Another aspect of the

population that may influence the results is the diversity within the group. The participants of

this study, while low in number, included multiple genders, ages ranging young adult to senior,

different cultural backgrounds, different races, and different financial upbringings.

Future research

The research of Andrews, Qian, & Valentine (2002) presents insight into one of the ways

that the experience of shame is assessed. While at this point in this research, traditional

assessment tools such as the Experience of Shame Scale (ESS) and Test of Self-Conscious

Affect (TOSCA) are not being used in conjunction with the SRO protocol, this could be a tool to

help determine the effectiveness of the SRO protocol in future research. The next step in this

research would be to test the effectiveness of the protocol, both in group and individual format,

with data about the patient experience. Do the patients, in fact, experience a reduction of shame?

Does this reduction of shame affect their behaviors and impulse control? With this particular

population, it would be useful to research if the use of the SRO protocol minimized the

likelihood a patient would self-sabotage when approaching reintegration into society. This could

also be applied with incarcerated offenders approaching release dates. It would also be

interesting to see if there is a difference when this protocol is put into place with groups with a

less diverse forensic background, such as focused on a particular offense. In this study, the

participants all had at least one diagnosed mental illness and a forensic history undisclosed to the

group. Would the results be different if the SRO protocol was implemented with a group who

were aware they had certain life circumstances in common such as sex offenders experiencing

homelessness?

Another area of future research that would be beneficial is a longitudinal study seeing

how offenders' sense of self-control upon release to the community affects the likelihood of

recidivism. Using the SRO protocol to increase a sense of self-control and decrease a sense of

shame, does this make a difference long term? Does the SRO protocol leave a foundation for

further work on coping skills and impulse control needed to function at a socially acceptable

level?

Conclusion

The findings from this study suggest that the SRO protocol could be a potential tool

allowing offenders to address their feelings of shame and fear of losing control through the use

of art therapy. The SRO protocol engaged group participants in insight, psychoeducation, taking

control, self-acceptance and empowerment. Participants successfully addressed the concepts of

shame and control and displayed increased insight in art as well as through verbal

communication with peers as well as staff. In unexpected findings, participants also began to

display a greater sense of control and recognition of needs as sessions went on, adjusting how

they participated to what they felt they could handle emotionally. Additionally, many

participants who have previously denied responsibility on a continuous basis also showed an

ability to break through denial and recognize responsibility for legal difficulties and personal weaknesses as well as how to work on them.

My interest in the creation of this protocol initially stemmed from my observations of clients who had a criminal history and also had a tendency to self-sabotage. This interest was cultivated as I witnessed the needs working with patients of an inpatient psychiatric facility who have committed forensic offenses. A fear of losing control and the existence of shame was evident though rarely addressed in many of these patients and clients. Using a trauma-informed approach and knowing the unique ability of art therapy to provide containment and distance from complex emotions, I was inspired to do further research into how to help these patients feel confident that they would not again lose control, minimizing the likelihood of self-sabotage. This research led to the creation of the SRO protocol.

The implementation of the SRO protocol up to this point has showed promising results to allow patients to confront their emotions surrounding their offense(s) and address any concerns a patient may feel about potential recidivism in a safe space. In settings that consist of many offenders such as prisons or a forensic psychiatric unit, patients often are concerned about showing weakness or being penalized if they admit they are not fully in control (Gussak, 1997). The SRO protocol not only provides a safe place to discuss these difficult emotions, but normalizes these common emotions as well. This allows the patients to work through them in a healthy way.

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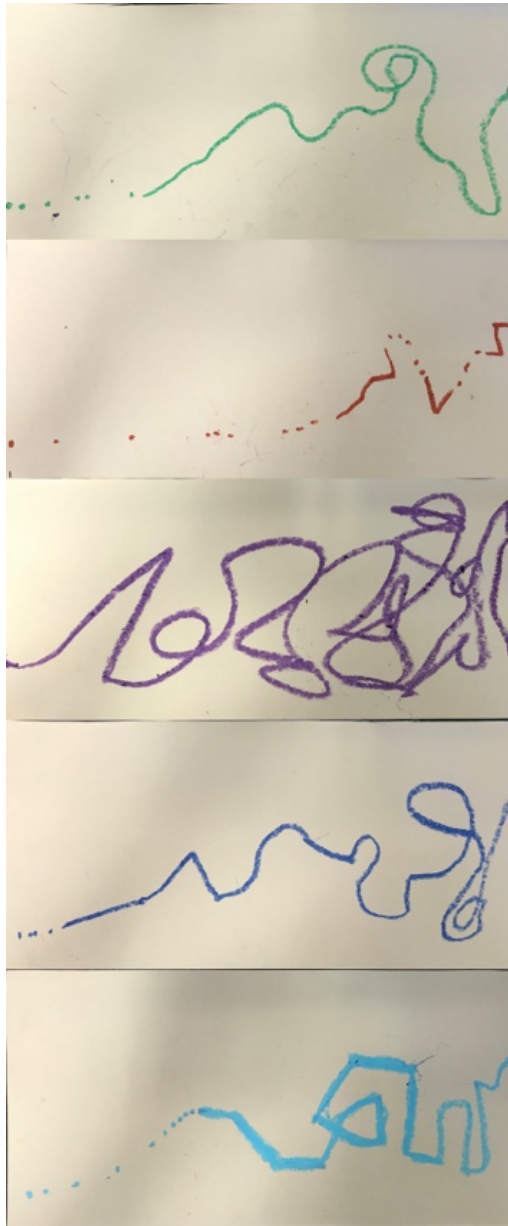
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Appendix A

Art Reflections

Figure 1: Establishing Safety with the

Group and Self

Figure 2: Art as Container

Figure 3: Understanding, Defining, and

Normalizing Shame

Figure 5: Self-affirmations

Figure 4: Taking Control

Figure 6: Empowerment