Art Therapy to Enhance Forensic Inpatient Treatment for Disenfranchised Grief from Ambiguous Losses: A Multiple Case Study

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Art Therapy to Enhance Forensic Inpatient Treatment for Disenfranchised Grief from Ambiguous Losses: A Multiple Case Study

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Abstract

This dissertation examines art therapy as a powerful tool to aid forensic psychiatric patients in dealing with ambiguous losses that go unacknowledged and untreated, resulting in disenfranchised grief. Grief becomes disenfranchised when it cannot be publicly acknowledged or supported due to a person's circumstances or the nature of the loss, which can be particularly difficult incarcerated people with severe mental illness. This study attempted to bridge the fields of art therapy, grief and loss therapy, and forensic psychology by exploring how disenfranchised grief manifested in a sample of six forensic inpatients, two of whom were capital offenders, and treated with art-based intervention. Designed as multiple case research, the inpatients participated in six sessions of individual art therapy that included a pre- and post-intervention art directive and work on a visual timeline that mapped their losses over time. They engaged as co-researchers by sharing their experiences of loss and contemplating how to break their cycles of grief. The art therapist researcher synthesized the data by creating visual portraits that were shared with the participants and checked for accuracy. Results suggested that the three art directives provided an effective structure that identified how their losses fit into their life stories, organized their emotions stemming from disenfranchised grief, and provided relief by having a tangible plan in place for treatment that they themselves had created. Another outcome was a model of the grief and loss cycle that may be experienced by this population, which can be implemented and tested by other professionals in their practices. This practitioner-led study may begin to fill in the gap in resources and humanize an overlooked population whose art making helped them find their voice and gave them a platform for self-expression.

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"If I have seen further it is by standing on the shoulders of Giants." –Isaac Newton

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Dedication

I dedicate this dissertation to the patients at MMHI, especially those who were my co-researchers. And to Joe, who still inspires me every day to do more.

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CHAPTER 1: INTRODUCTION

The Story of Joe

Three years ago, I began to work with a patient named Joe (a pseudonym) who was enrolled in the addiction program at the forensic psychiatric hospital where I am employed. Because we had developed a good therapeutic relationship, his team eventually reached out to ask if I could do individual art therapy with him and address end of life (EoL) treatment in particular. Goals for EoL treatment with incarcerated people focus on planning for care, providing greater choice in control over their environment, and aiding in obtaining early release if possible (Howe & Scott, 2012). Joe was choosing to forgo treatment for a terminal illness—treatment that could have extended his life. Because he was only 40 years old, both his treatment team and his family had expected him to fight the disease. They were frustrated by his lack of desire to live.

Joe's referral for EoL care seemed to me to be rooted in his team's desire to ensure he was at peace with his diagnosis and imminent death. There are many reasons people decline treatment in terminal cases, including a decreased quality of life, numerous potential side effects, and the possibility that treatment may not work (Frenkel, 2013). As I worked with Joe, I found that he had reasons for his choice, but they weren't about side effects or quality of life. Rather, he believed that his illness was punishment for his crime and therefore should be accepted.

Joe was a likeable person who was popular among both patients and staff. During our first art therapy session, he described his initial psychotic break. While attending college out of state, he had begun to think there was a college professor following him

everywhere. As he explained it to me, first he was scared of this person, then he befriended them, and then he gave them all his money. Although it was 20 years in the past, Joe still didn't know for sure if the professor was real, a delusion or false belief, or a hallucination in which Joe could see and hear the professor who in fact, wasn't really there. The event disrupted his life so much that he dropped out of school and moved back home with his parents. It marked the start of his cascading losses: the loss of his mental health, his sense of security, his ability to differentiate hallucinations from reality, his college career, his independence, his path to a future career. They were all gone within a matter of months.

Helping others on their journeys through grief was never something I had considered during my time as an art therapist. However, working with Joe, I began to wonder if there was any research that could help me be a better therapist for him. His grief started with the loss of his mental health and his losses only got more complicated from there. Grief and loss among the forensic population in the United States is understudied, as well as often overlooked (Ferszt, 2002; Harner et al., 2011). Historically in these types of settings, grief services are only sought at a patient's request and usually only if the patient experiences a bereavement loss, defined as the death of a loved one (Ferszt, 2002). I postulate that this is in part due to incarcerated patients not having the tools to identify non-bereavement losses. There also is some evidence that suggests that stigma and prejudice towards this population also plays a significant role in the lack of services offered to them (Corrigan & Watson, 2002).

During our sessions, Joe told me more about his life. His index offense (i.e., the crime that brought him to the forensic psychiatric hospital) also caused what he identified

as the biggest loss of his life. Every Friday, Joe would have dinner with his parents and then watch television with his father, who he described as his best friend. He would sleep overnight at their house and then his father would drop him off at his home on Saturday morning. One morning, after his father took him home, Joe killed him. He called the police and, according to Joe, calmly waited for them to arrive. He explained to them that the murdered person inside the house wasn't his father; it was an alien from outer space. He thought he had rescued his actual father by killing the "alien" who had appeared in his house.

It took several weeks before Joe could receive the right treatment to bring him to his behavioral baseline. Baseline refers to the patient's normal or usual behavior, as determined by self-reports, reports from family or friends, and sometimes from previous mental health care providers (O'Connor, 2003). For Joe, his behavioral baseline included having decreased symptoms of psychosis and regaining his orientation to reality and clear thinking. When Joe was at his baseline, he appeared to be an ordinary, nondescript man in his 40s. In other words, one could walk by him and not stop to question if he was a patient or a staff member. Treatment that helped Joe maintain his baseline included antipsychotic medications and compliance with addiction treatment, as drug and alcohol use aggravated his symptoms and affected his medications, per his reporting.

Joe recalled the day his mother visited him in jail and angrily told him, "No, you didn't kill an alien! You killed your dad!" The awful fact was that, of the many losses that Joe had experienced, the biggest was one he himself had created while unfortunately in the throes of a mental health crisis. From his offense, he not only lost his father but also experienced losses that affected relationships with other family members, his

freedom (for the rest of his life), and the ability to ever trust his mind again. In addition, he didn't feel he had the right to grieve his father because he was the one who killed him. As one of the many layers of meaning Joe attached to his losses, this belief was important to pay attention to in order to understand the context of each loss and its corresponding grief (Boss, 1999). I learned that Joe's losses were multilayered, beginning with childhood and seeming to escalate at the onset of his symptoms. His grief was complicated— due in part to the various forms it took, including depression, shame and guilt, and also because he wasn't sure he was allowed to experience the corresponding grief. Unfortunately, one week after telling me the story of his offense, his health failed. Two weeks later, Joe died.

Joe's story was the catalyst for my doctoral research interest. As an art therapist, his exemplified the many stories I've been allowed into, as it highlights "ambiguous" or unclear losses experienced by the patients in my work at a forensic psychiatric hospital. Grief is conventionally defined as the emotion that follows a bereavement loss (Doka, 1989; Stroebe et al., 2008). There is myriad knowledge on the process of grief that surrounds death and mourning (Bowlby & Parkes, 1970; Kubler-Ross, 1969; Kubler-Ross & Kessler, 2004). However, just like Joe, many incarcerated individuals experience distinct kinds of losses instead of or in addition to the loss of a loved one. Boss (1999) gave us a name for a loss that is harder and more complicated to define than bereavement loss: *ambiguous loss*. Doka (1989) took the concept a step further by examining the disenfranchised or unacknowledged grief that people often experience resulting from ambiguous losses. Further complicating incarcerated people's losses are the physical and mental spaces allotted for grief (Harner et al., 2011). There is very little privacy afforded

to this population, making the act of grieving, which can be personal and different from one individual to the next, even more arduous. For patients living with recurrent or severe mental illness, grieving ambiguous losses can become even more complex due to symptoms or medications affecting their ability to identify emotions or grieve in a manner that is not mistaken by staff as a reaction to symptoms.

Even as I was working with Joe, his story was motivating me to find resources that could help me to better help him and other patients with ambiguous losses. The institution where I work does not have a grief and loss program in place where I could gather resources. When a patient experiences the death of a loved one, institute chaplains are deployed and only at the patient's request. There was a void in treatment for the patients around their losses and subsequent grief, so I began to search for external resources. Kapitan asked, "What questions have art therapists not raised because we lack the language and critical framework to address them?" (2018, p.178). Indeed, part of the problem I was experiencing was that I lacked the vocabulary to aid in my search for knowledge of how to accurately frame and research the problem. If we art therapists do not have vocabulary to search for helpful resources, how can we expect patients to have the vocabulary to describe their feelings of loss and grief and ask for help? How might their inability to accurately identify their grief hinder their process of rehabilitation? My time with Joe ran out before I felt I could be of much help. Three years later, I still think of him often and wish I could have done more to aid in him in his feelings of grief. I am passionate about this research because I want to be better equipped to help others like Joe in an effective and timely fashion.

The Forensic Psychiatric Setting: An Overview of MMHI

In 2015, I was hired as the first art therapist at Mendota Mental Health Institute (MMHI), the State of Wisconsin's public forensic psychiatric hospital. The hospital provides a secure setting for people who have committed a crime in which a mental health issue was implicated. The MMHI campus has about a dozen buildings on just over a hundred acres of land. It is organized with 15 distinct units for a total of about 300 adult patients. The majority are male patients, as only one unit (20 beds) is reserved for female offenders. In order to access most of the units, there are grill gates (i.e., electronic gates that look like jail bars) that open and close when employees come into or leave the units. The gates, and other security measures such as cameras, are run by correction officers hired through Wisconsin's Department of Corrections. The units provide around the clock care and are run by nursing staff, including psychiatric care technicians who help with physical and psychiatric needs. One of the many jobs of the psychiatric care technicians is to work to deescalate the situation in the event a patient shows physical aggression.

A psychologist and a psychiatrist are also assigned to each unit. The psychiatrists meet with the patients individually for medication management. Psychologists have various roles throughout MMHI, but most often implement assessments and report to the legal system regarding specific patients. Because of their role, many of the psychologists at MMHI are well-versed in the state's legal system, specifically around mental health care laws. Therapy groups are offered by rehabilitation therapists both on and outside of the units in "treatment malls," which are secure areas that facilitate multiple groups at

one time. Patients who have earned the proper security level by maintaining their own safety and the safety of others on their unit, as well as complying with treatment, are allowed to attend groups off the unit.

Additionally, MMHI has a large team of social workers. For the most part, social workers are assigned to a specific unit, although they can sometimes "follow" a patient to different units if the patient moves. At MMHI, the social workers' primary role is to work with the courts and the lawyers, as well as the patient's family when appropriate, to ensure everyone is communicating about any upcoming hearings or other legal procedures. Therefore, they must be knowledgeable of mental health care laws. Often, they have developed solid relationships with the lawyers assigned to the patients. Many of the lawyers for MMHI patients are similarly well-versed in how the MMHI functions and tend to know many of the employees, due to working with multiple forensic clients over the years.

Although many facilities like MMHI are funded under a state's department of health services (see, e.g., Holmes, 2005; Mossman, et al., 2007; Tonkin, 2016), in Wisconsin the Department of Corrections (DOC) oversees all security issues. DOC staff are responsible for such things as transporting clients to and from court hearings and doctor appointments. The DOC officers monitor patient movement on camera, open grill gates to allow employees onto units, and escort civilians, such as lawyers or family members, on and off campus. They also patrol the campus and surrounding community to ensure everyone's safety. This is just a brief snapshot of how employees of criminal justice, mental health, and correctional systems work together in the context of MMHI

and in coordinated ways that attempt to make things run smoothly for the patients, staff, visitors, and even the surrounding community.

A Patient's Journey to the Mendota Mental Health Institute

A large part of forensic psychiatry is focused on aiding a population of people experiencing mental illnesses to maneuver through three social systems: mental health care, criminal justice, and corrections (Arboleda-Flórez, 2006). Therefore, forensic psychiatric settings are unique in that people who work within these three distinct systems often converge in their efforts to help those who have found themselves at such a crossroad.

Forensic psychiatry was first recognized as a subspecialty of psychiatry in 1973, and since then the field has grown to include multidisciplinary dimensions (Turner & Salter, 2008). By definition, forensic psychiatry is a branch of psychiatry that "deals with issues arising in the interface between psychiatry and the law" (Arboleda-Flórez, p. 88). However, the vagueness of the definition does not do much to convey how an individual may arrive at this particular intersection. While the process is slightly different from state to state, or even facility to facility, the typical journey can be long and fraught with challenges.

As an example, a person may have an acute mental health crisis, meaning that they rapidly began to experience symptoms of a mental illness, which cause them to behave in a way that is unusual, possibly harmful, and affecting their way of life. They may become increasingly paranoid and refuse to leave their room, or are not eating because they are convinced their food is poisoned. Both of these reactions to paranoia are something I see in patients every day at MMHI, but for the sake of this example, imagine

the person is a family member. Their loved one calls emergency services for help because the person has not eaten in days, is screaming from inside their room or displaying other frightening behavior, and clearly needs more help than family members can provide at this point.

When emergencies services respond, a law enforcement officer is usually the first on the scene (K. Pierce, personal correspondence, June 19, 2020). The person in crisis, we'll call him "Thomas," becomes increasingly paranoid when seeing a uniformed officer arrive. Thomas yells that if anyone comes near him, he will stab them. The officer must decide in the moment whether Thomas will go to jail for threatening someone's life or go to the hospital to assess his mental health crisis (A. Garcia, personal correspondence, July 7, 2020). If he is taken to the hospital, he will be treated through the civil system; the criminal justice system will not need to get involved (Swartz et al., 2006). He will be treated in the hospital and, once his symptoms are under control, he will be discharged and receive services in the community (Swartz et al., 2006). If instead the police decide that Thomas has committed a crime while in the health crisis, he will be booked into the county jail. This latter course of action is the beginning of Thomas's forensic psychology journey.

The forensic psychiatry track can be initiated at any point, once the emergency responders have decided on a jail booking (K. Pierce, personal correspondence, June 19, 2020). That means they can "flag" Thomas for psychiatric care, either immediately upon arresting him or at any point during his time in jail if they believe a mental illness is playing a role in his actions. According to Dane County (WI) Sheriff Pierce, a "flag" is the term used to signal the need for a mental health assessment. Although most law

enforcement officers are not mental health clinicians, many have training that helps them identify when an individual may need mental health care (Augustin & Fagan, 2011). According to Sheriff Pierce, an officer may flag a person any time after law enforcement involvement, including during an arrest or while in initial transit to the jail. Additionally, the district attorney can bring mental health concerns to the attention of the court and request that the person's competency be evaluated before further legal proceedings. Individuals booked into jail can also request a mental health intervention for themselves at any time (K. Pierce, personal correspondence, June 19, 2020). However, once a concern or question about the person's mental health is identified, they are no longer only part of the criminal justice system but then enter the psychiatry system as well, which creates the forensic psychiatric intersection mentioned earlier (Arboleda-Flórez, 2006).

With involvement from both criminal justice and psychiatric systems, the individual might find themselves at MMHI or a similar setting (Turner & Salter, 2008). They may be given a 14-day commitment, during which they will be evaluated for competency (i.e., a psychologist and/or a psychiatrist will evaluate the person to determine if they are competent to be held responsible for illegal behavior) (State of Wisconsin, 2015). According to Dr. Ana Garcia (personal correspondence, July 7, 2020, a psychologist on one of the admission units at MMHI, the goal is simply to determine a yes or no answer to the question "Is this person competent?" and the courts will then further decide how to proceed.

Depending on what the court decides, an individual may be committed to MMHI in order to "treat to competency." This decision means that the courts want to know if the person, with proper treatment, could become competent and therefore able to stand trial

(A. Garcia, personal correspondence, July 7, 2020). The duration of the treatment is determined by the legal team; however, it cannot be longer than one year (Wis. Stat. § 971.14(5)(a)1.1, 2018). Once the set time is up, the psychologists and psychiatrists testify based on clinical notes, assessment results, and observations from unit staff. They give the court their expert opinion on whether MMHI has determined that Thomas is either competent and able to stand trial or not competent and not likely to become competent even with medical interventions. In the event of the latter, the judge assigned to the case, along with the legal teams, decide how the case should proceed.

Depending on the severity of the offense, the judge may decide that the time already served at MMHI is enough retribution for their offense and conclude the case (Wis. Stat. § 971.14(5)(a)1.1, 2018). In more severe offenses, however, the district attorney may attempt to try an "insanity" case, which is the legal term for pleading that the individual did commit the offense but is not guilty by reason of their mental illness (Adjorlolo et al., 2019). A person like Thomas might end up at MMHI when they have been through the legal system and found not guilty by reason of insanity (NGRI; Torrey, 2012). I looked back over several years of censuses and found that on any given day at MMHI, about one-third of the patients are there either to determine competency or to assess if they can become competent for trial. The remaining two-thirds of the population reside at MMHI for a longer-term NGRI sentence (MMHI Census, 2019; 2020).

The length of time that patients remain at MMHI for an NGRI commitment is determined by the judge at their trial in compliance with state statutes (Wisconsin Department of Health Services [DHS], 2015). For example, Thomas may receive a 5-year sentence for threatening a law enforcement officer. He can choose to stay at MMHI for

the entire duration without appealing the sentence and, once his 5 years are up, he can leave and be completely free of legal obligations resulting from his case. People at MMHI are also allowed to apply for something called conditional release (CR) every 6 months during their commitment (DHS, 2015). This is a legal process in which, at the request of the patient, the court reviews reporting on how the patient has been doing in terms of medication compliance, treatment compliance, and all-around well-being (DHS, 2015). The court can then grant CR, which means the patient can leave MMHI but with a set of conditions they must follow upon their release. For example, after one year at MMHI, Thomas could be granted CR. The conditions set forth for him may include such things as abstaining from alcohol or other drugs, weekly meetings with a counselor and/or case manager, and monthly meetings with a psychiatrist for medication management, among others. With an initial sentence for 5 years and a CR after one year, if he violates any of these conditions during the remainder of his sentence (4 years), his CR will be revoked by the judge and he will return to MMHI. On the other hand, if he is able to meet all the conditions of his release, he will able to remain in the community for the remainder of his 4-year sentence.

In the case of Joe, his offense was homicide and much more serious than the fictional example of Thomas. Joe faced commitment to MMHI for the rest of his life, which is a commitment given to everyone who commits a capital offense and is found NGRI (DHS, 2015). He would still be able to apply for CR; however, the more serious the offense, the more challenging it is to be granted. There are a number of reasons patients with a capital offense often get overlooked for CR, at least for the first 10 years of their commitment. According Garcia (personal correspondence, July 7, 2020), they

may eventually be granted CR, but only after they have lived on the facility's least secure unit for at least 2 years, and it takes on average 8 years to go from maximum security to minimum security at MMHI. Per Garcia, "capital offenders move through the system slowly." This is partly due to pressure from the community in high-profile cases and partly to MMHI being pressured to not let anyone with such an offense out without sustained, long-term stability. Once granted CR, some offenders would need to follow their conditions for their entire lives or risk returning to MMHI (DHS, 2015).

Although forensic psychology can be defined in brief, simple, and abstract language, such a definition fails to fully capture the importance of this branch of psychology or its impact on the population it serves. Picturing "Thomas" and the circumstances he finds himself in helps us see how the criminal justice system and psychology intersect to form the field of forensic psychology, and how a person like Thomas ends up in a setting like MMHI.

Professional Standpoint

Years ago, I worked as a graphic designer and disliked the lack of interaction with human beings. Every day as I left work, I would feel like I had lost another opportunity to make a difference in anyone's life, including my own. I began to take psychology classes, then enrolled in the master's program at Mount Mary University for art therapy. I graduated and entered the field of art therapy in 2007, working as a clinical case manager in downtown Seattle. For several years I worked in an outpatient community mental health clinic with people who were living with severe mental health disorders. Additionally, many of the people I worked with were without homes, and just over half of my 70-person caseload had substance disorders.

My standpoint and view of the research problem presented in this dissertation is that of a White, professional class, cis gender female. I do not subscribe to a single school of psychological thought; rather, I agree with Wadeson's (2001, 2016) view that an eclectic approach to art therapy is useful, considering the diverse backgrounds and needs that can arise in any given day. I grew up in a military household, near military bases and hospitals, as my father is a surgeon and now-retired lieutenant colonel in the United States Army. My mother chose to stay home for me and my siblings' care and she was the person who first brought art into my life. Thus, in addition to having a supportive family, I grew up surrounded by art and science, both of which are important forces in my life. I also happen to be one of over 50 million people in the United States who are living with chronic mental illness (NIMH, 2019). Although I have never had to live in an inpatient setting for my mental health care, I have had to manage symptoms and medications my entire adult life. Thus, I empathize with people who have emotions that sometimes feel too big to hold, and I have always believed that creating art is a powerful means to channel those emotions and break them down into smaller, more manageable bits.

Each patient at the hospital where I work has their own background and story. I do not meet them at a good time in their life; instead, it is usually at a time of challenge and hardship. The patients are at the intersection of three systems that are fraught with problems today: criminal justice, medical, and correctional. Many of the patients I see have very little reason to trust a single one of these systems, let alone all three working together. Male offenders are the least likely group to seek help for mental health issues due to mistrust of medical professionals or the belief that nothing can be done to help

them—beliefs that can be further exacerbated by symptoms of a mental disorder (Howerton et al., 2007).

Due to the criminalization of mental illness, people with a severe mental illness (SMI) are over-represented in the criminal justice system (Hiday & Moloney, 2014). Breaking this down further into the subpopulations represented at MMHI reveals deeper fractures. Harding and Bott (2019) observed that Apache Native Americans in their care not only had a deep mistrust of doctors but of government institutions in general, due to extensive historical trauma. Latinos may underutilize mental health services due to institutional barriers (e.g., lack of interpreter services or accessible information) and the important role of family support (Villatoro et al., 2014; Breslau, et al. 2017). This situation can extend a cycle of mistrust by creating a lack of opportunities for therapeutic relationships to form (Villatoro et al., 2014). African American men make up 13% of the population of the United States and, disproportionately, 35% of the prison population (Hinton et al., 2018). According to The Sentencing Project (2020), 1 in 17 White males born in the 2001 will be incarcerated at some point in their life, compared to 1 in 3 Black males. Yet, it is at this rough and complicated intersection that my art therapy skills and treatment efforts are located. Having such a different background and upbringing from many of the patients at MMHI, it not only takes a while to build trust but it obligates me to center care and understanding within this larger context of their lives. Moreover, I believe in the value of the art therapy process. It always seems to build a strong therapeutic base between the patients and myself.

Description of the Research Problem

The patients in forensic settings throughout the country have survived some major losses in their lives. An immediate effect of their incarceration is their loss of freedom as well as lost relationships with family and friends who may turn their backs on them, leading to the loss of a safety net or close support system. The patients also have lost their ability to work, with poor chances of a job being there for them when they are released. Their crimes and psychiatric diagnoses make them marginalized and "othered," thereby losing social status or power in the community, with no real path to gain it back. Looking further, they have lost self-agency and access to what they need or want. They have lost their sound health and decision making over their health choices. They have lost out on many daily rituals that people not locked in a forensic or corrections setting take for granted: seeing a child on their birthday, taking a warm bath, or receiving a hug on a difficult day. Because they have a serious mental illness and have committed a criminal act, they possess two traits that are considered undesirable and not easily overlooked when or if they search for future employment or housing. One of the patients I worked with during this research project asked me,

> Janine, did you address the loss of credibility in your paper? No one believes anything I say anymore. I'm just a crazy criminal now. Even here [at MMHI], if I complain about something I feel is unjust on the unit, I'm told I need to develop better coping skills. So now I say don't say nothing.

They have lost their standing among family, peers, and society's social dynamic.

The patients in forensic psychiatric settings are often overlooked, as are their experiences with grief (Harner et al., 2011). For example, grief and loss counseling is not

offered at the hospital where I work and, based on my observation, is not listed on a single treatment plan as an objective. This population rarely receives helpful interventions aimed to address their layers of grief, in part because they don't even know how to identify it (Doka, 1989). They haven't learned efficient coping skills to increase their capacity to deal with loss. They may not even know how to ask for help with grief or have the ability to differentiate it from other emotions (Doka, 1989). Additionally, clinicians often lack training in the areas of ambiguous losses and disenfranchised grief (Boss, 2004). The grief manifestations from these losses can be potentially misdiagnosed due to common misunderstandings about them (Sagula & Rice, 2004). Therefore, unless the patient has lost a loved one, which is an easily identified loss with clear, well-studied bereavement loss interventions, the grief from ambiguous losses goes unchecked. Thus, the patients' grief remains uninterrupted and an opportunity to heal from their losses is lost.

Art therapy offers a unique aid in solving all kinds of problems (Gussak, 2020; Malchiodi, 2015). The grief the patients in these settings feel is unique in its ambiguity, while the patients themselves are unique for the many challenges they face in trying to process their grief under the circumstances (Boss, 2004). A unique problem requires a unique solution. I posit that art therapy can provide creative interventions that can help patients heal through identifying, connecting, and expressing emotions around their unique losses. Art therapists may be well positioned to conduct grief and loss programs in these settings because of the emphasis on meaning-making from difficult life events using innovative art interventions.

The purpose of my study was to examine art therapy as a possible treatment intervention for patients in a forensic psychiatric setting who were experiencing disenfranchised grief from ambiguous losses. It also served to explore the ways this type of grief manifests. Six patients volunteered for the study; motivated, I believe, by making a contribution to more effective treatment. An additional objective for me was to explore the use of art therapy directives as an opportunity for this population to voice their needs through artistic expressions of complex emotions. I sought to discover whether there is a difference in how grief manifests in a subpopulation of capital offenders. Because the role that mental illness played in their offenses can be overlooked due to their crimes, I explored whether and how this added to their experience of grief.

My study will inform art therapists, treatment teams in forensic psychiatric settings, and the patients in our care of the phenomenon of disenfranchised grief in this vulnerable population. Additionally, I intend to disseminate this knowledge to the fields of grief and loss therapy and forensic psychology by identifying symptoms of disenfranchised grief and providing interventions that expedite the rehabilitation process via a grief and loss treatment plan. The research will begin to fill in the gap of resources available by answering these research questions:

- Why is there a need to address experiences of disenfranchised grief from ambiguous losses as a treatment with the forensic psychiatric population?
- How does art therapy provide an effective intervention in exploring ambiguous losses and disenfranchised grief within this and similar settings?

In Chapter 2, I review the relevant literature on how psychiatric institutions evolved in the United States and intersected with the civil rights movement of

deinstitutionalization that was a forerunner to current legal structures in forensic settings. I examine the positives and negatives that the movement created, and how those ideas affect the patients in state forensic institutions today. I then explore stigma, myths, and their roles in the lives of people with severe mental illness (SMI). From there, I highlight the common illnesses and symptoms experienced by patients in these institutions and how treatment planning occurs. Then I delve into the history of grief and loss within the field of psychology. Finally, I explore the vital role art therapy plays in treating symptoms of grief.

In Chapter 3, I describe the research study design that I created as a method for exploring grief and loss with the forensic psychiatric population. I present the study results in Chapter 4 in the form of a creative portfolio that is organized as a series of personal portraits to creatively synthesize—and humanize—the patient co-researchers who shared their experiences of loss and began to contemplate how to break their cycles of grief. Chapter 5 discusses these results in context, reflecting on insights that were gained from this study as well as unanticipated challenges. The dissertation concludes with a look to the future about how additional research could benefit the field.

CHAPTER 2: LITERATURE REVIEW

I have organized the following review of the literature to illuminate characteristics of the forensic psychiatric setting, institutional and societal attitudes on mental health, and grief and loss therapy as the main components that must be understood in order to understand and place my research study into context. Because forensic settings can easily be misunderstood by people who have never worked in or spent time in such an environment, I begin by looking at the history of forensic psychiatric institutions in the United States and the role that deinstitutionalization continues to play in the life of patients in these settings. I explore some of the myths and stigma about mental illness that can impede understanding of the forensic population, many of which are driven by attitudes formed from how mental health illnesses are discussed in the media. Although a diverse array of professionals work with forensic patients, societal attitudes formed from media portrayals and stigma can unconsciously or implicitly influence their decisions around treatment. Relatedly, I compare mental health systems and criminal justice systems. Although they are often seen as two separate systems, it is important to understand their overlaps and how the added layer of the correctional system affects care for many forensic psychiatric patients.

Later in this chapter, I make a case for why grief and loss programs should be understood as an important component of the therapy that patients in forensic settings receive. I review historic and current grief and loss theories, highlighting those that are especially relevant for this population. Finally, I review the art therapy literature for what it offers to similar populations, making a case for how it may be uniquely suited to help in the treatment of grief and loss in forensic psychiatric patients. Throughout the chapter,

my focus remains on why grief and loss art therapy (or grief and loss therapy of any kind) is often overlooked for this population at a detriment to the patients.

A Historical Context of the Psychiatric Institution in the United States

When examining the role of state psychiatric hospitals, it is important to begin with a brief understanding of their history in the United States. State psychiatric hospitals were constructed to improve upon the care of people with mental illnesses (Parks et al., 2014). As far back as the 16th century, it is well documented that such people were considered "demented" and locked in local jails or almshouses if their family would not or could not care for them (Hunter, 1999; Parks et al., 2014; Sharfstein, 2000). They were often neglected and abused in these environments (Hunter, 1999).

In 1841, Dorothea Dix volunteered to teach Sunday school to women in a Massachusetts's jail (Modak et al., 2016). According to Parry (2006), as a woman, the only way Dix could participate in anything political was to write a letter called a pamphlet that would be read by a male representative to fellow state legislators. After observing the inhumane treatment of the women in the jail, Dix wrote her first of many pamphlets about treatment for mental illness based on moral and compassionate care (Dix, 1843; Parks et al., 2014). Her relentless work in the 1840s ignited a policy movement for establishing proper care for persons with mental illness, as well as for setting aside federal land for asylums (Parks et al., 2014). Rather than treatment via corporal punishment, care would be provided in institutions (Sharfstein, 2000). Dix's efforts led to the establishment of 32 state psychiatric asylums (Hunter, 1999; Modak et al., 2016; Parry, 2006). Because the funding came from state tax dollars, the "state psychiatric hospital" was born (Hunter, 1999). With a growing U.S. population

(Sharfstein, 2000) and little ability for communities to care for people with mental illness, what was intended to be small asylums became the larger public hospitals and facilities of today (Hunter, 1999).

By the early 1900s, the role of these institutions had somewhat shifted (Parks et al., 2014). They still cared for people with mental illnesses; however, they also housed people during epidemics, such as tuberculosis, offering treatment and a place to quarantine (Sharfstein, 2000). According to Fischer et al. (1996), descriptions of the state psychiatric hospital population at the time suggested that there was a subpopulation of patients "who had little, if any, clinical need for treatment in a psychiatric facility" (p. 1052). They explained that many people were hospitalized for nursing care or help with basic living skills because they did not have social or economic resources. This subset of patients remained long-term patients despite having no mental health needs (Parks et al., 2014).

With an increase in demand for these facilities, the census of psychiatric patients living in state hospitals on any given day surpassed half a million by 1955 (Fisher et al., 2001; Fisher et al., 2009; Parks et al., 2014). State psychiatric hospitals had grown into self-sustaining communities. Many, including MMHI, had their own land for growing crops, tending farm animals, and providing laundry facilities for the community, all of which were managed by patients (Parks et al., 2014). However, public awareness of abuse in some of these settings, along with new medications and laws, all fueled the movement to come, known as deinstitutionalization (Harcourt, 2011; Yohanna, 2013).

Deinstitutionalization: A Brief History

Recent findings estimate that in the U.S. about 38% of the residents in assisted living facilities have some form of mental illness, including schizophrenia, bipolar disorder, and depression (Morgan et al., 2016). According to Harvard University (2020), one-third of the total homeless population (200,000 people) have severe mental illness. There is a long history of how people with SMI ended up living on the streets or in assisted living facilities. Deinstitutionalization is a part of that history.

Deinstitutionalization was a movement that evolved out of the U.S. Civil Rights era of the 1960s "from large-scale, institution-based care to small-scale, community-based facilities" (Dear & Wolch, 1987, p. 16). One of its values was the integration of everyone into U.S. society equally, including individuals living with severe mental illnesses (Gudeman & Shore, 1984). At the time, institutions were seen by the public as doing more harm than good, as well as a site for civil rights abuse (Dear & Wolch, 1987).

Three factors drove the progression of deinstitutionalization. First were new and effective psychotropic medications used to treat people with severe mental illness, including schizophrenia (Yohanna, 2013). These drugs offered hope for relief from the debilitating symptoms of illness that cause psychosis (Amadeo, 2020; Yohanna, 2013) and the hope of a cure for the first time (Talbott, 2004). The drugs fueled optimism that that people with the severest forms of mental illness could live a full life free of hospitalizations or institutions.

The second contributing factor was the widespread belief that institutions were cruel (Harcourt, 2011). News coverage tended to highlight negative events, such as patient abuse (Weinstein, 1982). Fictional portrayals, as in the novel *One Flew Over the Cuckoo's Nest* (Kesey, 1962), resonated with the public's perception that mental

institutes were inadequate and full of atrocities (Shen & Snowden, 2014). Staff were viewed as authoritarian and the patients as wards forgotten by their families (Goodman et al., 2013; Weinstein, 1982; Yohanna, 2013). The idea of moving people out into the community and living on their own was popular and fed the movement (Talbott, 2004).

The third goal of deinstitutionalization was to save money. The Social Security Act Amendments of 1965 (known as Medicare), which helped provide healthcare to low-income families, did not fund mental health facilities (Shen & Snowden, 2014; Torrey, 1997). As a result, many patients living in long-term mental health facilities were transferred to community care (Amadeo, 2020; Raphelson, 2017). Currently, many low-income patients rely on Medicare for their mental health coverage needs, which prevents them from benefiting from long-term, institutional care if they need it (Ralphson, 2017). Did deinstitutionalization work? Fifty years later, the question is still debated.

Among the people who benefitted from deinstitutionalization were adults with such conditions as Down syndrome, autism spectrum disorder, and less severe mental disorders (Amadeo, 2020). The positive outcome for these specific populations depended upon their ability to navigate community services, as well as having solid social and familial supports in place at the time of discharge (Yohanna, 2013). They could live on their own or with family. Other benefits from the movement include public awareness and support for the culture of treatment for chronic illness (Torrey, 1997); treatment teams sought ways for their clients to participate in society whenever possible (Torrey, 2012). Many institutions also reviewed their internal practices and procedures, and updated them to better accommodate the self-autonomy needs of people living in long-term care facilities (Goodman et al., 2013; Ralphson, 2017; Yohanna, 2013).

Deinstitutionalization bore other benefits for people with SMI that have lasted through the years. Because patients were encouraged to live and seek services in the community, treatment plans began to take a strengths-based approach (Brun & Rapp, 2001). That is, rather than focusing on illness and symptoms, which was part of the legacy of psychiatry as a branch of medicine, the treatment focus shifted to how a person can use their own strength and abilities to recover or promote their own health (Xie, 2013). This shift newly empowered patients via their self-autonomy for their health by scaffolding treatment onto areas they excelled in (Brun & Rapp, 2001). Increases in self-esteem and self-efficacy among people living with mental illness have since been documented (Xie, 2013).

Another lasting benefit was the inclusion of family members and or guardians in a patient's treatment (Sheffield, 2013). Because many people released from institutions moved in with their family, families found themselves increasing their knowledge of mental health issues (Cohen, et al., 2008; Duncan, et al., 2010). This has helped the person with SMI gain confidence in treatment options by having trusted, knowledgeable family members involved in decision making (Cohen et al, 2008). Additionally, these family members often become vocal advocates for awareness of mental health issues in local communities (Sheffield, 2013).

Finally, several court cases from the deinstitutionalization movement changed legal requirements for hospitalization against one's will for long-term stays (Yohanna, 2013). For example, the idea of "least restrictive setting" was implemented through a 1966 legal mandate that, whenever possible, patients must be discharged to an environment that is less restrictive than a hospital (Torrey et al., 2008). Shortly after that,

the U.S. Supreme Court determined that patients must be deemed to be an imminent danger to self or others in order to be hospitalized against their will (O'Connor v. Donaldson, 1975). Finally, in 1999, mental illness was classified as a disability and therefore part of the Americans with Disabilities Act (Olmstead v. L. C., 1999). Governmental agencies (including state hospitals), thus, are required to make "reasonable accommodations" for people to access community-based treatment whenever possible (Yohanna, 2013). These developments have paved the way for people with SMI to be treated in the least restrictive environment possible and without unreasonable lengths of time.

Despite the benefits of deinstitutionalization for some individuals and their families, not all outcomes were positive. Many patients with the severest forms of mental illness were not good candidates for independent living and would have benefited from transitional housing and related supports (Ralphson, 2017). Others lacked basic living skills, such as the ability to cook for themselves or to manage their own money (Abram & Teplin, 1991; Dear & Wolch, 1987; Ralphson, 2017). Torrey noted that deinstitutionalization helped create a mental illness crisis in the US. by "discharging people from public psychiatric hospitals without ensuring that they received the medication and rehabilitation services necessary for them to live successfully in the community" (1997, p. 82). Long-term inpatient facilities historically had helped these patients with such needs; when they lost their funding, they had less capacity to allocate their beds to people with psychiatric needs (Torrey, 1997). Therefore, even after former patients did poorly in the community, there were no places for them to return to (Ralphson, 2017). They were on their own with little support.

Another unanticipated outcome from deinstitutionalization was that the new medications that had provided a source of great optimism ended up being less helpful for some patients than originally thought (Yohanna, 2013). Only about 13% of patients with psychosis experience remission, even with treatment (Penttila et al., 2014). Therefore, someone with schizophrenia or other mental illness who experiences psychosis may at times re-experience symptoms. In the presence of symptoms, the person may need extra support to complete daily skills, prompts to take their medication, or reminders for upcoming appointments—all things that are monitored in a facility but harder to monitor in the community (Torrey, 1997).

Since deinstitutionalization, there have been countless studies and books on its positive and negative long-term effects on patients and communities (see, e.g., Abram & Teplin, 1991; Dear & Wolch, 1987; Lamb & Bachrach, 2001; Lurigio et al., 2004; Ralphson, 2017; Torrey, 1997). Many researchers have concluded that there was not enough funding over the years to create the comprehensive community mental health clinics needed to support this population (Lamb & Bachrach, 2001; Dear & Wolch, 1987; Kliewer et al., 2009). Instead, services were scattered throughout larger cities, making it difficult for people to coordinate care for themselves (Amadeo, 2020). Kliewer et al. (2009) found that smaller communities also were ill-equipped to take on individuals with SMI due to having less experience with severe mental illnesses and lack of funding to hire experienced professionals. Many clinicians needed to learn and train on how best to work with this new set of patients and their needs (Kliewer, et al., 2009; Mechanic & Rochefort, 1990).

The outcome of several high-profile court cases at the time of deinstitutionalization also made it very difficult to get a person hospitalized against their will for symptoms of mental illness (Wis. Chapt. 51.01.13b). The laws that came out of cases from the 1960s and 1970s made it clear that society could not hospitalize its mentally ill population without firm legal grounds to do so and these social policies are still in place today (Kissinger, 2011; Ralphson, 2017). Stipulations for involuntary hospitalization include threatening harm to self or others, inability to self-care due to illness, or a severe deterioration of functioning ability (Kissinger, 2011; Lessard v. Schmidt, 1972). However, too often families and mental health professionals are left confused by what to do when a loved one or patient needs more intensive help but refuses hospital care (Kissinger, 2011; Ralphson, 2017; Yohanna, 2013). If family or health practitioners are not available to help, a person can end up in the criminal justice system instead of care (Lamb & Bachrach, 2001), which is another consequence of deinstitutionalization (Torrey, 1997).

Lamb and Bachrach (2001) found that both historically and currently there is a large number of people with severe mental illness in the U.S. prison system. They attributed this finding to the more stringent criteria for civil commitment that evolved from changes in 1970s-era laws, as well as inadequate community support previously mentioned. In fact, many of the people who have SMI in the U.S. criminal justice system today parallel the demographics of patients who used to be in long-term institutions and state hospitals prior to deinstitutionalization (Lamb & Weinberger, 1998). Rather than being hospitalized and receiving psychiatric care, they are committing minor crimes in part because of the manifestation of their illness (Wallace et al., 2004). For example, I

work with a patient who has been at MMHI for over 5 years for disarming a police officer. The patient was psychotic at the time and thought the officer was there to harm his little sister. He had to stay in jail for 18 months until a bed opened at MMHI. Lamb and Wienberger observed that our society "has a limited tolerance for mentally disordered behavior, and the result is pressure to institutionalize persons who need 24-hour care wherever there is room, including jail" (1998, p. 1042). The result is the criminalization of mentally-disordered behavior (Abram & Teplin, 1991). People who previously would have been treated in mental health institutions are instead coming to the attention of their community for what is thought to be criminal behavior and are arrested, entering the criminal justice system instead of the mental health system.

The courts have made it difficult to have someone involuntarily hospitalized, despite that it can sometimes be an important step to early treatment interventions (Kessler et al., 2005; Yohanna, 2013). According to Kissinger, when it comes to mental illnesses, "the problem with leaving it up to a person to decide if he or she wants psychiatric care is that not everyone with mental illness knows they have it" (2011, p. B7). The court decisions that served to emancipate people with SMI also severely limit the ability for families and medical professionals to intervene (McCance-Katz, 2018). If a person has no insight into their illness, does not believe they are sick, or has active symptoms that are confusing them in some way, why would they volunteer to be hospitalized? Nor should we expect them to. However, having a system in place that supports rather than criminalizes them could benefit people with SMI, their families, and communities (Kessler et al., 2005; McCance-Katz, 2018; Yohanna, 2013).

Consider the example of Thomas, who was experiencing a mental health crisis and whose symptoms included paranoia. If family or friends, despite his unwillingness, were able to help him with treatment in a medical setting to reduce symptoms, perhaps his psychosis would have abated and returned him home within a few days. Instead, with no one to intervene, he could not be helped until he made a threat that catapulted him into the legal system. Thomas's mental health crisis was treated in jail instead of in a mental health setting. Implicated in this tragedy is a broken system that cycles people with SMI through hospitals and jails, if they are fortunate. Many who are not so fortunate may not survive, or end up living on the streets, unable to thrive and fully care for themselves (Torrey, 1997). Treffert coined the term "dying with one's rights on" (1973, p. 1649) to describe the dichotomy of protecting the rights of this population at the expense of their own well-being. Their rights are protected, but at what cost? Almost 50 years later, his sentiment still rings true.

Research supports the contention that in the U.S. people with severe mental illnesses often have difficulty integrating into their community (Mandiberg, 2012; National Institute on Mental Health [NIMH], 2019; Pahwa et al., 2014), leading to behaviors that draw the attention of law enforcement. Most commonly, they are arrested for disorderly conduct, trespassing, vandalization, or drug possession, all of which tend to be due to symptoms rather than criminality (Abram & Teplin, 1991; American Psychiatric Association, 2014). They also have less access to affordable housing (NIMH, 2019). Some people may turn to drugs as a way to self-medicate, while community clinics lack the resources needed to help (Yohanna, 2013). State institutions such as MMHI provide psychiatric as well as medical treatment, vocational training, and a safe

surrounding. In the absence of the community supports that were envisioned with deinstitutionalization, the loss of these institutions over time can be seen as a disservice to some people with severe mental illnesses (Torrey, 1997; Yohanna, 2013).

Stigma, Myth, and Marginalization in Mental Health

Myths and misinformation contribute to the oppression and stigmatization of people living with mental illnesses. Stigma can affect a wide range of experience, from the quality of life a person may have to how social, governmental, and legal policies are created to serve their mental health care (Choi, 2001; Corrigan & Watson, 2004). The consequences of stigma and stigmatization also can spread over many systems, from the increased violence against and isolation of people with mental illness to a reduction in resources for the population at large (Corrigan et al., 2002). Marginalization is defined as a population, group, or individual on the periphery or boundary of mainstream society (Alexander et al., 2003; Choi, 2001; Hall. et al., 1994). In the case of people with mental illnesses, exposure to stigma and discrimination creates environments with potential to threaten their well-being. People living in marginalized environments often experience poor health outcomes, inequalities in health care access, and deficient health care resources (Alexander et al., 2003; Szasz, 2008).

Stigma plays a large, often silent role in the journey to places like MMHI for many people. It is present in how people with SMI are treated in society, how often they have interactions with emergency services, and what kind of psychiatric treatment is available or offered (Corrigan & Watson, 2002). Before explaining how stigma affects a person with severe mental illness, however, it is important to first examine what stigma is and the elements at play in its creation.

Over 50 years ago, Goffman defined stigma as any “attribute that is deeply discrediting” and reduces someone from being “a whole and usual person to a tainted, discounted one” (1963, p. 3). The myths and misinformation that trickle down through

society make it possible for a person with mental illness to feel and be viewed by others as "tainted" or "discounted." Goffman's definition still holds and is often cited in literature regarding stigma from mental illness (see, e.g., Corrigan & Watson, 2002; Dovidio et al., 2000; Overton & Medina, 2008). Crocker et al. (1998), who examined stigma in a social context, described the formation of stigma as arising from a place of power within society, whereby people are identified by a societal group as having certain characteristics or traits that are devalued by the rest of the group. The person with the devalued attributes becomes stigmatized when not accepted into the societal group. Corrigan and Watson (2002) further break down stigma into two types: public stigma and self-stigma. Accordingly, public stigma is the general population's reaction to people based on commonly-held beliefs, whereas self-stigma comprises the negative beliefs or prejudices that people turn inward onto themselves.

Corrigan and Watson (2002) identified three components that make up stigma, consisting of stereotype, prejudice, and discrimination. With respect to public stigma, stereotype is "a negative belief about a group" (p. 16). For example, people with SMI often are perceived as lazy, weak, or dangerous. Prejudice involves agreement with the stereotype based on a negative emotional reaction toward the stigmatized person, such as feeling frustration or fear, which reinforces the corresponding stereotype. Discrimination is the behavioral reaction to the prejudice, such as avoiding people with SMI, denying them employment or housing, or bullying them. In the example of Thomas, described earlier, perhaps the people in his community or apartment complex held a negative stereotype that people with SMI are dangerous. Believing this stereotype to be true, his neighbors may fear Thomas when passing him in the halls, which is a negative emotional

reaction that reveals prejudice. Their reactions produce, in turn, discriminatory behavior against him, such as excluding him from all neighborhood activities. The top three prejudices and subsequent discriminatory behaviors surrounding people with SMI have been found to be: (a) fear and exclusion, in the belief that they should be feared and kept out of communities; (b), authoritarianism, in the belief that they are irresponsible, so their life decisions should be made by others; and (c) benevolence, in the belief that they are childlike and need to be cared for (Corrigan & Watson, 2002).

By layering the idea of public stigma over Thomas's journey to MMHI, his trajectory becomes clearer. If the person who initially called emergency services to report Thomas was already fearful of him due to stigmatizing prejudice born of a stereotype, it is possible they overreacted to the situation. Maybe Thomas just needed a reminder from someone to take a medication that he missed that day, or some other factor could have grounded him that was overlooked. Perhaps it was correct to call for help; however, if the emergency responders harbored stigma, particularly if Thomas was behaving according to stereotyped expectations, it could affect their determination of whether to take Thomas to a hospital or to jail. Consider, as well, the potential for prejudice and discriminatory behavior on the part of the jail staff, fellow inmates, or the employees of the court system and how these may influence the outcome of Thomas's treatment while in their care. Any one of these factors could affect Thomas upon his release from MMHI. He may no longer have an apartment to return to and when he inquires about vacancies in his former apartment building, the landlord may refuse to rent to him, due to his past incident with law enforcement. There may be fear of or pressure from other residents who do not want to see Thomas back in the building. Thomas may have to move to a new or unfamiliar

neighborhood with fewer social supports in place or end up without housing altogether. If even one person involved in the chain of events during Thomas' mental health crisis believe that people with SMI require others to make their life decisions for them, or that they belong to a population that should be feared and kept out of local communities, their subsequent reactions could shape Thomas's entire life from that point forward.

Self-stigma involves the same three elements (Corrigan & Watson, 2002), but they play out somewhat differently for a person with SMI. The stereotype component of self-stigma begins with a negative belief about oneself; for example, Thomas believing he is, in fact, incompetent. Thomas may then cede to that belief, which produces a negative emotional attitude such as low self-esteem or low self-worth. With these prejudices directed at himself, he behaves in a self-discriminatory manner, such as self-sabotage. Perhaps he doesn't pursue things like work, school, or even friends because of his self-beliefs, and he pre-judges what he believes will be others' reactions toward him. An on-going cycle of stigma costs opportunities for people with mental illnesses while fueling the misconceptions the public may carry (Corrigan & Watson, 2004).

Knowledge about mental illnesses is ever-evolving as new research is reported monthly (Tekin, 2020). Because the causes and outcomes of mental illnesses have long been misunderstood, many myths endure from one generation to the next that are still attached to mental health care (Corrigan et al., 2002; Corrigan & Watson, 2002). It is unfortunately common in U.S. society to believe that people with mental illnesses are not morally strong or that they embody an inherent weakness of humankind (Corrigan & Watson, 2002; Overton & Medina, 2008). From a literature review on the subject, Parle (2012) concluded that it "still seems to be a general consensus that anyone with mental

illness is unreliable, especially in terms of looking after children" (p. 13). This finding supports Corrigan and Watson's (2002) research that identified benevolence as one of the top prejudices toward people with SMI in the perception that they are immature, incapable of responsibility, and should be treated like children. There is evidence that the belief that they lack decision-making abilities and must function with reduced intelligence is held throughout the world (Angermeyer & Matschinger, 2005). This attitude perpetuates stigma, further distancing people who have SMI from mainstream society.

Additionally, myths about mental illness are particularly misconstrued towards certain diagnoses. People with schizophrenia are often viewed by the general public as dangerous or volatile, with the belief that they should be locked away for everyone's safety—again reinforcing the prejudice that people with SMI are to be feared and excluded (Corrigan &Watson, 2002; Crisp, 2000). Similarly, depression is a condition that carries the stigma of being unwilling to just "snap out of it" and that one is simply too lazy to get out of bed or be productive (Crisp, 2000). This myth reinforces the prejudice that people with SMI are irresponsible and need help making major decisions (Corrigan & Watson, 2002; Stalter & Byne, 2000; Thornicroft, 2006). These and other misconceptions can have dire consequences for people with mental illnesses, such as marginalization, and can poison the general public's opinion on the subject due to such inaccuracies.

Myths and stigma against mental illness contribute to the stigmatizing process of othering. According to Johnson et al. (2004), a person becomes an "other" when they are identified as different from or outside the mainstream and its expectations. Othering

serves to “reinforce and reproduce positions of domination and subordination” (Johnson et al., 2004, p. 253). The concept is constructed around a belief that what is “other” or out-group is the possession of an unwelcome trait or characteristic that one’s “self” or in-group does not have (Brons, 2015). Because the dominant group defines the parameters of what traits do and do not belong to itself, the other (out-group) is pushed to the outside of social norms, which gives the self (in-group) power over the other. In many instances, this power simply rests on differences in traits and may involve subtle social dynamics of exclusion (Barter-Godfrey & Taket, 2009; Brons, 2015; Johnson et al., 2004) that nevertheless perpetuate violence against the other.

Reflecting on this matter further, I recall working in an urban community mental health center where I witnessed daily how the population I worked with was othered. I observed people walking down the sidewalk who would cross the street so they would not have to pass by my clients. The clients would sometimes start up friendly conversations with strangers who would simply ignore them as if no one was speaking. In my current job, I sense that people in the surrounding community seem to want to forget that a large forensic hospital like MMHI even exists.

Thomas Szasz: How Labels can Lead to Stigma

Psychiatrist Thomas Szasz caused a stir in the world of psychology when, in 1961, he published his work entitled *The Myth of Mental Illness*. He argued that the condition of mental illness itself was a myth because there is no biological proof of its existence. Physical illnesses can be identified by the presence of pathogens and disorders of anatomy, as well as test results and imagery that can reveal the body’s malfunctions precisely. In contrast, Szasz’s argument was that psychologists and psychiatrists were

using groups of symptoms to "invent" new diseases and their causes. He wrote, "strictly speaking, disease or illness can affect only the body; hence, there can be no mental illness" (p. 267). What I appreciate about this idea from the perspective of today is that because the brain is part of the body, mental illness should not be considered a separate entity. Mental illness is an illness of the body like any other type of illness.

Relevant to this discussion, Szasz (1961) argued that psychiatric diagnoses are "stigmatizing labels, phrased to resemble medical diagnoses and applied to persons whose behavior annoys or offends others" (p. 267). His idea was that rather than mental illness, people had personalities or idiosyncrasies that, because they are outside of social norms, were deemed "annoying" (p. 267). Psychiatrists then label these annoying people, creating stigma for them and for a society, which "precludes regarding individuals as responsible persons and invites, instead, treating them as irresponsible patients" (p. 262). Such treatment can fuel the cycle of self-stigma and public stigma previously discussed. Treating someone as an "irresponsible person" can perpetuate a prejudice that turns into discrimination against people experiencing the mental illness. As conferred by mental health experts and reinforced by their families and social groups, they in turn believe they are irresponsible and therefore unable to even try to find work, say, or get an education (Corrigan & Watson, 2002). The public can then justify not considering this population for employment or other opportunities because of the self-perpetuating belief that they are irresponsible.

Media and Mental Illness

Mass media plays a large role in sustaining stereotypes, discrimination, and stigma that surround this population. It seems rare to turn on the television and see

something positive regarding mental illness. More common is the news report on a mass shooter or Hollywood celebrity and how mental illness played a part in their actions.

Television, movies, and news stories are primary sources of information about mental health issues for many people in the U.S. (Caputo & Rouner, 2011; Yankelovich, 1990). The imagery the media chooses to use, incorrect psychiatric terminology, and other biases can contribute to a misinformed public (Edney, 2004; Stout et al., 2004). Additionally, how mass media portray characters with mental illness can add to public stigma (Edney, 2004; Wahl, 1995). I know many people personally who live with mental illness and have productive, meaningful lives. I am one of them. However, from watching television and movies, it can be easy to assume that everyone with depression attempts suicide, people with obsessive-compulsive disorder must constantly recheck locked doors, and schizophrenia poses a danger to all. Indeed, Wahl's study from 30 years ago (1992) found, from analyzing a 2-week sample of U.S. prime-time television (i.e., from 8:00PM to 11PM EST), that characters with mental illness were 10 to 20 times more violent than the U.S. population living with mental illness at the time, and this finding still holds today. In light of Corrigan and Watson's (2002) taxonomy of stigma, one might ask whether prejudices are born from media portrayals or whether the media use these stereotypes because of the belief that they are true.

Gerbner's *cultivation theory* (1969, 1998) proposes that there is a relationship between watching television and other media and a person's beliefs about reality. The more consistent and omnipresent a message conveyed by the media is, the more likely a person's convictions and beliefs will align with that message as their viewership increases. The cultivation of biased beliefs from the media is supported by research that

has shown that people who watch a lot of television tend to have a more negative perspective of people with mental health disorders than those who watch very little television (Edney, 2004; Granello & Pauly, 2000). Given the widespread influence of mass media in the U.S. today, perhaps people with direct knowledge of mental illness should have a voice in how characters and events are portrayed. Gupta et al. (2018) examined the role media plays in shaping society's ideas and understanding of various mental health issues, such as suicide and violence among those with mental illness, and reported that when these issues are presented more accurately, there may be a corollary effect on how they are perceived in the real world.

Perhaps the most well-known example is Kesey's (1962) *One Flew Over the Cuckoo's Nest* that presents a fictional portrayal of a state psychiatric hospital in Oregon told from the point of view of one of the patient residents. The book and subsequent movie draw upon many of Goffman's (1961) theories on the social processes of "total institutions" and the mortification of self. According to Goffman, a total institution is a place where people share similar situations, live together, and work together, as with prisons or assisted living facilities. In contrast, people living out in the community have different places in which they work, reside, and recreate. The distinguishing characteristic is that there is a "breakdown of barriers normally separating these three spheres" for total institutions (Goffman, 1961, p. 6). People are constantly together and under institutional authority. Their days are meticulously scheduled. They are stripped of individuality; their possessions that make them who they are, are stored away; they become nothing more than a patient number (Goffman, 1961).

All of the above scenario is encapsulated in *One Flew Over the Cuckoo's Nest*, which although fictional, likely was influenced by Kesey's work experience as an attendant in a psychiatric hospital within the same timeframe as Goffman's writing (Fine & Manning, 2003). Taking into account that he was describing a state hospital as they existed in the late 50s and early 60s, as I re-watched the movie for my research, something interesting struck me: for all the work Goffman did to spotlight the harmful effects of stigma on people with mental illness, his book on asylums also helped in creating a public stigma about mental health institutions. It seemed that placing a stigma on institutions also placed stigma on those whose lives benefited from living in these facilities. His narrative highlighted the problems of the total institution without consideration of their benefits, and this bias was solidified by the popularity of Kesey's novel and subsequent film.

When I was a junior in high school, I had to read *One Flew Over the Cuckoo's Nest* and watch the film in an introduction to psychology class, and it is still on the curriculum as recently as this past school year. Although the book is valuable in drawing parallels to psychological theories and theorists such as Goffman, it also epitomizes the dominance that media can exert on public opinion. Kelly (2005) wrote, "In the thirty years since [its] release . . . it has become clear that this particular film has had an especially strong and enduring effect on public perceptions of mental illness and its treatment" (p. 2). Indeed, when I have disclosed to members of my community where I work, people have asked, "What's it like working in One Flew Over the Cuckoo's Nest?" Even while at work, I often hear patients refer to staff they perceive as unfair as "Nurse Ratched," a reference to a punitive character in the book.

It is clear that the beliefs people have about mental illnesses affect how they perceive and treat individuals with mental health disorders, leading to prejudice and stigma (Corrigan & Watson, 2002). There is a lot of work to be done in order to combat this cycle. Corrigan and Watson (2004) suggested that one way to change attitudes is to change the language of *mental illness* and refer to it as *brain disease* instead. They argued that by equating mental illnesses with other medical disorders, such as diabetes or heart disease, the public can understand a mental illness to be a "biological disorder that people do not choose" (p. 477). They added that education about the possible causes of a mental illness, including psychosocial stressors from surviving child abuse or other traumas, could be a helpful as well. Moreover, when the public hears directly from someone in the community who has a mental illness, the perception of otherness is diminished by humanizing the person (p. 478). A misinformed public gains awareness when they can experience the person rather than the disease.

Szasz's (1961) controversial argument of mental illness as a "myth" was based on a similar idea. He wanted to reclassify mental illnesses as simply "problems of the living" (p. 116). He explained that once a person is classified as having a mental illness, there is a danger of misidentifying their "strategic behavior" as a bodily disease (2008, p. 15). Although people do suffer from illness, one might clarify that the illness is derived not from disease per se but from complex interactions of biology with their environment, often producing behaviors outside of societal norms. Szasz postulated that by referring to these behaviors as problems of the living, we remove the stigma around the odd and therefore stigmatized behavior.

Szasz's interesting thought experiment led me to wonder: would the patients at MMHI experience less stigma if the institution was called "Mendota Institute for Problems of the Living"? Perhaps, but taken at face value, Szasz's stance seems naïve. For example, when considering the case of Joe, from the opening vignette, it would be misinformed and therefore hazardous to argue that he killed his father due to having a problem with his state of living. Taking this position could overlook the presence of psychosis and its treatment. Furthermore, referring to homicide (even one committed while under throes of psychosis) as a problem of living obscures the fact that the offense was a heinous act. Although forensic psychiatric patients do not deserve be so stigmatized, neither would it be responsible to explain away those who committed heinous crimes. Unfortunately, when crimes such as these are reported in the news media, they add to the stigma experienced by all patients with mental illnesses, and the cycle continues (Gupta et al., 2018; Owen, 2012; Ross et al., 2019).

Salter and Byrne (2000), both of whom are psychiatrists, argued that mass media could be used in a more positive way to help reduce stigma. They contended that since the general population gets so much of their information from mass media, using it as a tool to combat stigma likely would be a start. They put the onus on psychiatrists, stating that they should regularly correct media reports that use psychiatric terms pejoratively (e.g., describing a person living a double life as a "schizophrenic" situation) or ask to vet new stories beforehand (Rossler, 2016). Hart and Phillipson (1999) called on their fellow psychiatrists as well as individuals living with mental illnesses to call out news outlets. One can also find examples of "stigma busting" on social media where casual use of

harmful language and imagery is called out by mental health care consumers and allies, but studies have yet to examine the effects of such campaigns (Bagley & King, 2005).

The Role of Stigma in Treatment

Stigma also has the power to affect the treatment that gets offered to people diagnosed with a severe mental illness. For example, in their systematic review of 28 research studies on stigma held by health professionals toward people with substance disorders, van Boekel et al. (2013) found that providers typically held negative attitudes that resulted in diminished patient empowerment and poorer treatment. Providers, often subconsciously, hold prejudices that patients with mental health needs are medication-seeking, manipulative, and difficult to work with (Knaak et al., 2017). Subsequently, many patients with mental health care needs report longer wait times at doctors' offices and feeling dismissed by their healthcare providers (Henderson et al., 2013). Knaak et al. (2017) also found that many providers were not aware of their unintentional behaviors towards this population until they received anti-stigma training.

Stigma held by providers can also affect the quality of care people with SMI receive by disrupting which services these patients have access to (Henderson et al., 2013; Knaak et al., 2017). Stigma at the administrative level of health care can lead to a lack of resources available from not investing in available treatment options for patients or appropriate trainings for providers (Zartaloudi & Madianos, 2010). Stigma and unconscious biases held by providers can grow into a workplace culture (Knaak et al., 2017); that is, as providers harbor prejudices against patients with mental health needs, their workplace fails to respond effectively, such as in providing anti-stigma training,

which in turn keeps the facility from investing in resources for an already underserved population (Thornicroft et al., 2018).

This cycle of stigma affects the help-seeking tendencies of patients (Zartaloudi & Madianos, 2010). Patients with mental health care needs often feel that they are kept out of decisions regarding their own health (Hamilton et al., 2016), are spoken to in a patronizing manner, are coerced into treatment (Knaak et al., 2017), and/or that full treatment options are withheld from them (Clarke, 2007). Not surprisingly, Komiya et al. (2000) found that the more strongly a patient feels stigmatized, the less interaction they will seek from health care professionals. When patients do see a professional, they often are at risk for being misdiagnosed due to providers misattributing mental health symptoms and missing their physical health needs (Thornicroft et al., 2018). Because of these factors, patients often have a longer lag time between physical health problems and proper diagnosis.

Treatment in Forensic Psychiatric Settings

Using Mendota Mental Health Institute as one example, treatment in a forensic psychiatric setting is conceived based on several factors. First, the court system—a judge or legal team—can determine what treatment a patient needs in order to move forward through the legal process (Berstein & Steltzer, 2003). For example, a judge may decide that person will not be granted conditional release until they have had 2 years of addiction treatment if it was deemed that drugs or alcohol played a factor in the patient's index offense. Because this example is often a reality for many of the patients at MMHI, we have an Alcohol and Other Drug Addictions program as well as a Behavior Specific Program that provide treatment for sexual addictions or offenses.

Treatment is also formulated from staff observations. In the case of MMHI, the rehabilitation team consists of occupational therapists, recreational therapists, and vocational therapists, as well as social workers, teachers, music therapists, and art therapists. As staff, we have diverse educational backgrounds and can provide a broad range of treatment in areas where we have observed a need. As an example, there is a large subpopulation of patients with personality disorders. Because of their prevalence, many therapists have trained in dialectic behavioral therapy (DBT) because it is shown to be an effective treatment option for them (Rizvi & Linehan, 2001) and now there is a DBT program in place. As another example, after hearing from patients that many either did not know or knew little about their diagnosis, I started an educational group that explains the mental health diagnosis and corresponding symptoms. Details about these symptoms are anonymously suggested by the group members, giving them some education and information about questions they may harbor.

Further suggestions for treatment often come from the patients themselves. Anonymous patient surveys are offered three times a year at MMHI. Many patients feel comfortable bringing their ideas to their treatment teams or directly to a group facilitator. This has led to such groups as learning Spanish for the workplace, led by the vocational therapists, or a music therapy AODA group that discusses musicians who have overcome their addictions. Group facilitators tackle subjects that are important for treatment in a way that is interesting or motivating for the patients based on their input.

However, examining treatment options under the umbrella of stigma presents a different point of view to consider. Arguably, the most influential component of public stigma that I have witnessed is the previously mentioned prejudice of authoritarianism,

especially for patients living at MMHI who have been deemed “not competent.” Authoritarianism has been linked with inferior treatment and increased coercive handling by staff or peers (Corrigan et al., 2001). This plays directly into the discriminatory belief that people with SMI should be treated by restricting their liberties and having their life decisions be made by others. According to Lamb et al. (2004), these misguided beliefs have cultivated the perspectives of law enforcement as well as people in the community “that deviant behavior [of people with SMI] can be dealt with quicker and more efficiently within the criminal justice system than the mental health system” (p. 109). In reality, this does nothing to increase public safety and places a larger burden on the corrections systems, as well as state and local budgets (National Alliance on Mental Illness, 2021). Once a person with SMI enters the criminal justice system, it often becomes a revolving cycle. Those with SMI experience longer sentences for the same crimes as their non-SMI counterparts in part because people with SMI have a hard time keeping track of all the rules imposed upon them and receive numerous infractions that lengthen their stay as a result (Turner & Salter, 2008). This dilemma can lead to loss of jobs, incomes, housing, and standing in the community, fueling a cycle of recidivism (Bouman et al., 2009).

When a judge determines the person will not be granted conditional release unless they complete 2 years of AODA treatment, one might ask, What if the patient doesn’t want AODA treatment? In the case of someone like Thomas, he will “fail” the conditions of conditional release and not be allowed to return to the community, excluding him further. Although AODA treatment might truly benefit Thomas, one cannot say whether

stigma has in some way affected the judge's decision to put that condition on his treatment.

Self-stigma can also influence treatment options. Corrigan et al. (2009) found that self-stigma and discrimination can be caustic barriers that impede a person's recovery or worsen their quality of life. Studies have found that the most reported type of self-stigma is alienation or not feeling fully part of society (Brohan et al., 2011; Ritsher et al., 2003). People who have moved to the U.S. from other countries, particularly non-English-speaking countries, have reported feeling an extra layer of alienation around their mental health needs due to feeling misunderstood or having trouble communicating without an interpreter available (Breslau et al., 2017), furthering feelings of low self-esteem and self-efficacy. If a patient accepts the judgment that they are incompetent, which can decimate their sense of self-worth, they may not feel deserving of receiving treatment or, perhaps worse, may feel unworthy even of feeling better (Ritsher et al., 2003). They then lose all self-advocacy and do not participate in treatment, let alone come up with ideas for treatment that they might find interesting or beneficial to their particular needs.

Rehabilitation of Mental Illnesses in Forensic Populations

In forensic psychology, all types of mental illnesses are represented within the population's entirety (Siu et al., 2018). Diagnoses include schizophrenia spectrum disorders, which are illnesses with symptoms that affect the thoughts of a person in the form of delusions or hallucinations, as well as other less common symptoms (Houidi & Paruk, 2018). Due to their nature, these disorders are often referred to as thought disorders (Uher et al., 2014). Bipolar disorders and depressive disorders are also common among forensic patients, and are referred to as mood disorders due to how their

symptoms manifest and affect mood (Uher et al., 2014). Finally, personality disorders that may be present among forensic patients include borderline personality disorder and antisocial personality disorder (Wakefield, 2013). The most common mental illnesses for the patients at MMHI are thought disorders, followed by mood disorders and personality disorders, respectively.

Symptoms

Psychosis itself is not a mental illness but a symptom found in numerous mental health diagnoses (Arciniegas, 2015). Because the largest group of mental illness represented at MMHI is thought disorders, it is important to examine this commonly experienced symptom (Yung et al., 2004). Psychosis is defined as the presence of hallucinations, delusions, or both in a manner that affects the person's way of life (American Psychiatric Association [APA], 2013; World Health Organization [WHO], 2019). Its diagnosis is predicated on the assessment that no drugs or substances are present that could account for the person's hallucinations or delusions (APA, 2013). Additionally, the nature of the person's disordered thinking is involuntary and not grounded in reality (Hussain et al., 2005).

Impaired reality testing is central to psychosis, according to Arciniegas (2015). Hallucinations, which can be visual, auditory, olfactory or tactile, are perceptions that are experienced without any external stimuli triggering them (APA, 2013; WHO, 2019). For example, a person may see people who are not actually in the room or smell rotting food when no food is present. In contrast, delusions are false beliefs that a person holds about certain situations or people (WHO, 2019). These can be persecutory, body-oriented, or jealous in nature, among other types of delusions. Persecutory delusions are most

common and are based in perceived threats, such as someone believing the police are "after" them or that a government agency is trying to read their thoughts, which can fuel paranoia (Freeman et al., 2002). The person experiencing delusions will continue to believe them to be true even in the presence of evidence proving otherwise (Arciniegas, 2015).

At MMHI, over half of the patient population has experienced some form of psychosis (MMHI Patient Census, 2020, 2021). There are several reasons why psychosis is so prevalent in forensic psychiatric patients. Substance use and criminal behavior, such a theft or trespassing, have been linked to the experience of psychosis (Bhui et al., 2015). In the case of substance abuse, someone who is suffering a break from reality may have poor insight into what is happening and may try to self-medicate with drugs or alcohol (Yung et al., 1996). Bhui et al. (2015) further explained that paranoia or false beliefs may drive a person to commit such crimes as entering a stranger's home, setting a fire, or stealing a vehicle, as an attempt to relieve the paranoia or satisfy the false belief. Although these actions seem justifiable to the person in that moment, they are still illegal and therefore may result in interaction with the criminal justice system and, ultimately, treatment at a forensic psychiatric hospital.

Among the subpopulation of people residing in a forensics facility, patients like Joe (described in the introduction) have committed a capital offense while experiencing some form of psychosis. It is important to note that in these cases, committing a murder is an ego dystonic act (Leibman, 1989), meaning that the psychotic behavior that produced the act is inconsistent or in active conflict with the person's ego, free will, and self-beliefs (Belloch et al., 2012). Once the person becomes re-acclimated to reality, they have a hard

time believing they were capable of committing the abhorrent offense (Belloch et al., 2012; Leibman, 1989). Among the horrors they must live with is the discovery of their offense when no longer experiencing psychosis. How do they cope with this knowledge?

Rehabilitation and its Goals

The kind of care that forensic patients receive as they recover from psychosis or other symptoms is provided within the structure of rehabilitation services. The notion of rehabilitation is difficult to delineate because it cuts across a large spectrum (Siu et al., 2018). As Lindqvist and Skipworth (2000) noted, its "outcome is the result not only of the sum of individual contributions within the treatment system, but also of the interacting effects of these various efforts" (p. 320). MMHI, like many forensic psychiatric hospitals, offers a variety of rehabilitation programs that are provided via a multidisciplinary team, which creates a milieu of interacting effects from different perspectives. This promotes rehabilitation in that patients learn how to employ many different tools for problem solving, symptom management, and the like. As a result, the patients have many options for personalized treatments and, hopefully, leave MMHI armed with various coping strategies for their needs beyond the institute.

The goals of treatment for an offender in a forensic psychiatric setting may vary, depending on the illness as well as the offense (Siu et al., 2018). At MMHI, the issue that must first be assessed and treated is the reduction of any symptoms that cause stress or physical harm. In such a situation, priority goes first to managing the physical safety of the patient (Balfour et al., 2017; McKenna et al., 2015). If they are in such extreme anguish that all they can think about is harming themselves, augmented therapies such as art therapy or AODA programming cannot be introduced until they have stabilized.

Stabilization in this context would require that harmful symptoms, such as a desire to self-harm, have subsided and the person is able orient to reality (McKenna et al., 2015).

After any self-harming situations are resolved, one of the main goals of treatment that follows is symptom reduction (Lysaker et al., 2010). For many of the severe mental illness diagnoses at MMHI, symptoms can be reduced with a combination of medication and therapy (Penttilä et al., 2014). However, it is important to point out that the stabilization process on which treatment depends may take a week to several years. Parameters for the complete remission of psychosis were set in 2005 in a study by Andreasen et al. and have been widely accepted in the field of psychiatry (Harrow & Jobe, 2013; Penttilä et al., 2014; Wunderink et al., 2013). Based on these guidelines, Penttilä et al. (2014) conducted a meta-analysis of 33 studies of the long-term effects of untreated schizophrenia and found that only 13.5% of the population sampled ever reach remission of their schizophrenia-related disorders. This research suggests that some symptoms, including psychosis, may never completely resolve, even with medication and augmented treatment (Carter et al., 2019). Therefore, the additional therapies provided at a forensic psychiatric hospital like MMHI may never be accessed because the severity of their symptoms fails to subside.

Treatment Goals and Planning

A patient may have to wait for a bed to open up at MMHI, meaning they are in jail, awaiting placement and proper treatment for months (MMHI Census, 2019, 2020). Treatment in forensic psychiatric institutions is a layered process (Arboleda-Flórez, 2006). The combination of legal structures and the presence of symptoms requires the patient to be placed in the hands of hospital personnel for much of the decision-making

process at the time of admission (Corrigan &Watson, 2004; Lambie et al., 1997). From admissions, they will proceed to an intake process on their unit with a psychiatrist, psychologist, social worker, and usually a therapist from the rehabilitation team. Although the hospital receives patient information from jails, hospitals, family, and community providers before the patient even arrives, the intake is an opportunity for the team to hear the patient's situation in their own words. The chance to explain the events that led them to admission can be empowering, as until this point it is quite possible they have not felt heard or able to tell their point of view. After weeks or sometimes months of being subjected to decisions been made by others, the patient can give input into what they think could be helpful in their treatment.

The role of the treatment planning process is to ensure that people are provided with the appropriate combination of services and supports to minimize the negative impact of mental illness on their lives (Liberman et al., 2001). Having the patient present and participating in this process is intended to ensure their voice is heeded in planning their treatment (Bellack, 2006). Moreover, active participation by the patient can help restore some of the personal power that was taken from them during the legal process (Brun & Rapp, 2001). The invitation to become involved in their own treatment and recovery also allows staff to listen to and gauge what Yanos (2010) described as the patient's "illness identity," which can help play a role in recovery. Illness identity is "the set of roles and attitudes that people have developed about themselves in relations to their understanding of mental illness" (Yanos, 2010, p. 74). Because recovery is experienced as personal and subjective, it is helpful if the person can self-define at least part of their recovery goals (Bellack, 2006). At MMHI, after the person has resided on the unit for 2

weeks and if their symptoms have abated sufficiently, they are encouraged to attend therapy groups and any individual sessions that may have been stipulated in their treatment plan.

Knowing how the person views their own illness can help guide the team in establishing recovery goals by highlighting any insights revealed in the patient's narrative or lack thereof (Brun & Rapp, 2001). Historically, the medical model has emphasized pathology and the presenting problems and failures in people with SMI, which did little to help patients focus on recovery (Xie, 2013). In recent years, however the strength-based approach centers treatment on the individual's unique set of strengths and abilities as the scaffolding for overcoming or resolving problems (Brun & Rapp, 2001). According to Xie (2013), the strengths-based approach aligns mental health recovery with a focus on the person's ability, "helping them developing the confidence to embark on the journey of recovery and aiding them to progress towards mental health recovery" (p. 7). Such an approach is particularly helpful in working with offenders, as it increases their self-confidence and directs attention to what they are doing well (Brun & Rapp, 2001; Fortune et al., 2012). They can grow their interests while using what they identify as a strength as a means for reaching their treatment goals (Xie, 2013). Research suggests that this model may reduce the risk of reoffending once they leave the forensic setting due to their new awareness of their strengths (Fortune et al., 2012; Ward & Maruna, 2007).

At MMHI, the patient works together with the unit-based rehab staff and social worker as well as others on the treatment team to determine which therapeutic groups or individual sessions would be appropriate, as guided by the illness identity, symptom

management, and index offense. Although individual treatment goals will differ from person to person, two main goals of inpatient psychiatric rehabilitation are to reduce symptoms in individuals and to reduce overall recidivism (Fortune et al., 2012; Lambie et al., 1997; Patrick et al., 2006; Snyder et al., 2012; Willis & Ward, 2011). Recidivism is defined as a return to the hospital or arrest for a new charge, per Bonta et al. (2019). The general definition is not tied to time parameters (e.g., recidivism within a year of discharge). A gap in research exists here: despite a number of studies on prisoners with mental health diagnoses and recidivism, the only studies I could find specifically about recidivism among patients discharged from forensic psychiatric settings were conducted outside of the United States (see, e.g., Delfin et al., 2019; de Vogel et al., 2004; De Vries Robbé et al., 2015). This difference suggests a possible research bias toward the population or disparities within the U.S. mental health and criminal justice systems. Regardless, there is one study of a prison population with SMI that does give some indication of recidivism in the U.S. Zgoba et al. (2020) completed a post-release study of 10,000 prisoners from New Jersey's Department of Corrections. They found that 50.4% of released prisoners with SMI in the sample were rearrested within 3 years. Additionally, ex-prisoners who were identified as having SMI and substance abuse disorders had higher rearrest rates, at 55%.

To my knowledge, Zgoba et al.'s finding (2020) is similar to the statistics of MMHI, with a few exceptions. First, due to the very nature of a forensic psychiatric hospital, 100% of patients who are released then return to MMHI have SMI, which is different than a jail or prison population. In comparison with the study's results, MMHI's recidivism rate is 30% within 1 year of release and 60% over a 5-year period. These

numbers suggest that the recidivism rate for forensic psychiatric patients at facilities like MMHI may be similar to individuals released from prison who have a mental health diagnosis.

Further studies suggest that offenders with mental disorders have a higher risk of recidivism compared to their counterparts who commit an offense but do not have a mental health diagnosis (Maier et al., 2016; Seewald & Fazel, 2012). Recidivism is considered to be the result of a combination of factors (Zgoba et al., 2020; Gaum et al., 2006; Seewald & Fazel, 2012). Most commonly cited are the consequences of living in a new environment after discharge, an inability to trust due to previous trauma or from being incarnated (Gaum et al., 2006), impulsivity associated with some mental illnesses (Zgoba et al., 2020; de Vogel et al., 2004), and medication noncompliance (Zgoba et al., 2020). Ways to help interrupt the cycle of re-offending include treatment that (a) strives to help patients build coping skills that increase distress tolerance when in difficult situations (Lamberti, 2007), (b) augment problem-solving skills and (c) increase positive social relationships (Andrews et al., 2006), improved medication compliance (Zgoba et al., 2020), and AODA treatment when appropriate (Lamberti, 2007). At forensic psychiatric hospitals like MMHI, it falls upon the rehabilitation teams to create programs that support patient growth by increasing their knowledge and insights into these skills.

Treatment modalities also provide a space for personal expression and insight into feelings and behaviors, generate alternative solutions for problems as they arise, support peer relationships, and create plans for discharge and access to community resources (Xie, 2013). For example, someone who has been granted CR may begin to attend groups in which the facilitators simulate a job interview or a meeting with a community

case manager. Patients practice how they would interact in these situations and gain real-time feedback on any questions that may arise.

Fortune et al. (2012) argued that "a combination of effective rehabilitation programs, a greater use of community measures and adopting a developmental perspective on preventions are likely to culminate in reductions in recidivism" (p. 3). Rehabilitation proceeds differently from patient to patient in a forensic setting because no two patients' circumstances are the same; however, there are commonalities across many forensic settings (Arboleda-Flórez, 2006). MMHI shares an emphasis on symptom and recidivism reduction with other forensic hospitals (Fitch, 2014). The psychiatrists at MMHI provide medication consultation, whereas the unit staff and rehabilitation department's sub-teams provide groups, individual sessions, and counseling on nonmedical issues, as well as report back any changes in patient behavior.

At MMHI, patients are free to refuse any programming that is offered to them unless it is court ordered (known as an "order to treat"), although refusal may prevent them from advancing to a less restrictive/less secure unit. Restrictions are part of the reward and punishment structures that are used throughout the criminal justice system to control and reduce maladaptive behavior (Holmes & Murray, 2012); in the forensic psychiatric setting, different levels of security units are also used to help modify behavior. The less restrictive the unit, the more benefits and freedoms a patient can earn, such as ordering out food once a week or applying for off-unit work crews. In return, the patients on less-restrictive units are required to attend more treatment groups throughout the week. The treatment team, along with the patient if they are active in their own treatment planning, determine which programs or treatment groups are central to the

treatment plan (called core groups or core treatment), and therefore require their attendance unless excused due to court/lawyer appearances or illness. If they fail to attend a core group, they receive an "occurrence." After three occurrences, they lose one or more security levels and the corresponding privileges.

Forensic institutions often collaborate across facilities, departments, or systems for programming (Fitch, 2014). MMHI's rehabilitation department is in ongoing communication with the other state psychiatric facilities about new programming ideas and developments. Within the last 5 years, changes such as adding an art therapy program and a sensory modulation coordinator have occurred in the rehabilitation department. The sensory coordinator is an occupational therapist who goes to the units to assess impulse control or other underlying issues that could be treated with sensory interventions. Both of these additions came to fruition due to their successes on other rehabilitation teams at state facilities.

Grief and Loss in Forensic Psychiatric Settings

The patients at MMHI and in forensic settings throughout the country are living with major losses due to their life circumstances. On the surface it is apparent that they have lost relationships, including family and friends, through the events of their illness and incarceration. From their own telling, many patients I work with found that the people they thought would always be there turned their backs on them. They lost their capacity to find work, and if they had employment before admission to MMHI, the chance of it being there for them when they get out is unlikely. They have lost many personal freedoms: they cannot go outside for fresh air whenever they want; they cannot even use the restroom without permission. They may have lost mental and physical health

if they had good health earlier in life. These are just some of the surface losses that patients at MMHI and similar forensic settings have endured.

Seen from the lens of human grief and loss, their experiences with loss go much deeper. Patients in forensic hospitals have lost power to make decisions about their health. They have lost the safety net of a personal support system. They have lost out on many rituals that other people take for granted such as having a family dinner, celebrating a holiday, or going to a funeral when a loved one dies. Going further, when I have asked patients to identify losses they have experienced, rarely does someone identify the loss of a dream. When I ask, "When you were little, what did you want to be when you grew up?" never has the response been "to be a patient living in a forensic psychiatric hospital." Their losses extend to being marginalized and othered as well, having lost a sense of personal power within their communities, with no clear path to gain any of their power back. They have a serious mental illness and have committed a criminal act. Therefore, they possess two traits that society deems especially undesirable, which they internalize as self-othering; these are traits not easily overlooked. They have lost their standing in society's social dynamic. Despite all of this reality, there is no grief and loss program at MMHI, nor is there an explicit means for the patients to address their grief and loss in therapy.

Grief is the emotion that is experienced after a loss, whether of a person, object, role, or dream (Averill, 1968; Doka, 2002; MacWilliam, 2017). A grief reaction is complex, with physiological and psychological components as well as cultural influences (Averill, 1968; Shulman, 2018; Stroebe & Stroebe, 1991). How people experience their grief, show it outwardly or disguise it, and how it manifests in other areas of their lives is

different from one person to the next (Doka, 1989). Nevertheless, the stronger the attachment a person has to what is lost, the stronger the grief reaction will be (Bowlby, 1969; MacWilliam, 2017).

Grief and Loss Theories

Historical Overview

According to Archer (1999), who traced the history of the subject, grief surfaced in the field of psychology in the early 20th century. Psychologists, along with anthropologists and sociologists, had long agreed that grieving is universal among cultures and throughout recorded history (Archer, 1999; Gilbert, 2006; Parkes, 2001). However, in many historical contexts, grief is considered to be a form of bereavement stemming from the loss of a loved one (Archer, 1999; Doka, 1989). It was not until the mid-20th century that psychologists looked at other losses through the lens of grief.

Robert Burton (1577–1640) was a British scholar who studied grief as a phenomenon within the social sciences. His book on the subject, entitled *The Anatomy of Melancholy* (1651), was published shortly after his death. Burton described grief as "the cruel torture of the soul" (p. 259) and a melancholy that affects everyone at some point in their lives. His work was the first to mark a distinction between melancholy created by a life event such as death of a loved one and as a trait of depression (Granek, 2010). Establishing this distinction paved the way for other European and U.S. scholars to begin to develop theories of grief and loss in human development and behavior.

Shand is believed to be the first to study the psychology of grief with his seminal text on instincts and emotions entitled *The Foundations of Character* (1914). He examined grief not only in terms of the loss of a loved one, but also of other deeply-felt

connections that humans form. He asserted that a stable connection with a person or object leads to joy; if that person or object is severed from one's life, "sorrow tends to accomplish proportionately to its own strength" (p. 365). In other words, the stronger the attachment a person has to another person or object, the stronger the grief that will arise in their absence.

Shand (1914) recognized that grief takes on different characteristics as a reaction to the loss; no one person can be expected to react in the same manner. He categorized common grief reactions into four types: (a) behaviors that are aggressive to the outside world, such as screaming or self-harm; (b) behaviors that are depressive or low in energy, such as lying in bed for days or being unable to eat; (c) behaviors that are a suppression of grief, such as acting as if one is ok when one is not; and (d) frenzied or frantic activities, such as keeping occupied with busy work or over-cleaning. Despite this clear contribution to knowledge, Shand often goes unmentioned in the grief and loss teachings of today, which is remarkable. From his studies, he established not only the fact that people react to grief in different ways, but he created the groundwork for attachment theory (Bowlby, 1969) later in the century.

Instead of Shand, it is Freud who is regarded as the founder of contemporary views in the areas of grief and loss (Granek, 2010). Freud introduced many new theories to the world of psychology; however, two ideas in particular have helped establish the basis for how current grief and loss thoughts are understood today. First was Freud's (1909) focus on everyday life events as significant areas for psychoanalysis, such as how the unconscious mind affects human behavior or even the importance of slips of the tongue. Second was his idea that the overall mental health of a person is often linked to

these everyday events. He postulated that health and pathology shared the same spectrum, and that there isn't a clear barrier for where one begins and other ends (Freud, 1909). These thoughts, taken together, illustrate the idea that we can make "the unmeaningful, trivial, the ordinary full of meaning for the formation of self" (Illouz, 2008, p. 38). All of the everyday events in peoples' lives, and the person's reaction to them, are what make up the individual self.

By popularizing the idea that insignificant human behaviors and everyday events were important to the field of psychology, grief as an area of psychological study emerged (Granek, 2010). In 1917, Freud published the book *Mourning and Melancholia*. He explained melancholia as caused by an unknown or unconscious loss, whereas mourning occurs when a person experiences a conscious loss. In other words, melancholia, though activated through loss, had an unknown cause, which led to pathology, such as a depressed mood. This was in contrast with mourning: grief was a bereaved person's experience from an identifiable loss. Granek (2010) suggested that, according to Freud, "the mourner had the task of detaching their libido/emotional energy from the deceased and sublimating it into other areas of their lives" (p. 52). Such a task is akin to giving the mourner homework as a means to work through their grief journey, an exercise used today.

Deutsch (1937) was the first to recognize that grief may not always follow a typical course and thus may turn into a pathological condition. She wrote that grief may be "excessively intense, even violent" as well as "unduly prolonged to the point of chronicity" (p. 12). In alignment with Shand's theory, Deutsch observed that grief can come in many forms from many causes, and there was no "normal" cycle. Another

important point she put forth was to regard people experiencing the absence of grief as an "edge" case that was as equally important to acknowledge as someone experiencing grief to a debilitating extreme. In today's arena of forensic psychology, this is important, as the absence of feelings can be a negative symptom of mental illnesses, including personality and thought disorders (Der-Avakian & Markou, 2012).

Drawing from Deutsch's work, Lindemann (1944) studied what he called "acute grief" in one of the first essays on grief I ever read and still find haunting, yet inspiring. His theory was based largely on the work he did with survivors of the Cocoanut Grove nightclub fire in Boston in 1942 that killed 492 people. Lindemann (1944) argued that acute grief was a syndrome with specific psychological and somatic characteristics. Five symptoms included (a) physical suffering, such as weeping or difficulty breathing; (b) preoccupation with images of the deceased; (c) guilt; (d) hostile reactions; and (e) loss of pattern of conduct—in other words, having difficulty completing normal, everyday tasks (p. 189). He postulated that a person could experience these symptoms immediately after a loss or they could take months or years to manifest. The duration of a grief reaction seemed to depend upon the success with which a person did grief work, namely, "emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships" (Lindemann, p. 190).

Lindemann (1944) did not believe grief to be a process that was done all at once, but rather occurred over time and required the aid of a helping professional. A challenge that he noted was that many people who suffer from grief tried to avoid intense feelings created by the loss that occurred. However, this strategy caused the griever to experience

deferred responses, meaning that the grief would eventually reappear despite such avoidance. Distorted reactions, as another strategy used to manage grief, produced symptoms similar to mania, such as rapid talking or depression, with insomnia or no appetite (Lindemann, 1944).

What emerged from this essay were some revolutionary claims for the treatment of grief at the time. In his opening line of the article Lindemann (1944) wrote that on the surface, "acute grief would not seem to be a medical or psychiatric disorder," but only "a normal reaction to a distressing situation" and that "the understanding of reactions to traumatic experiences whether or not they represent clear cut neuroses has become of ever-increasing importance to the psychiatrist" (p. 186). Lindemann was establishing that grief should indeed be treated as a psychiatric disorder. By creating a taxonomy of symptoms and expanding on what was commonly but erroneously believed to be normal and abnormal behaviors, he was providing a structure for professionals to manage and treat grief as a disease and possibly a medical condition as well.

Lindemann believed professionals should check in with their grieving patients regularly and help them manage their grief work. Much like Duestch, Lindemann found equal importance in the absence of a grief response and warned that this could cause grief to manifest in other ways or cause the duration of the condition to last much longer than for those who were doing their grief work. In the forensic psychiatric population, absence of grief could be a symptom of mental illness or side effects of medication. Regardless, the assumptions Lindemann made in 1944 carry through to grief and loss theories in practice today.

There are more researchers in the history of grief theory whose work seems to resonate with forensic psychiatric populations in particular. For example, Bowlby (1907–1990) was best known for his groundbreaking theory of attachment in human development, postulating that there was an important connection between interpersonal relationships and the effects of separation, which was the perceived threat or the pain caused by these effects (1969). He believed that children form attachments out of a need to stay alive, and the stronger the attachment to their caregiver, the more pain they have when the relationship is severed (Bowlby, 1969). It is in this pain where he began to study the impact of grief on people. In 1969 he released the start of what become a trilogy of works, entitled *Attachment and Loss*. He differed from other psychoanalysts of his time in that he did not seem to think there was abnormal grief, but rather that grief reactions were based on the importance of the relationship to the person (Klass, 1988). If an important relationship had been severed, grief resulted, and there was nothing abnormal about the process.

Bowlby and his colleague Parkes broke down this natural grief response into four phases (1970). Phase one is shock and numbness: the loss is difficult to accept and the person may struggle with emotional and physical distress in this phase. If the person cannot express their emotions adequately, they will not move through the second phase, which is yearning and searching. Here the person is seeking out reminders of the deceased as a means to fill the void the loss has left in their life. If they don't find a healthy way to fill the void, they remain stuck in this phase. Phase three is despair and disorganization, in which the person has accepted that their life is forever changed. However, this may cause despair around the fact that nothing will be as it was before the

loss. Accordingly, a person who does not advance through this phase may be overcome with depression and hopelessness. The fourth phase is reorganization and recovery. In this phase, the person begins to make new goals for themselves and learns how to live a healthy life in the aftermath of a loss. As with Lindemann (1944), Bowlby and Parkes (1970) employed a stage model similar to many other theorists (Lindemann, 1944; Kubler-Ross, 1969; Worden, 2018). They used this structure as a guide of what to look for when helping navigate people out of the first three phases and graduate to the final phase.

In 1969 Elisabeth Kubler-Ross (1926–2004) published *On Death and Dying*, a book that popularized five common stages people might experience in the face of death. What distinguished this book was not so much the phases she laid out, but that she was getting her insights from interviewing terminally ill patients, something that was unique at the time (Kubler-Ross, 1969; Woo, 2004). By listening to people who were actively experiencing the dying process, she was able to build a structure via stages that were common to the terminally ill population: denial, anger, bargaining, depression, and acceptance (Kubler-Ross, 1969/2014). At the time, many doctors did not consider the experience of their dying patients, as they tended to focus on saving people with new medical advances and technology (Woo, 2004). Kubler-Ross observed that patients with terminal illnesses were being left unattended in hospitals "as if death might be contagious" (1969, p. 22). She observed that as U.S. medicine was evolving its treatment of seriously ill patients, some important cultural traditions were being forgotten. For example, instead of dying at home surrounded by loved ones, patients were admitted to the hospital and isolated as the dying process took place (1969/2014). She began to listen

to the wishes of the patients and discussed their feelings with them, helping those who were dying feel validated. This work brought the idea of grief to a new population. Rather than focusing on people who had survived a loss, she focused on the experience of those who were actively losing a health battle that would cost them their lives.

Kubler-Ross went on to study and write about death and grieving for the rest of her life. Among critics of her work, some have discussed whether grief should be understood as having stages at all, given that everyone's experience differs so vastly (James & Friedman, 2008). There is also a contention that presenting expectable stages or phases to a griever could do harm by making people feel they have done something wrong if they miss a stage or stay in a stage too long (Neimeyer, 2000; Stroebe et al., 2017). In her own defense Kubler-Ross wrote in 2004:

> The stages have evolved since their introduction, and they have been very misunderstood over the past three decades. They were never meant to help tuck messy emotions into neat packages. They are responses to loss that many people have, but there is not a typical response to loss, as there is no typical loss. Our grieving is as individual as our lives. (Kubler-Ross & Kessler, p. 7)

Much of Kubler-Ross' ideas come from understanding the process of terminal illness, which is not the daily loss I witness in a forensic psychiatric hospital. However, I resonate with the circumstances of a population being left in a hospital and forgotten about when it comes to their grief. I appreciate Kubler-Ross' contributions to an understanding of grief as a complicated subject for a particular group of people and her desire to try and make sense of it for the rest of the world. Deutcsh (1937) and Lindemann (1944) also posited that untreated grief can manifest in other areas of a

person's life, including and especially grief that stems from losses other than loss of a loved one, which are often overlooked.

Disenfranchised Grief

Disenfranchised grief, a term coined by Doka (1989), is defined as grief from a loss that has not been or cannot be "openly acknowledged, publicly mourned, or socially supported" (p. 5). Doka's (1989) idea is that a person's grief becomes disenfranchised when: (a) they are not afforded the right to grieve, due to a loss that may not be validated by others; (b) the grief goes unrecognized, due to the nature of the loss; and/or (c) the ways in which an individual expresses or silences their grief is deemed outside of societal norms. Doka's concept "integrates psychological, biological, and sociological perspectives on grief and loss" by examining the internal processes of individuals while also examining the norms put in place by society (2002, p. 5). He acknowledged that different cultures have different grieving processes; thus, a person may experience disenfranchised grief in one culture, whereas in a different culture such grief may receive wide and public support. For example, someone living in an area with a well-connected gay community might receive abundant support from a breakup or death of their gay spouse. Someone living in a remote place without a similar support network may not feel they can openly grieve for their spouse or even admit that the loss is affecting them. The latter is an example of disenfranchised grief that occurs due to the societal norms in place.

Doka's definition of disenfranchised grief is particularly relevant to patients in a forensic hospital because often their losses are not openly acknowledged, due to a combination of societal beliefs, prejudice against people with severe mental illnesses, and

in some cases, their mental illness creating an obstacle for grieving. Additionally, their losses may not be identified correctly. For example, when a loved one dies, it is easily named: “I’m sad because my grandmother died.” It may be much more difficult to identify and acknowledge “I’m grieving because I thought I’d be graduating college this month, but instead I’ve been hospitalized for a year.” Doka (2002) discussed reasons for disenfranchised grief, including losses that are not acknowledged or grievers who are not recognized by others as grieving: “In short, although the individual is experiencing a grief reaction, there is no social recognition that the person has a right to grieve or a claim for social sympathy or support” (2008, p. 223).

I have witnessed this lack of social recognition in my art therapy practice at MMHI. One patient who was denied the right to attend his sister’s funeral reacted by behaving aggressively towards staff and peers on his unit. He was placed in a seclusion room for his and others’ safety. I knew that he was close to his sister and that getting the denial to attend the funeral must have been difficult for him to hear. However, a coworker said to me, “well, he got himself here through his own bad choices, he doesn’t get to right to right to say ‘good-bye’ to her.” It was such a loaded statement that it caught me off guard. The patients at MMHI are there because their mental illnesses were deemed to have a role in their crimes. Describing the consequences as a matter of choice ignores this reality. A human being should have the right to grieve one of the few supports in his life regardless. He loved her and now she is dead. Isn’t this the “right to grieve” in its most basic form? The criminalizing lens revealed in this example, which regards the patient without consideration of their illness, can blur the ability to see the

person as human, making it difficult to acknowledge their basic human feelings and needs. In this instance, it caused the patient's grief to become disenfranchised.

Doka and Aber (1989) wrote that the psychosocial loss associated with disenfranchised grief is a form of psychosocial death. They write that psychosocial death happens when "the persona of someone has changed so significantly, through mental illness or organic brain disease," that others feel the person they used to know is dead, even though they are biologically still alive, such as from Alzheimer's disease (2002, p. 12). They compared such grief to the horror movie *Invasion of the Body Snatchers* in which an unknown presence enters the body of seemingly well-functioning people and slowly takes over their lives. Although it is an interesting comparison to make, the authors applied it to the disenfranchised grief of family members or close friends in regards to someone they love whose persona is forever changed. Cole et al. (1986) expanded upon this idea when they noted, "family members may also feel a profound sense of loss, as a loved one who was once a vital person gradually loses mental physical [or] social abilities" (1986, p. 28). Applied to the case of Joe, from this dissertation's opening vignette, it is possible that his family felt this type of loss, given that his behavior was beyond their typical experience of him. His psychosis could have felt like an "invasion of a body snatcher." However, I would argue that Doka's theory misses an opportunity to elaborate on this idea from the perspective of the person experiencing the psychosocial death. How did Joe feel in the moment his medications began to work and he started to reorient to reality? How does a clinician do grief work with someone who has psychosocially died? In trying to uncover this perspective, I found a chasm in available research, so I reached out to Dr. Doka directly. He provided me with a few

resources but ultimately stated, “none of them exactly address the issues you raise” (personal communication, June 8, 2020).

Doka’s theory provides language for the type of grief forensic patients may experience and even delves into the reasons why a person’s loss may lead to disenfranchised grief. However, like many other theorists, his primary focus does not include the major losses experienced by the forensic psychiatric population, leaving a gap in knowledge. The population would benefit from practitioners who can identify disenfranchised grief and have tools to treat it, just as it is provided for grief caused by more common types of loss. In the forensic psychiatric population, this is especially important as it could help explain behaviors or symptoms whose root cause has been difficult to pinpoint in a patient. Theories of grief and loss help in understanding patients who have lost a loved one, experienced a divorce, or lost their job. However, more research is needed to understand the unique losses of forensic psychiatric patients. It is important to consider the experience of those who have been invaded by an illness likened to a body snatcher, only to come back to reality with even more confusing losses. When in the throes of an acute mental illness a person commits a horrific crime and experiences psychosocial death, how do we best treat the dead?

Forensic Grief

There is a body of literature on the losses and trauma that prisoners have experienced throughout their lives that is helpful in understanding the needs of forensic patients. From her work with prisoners, Schetky (1998) wrote of the cumulative losses they endure and how it was apparent that those in her group sessions had little experience processing grief. According to their own accounts and from prison records, researchers

have found that most prisoners in their study samples have not received services or support to address their grief and trauma (Finlay & Jones, 2000; Leach et al., 2008). In the process of successfully navigating grief, forensic populations have numerous challenges. They must learn to develop coping skills, to mature and nurture their emotions, and to find support in an environment that is sometimes harsh, both physically and mentally (Harner et al., 2011). Additionally, factors such as denial, ambivalence, guilt, shame, and low pain tolerance can create barriers for any sort of relief (Harner et al., 2011; Lane, 2015).

Another concern is that if symptoms of grief are overlooked, there is potential to be misdiagnosed (Breen et al., 2015; Kleinman, 2012). For example, if a patient or inmate has a history of depression and they have not experienced an obvious loss, such as having a loved one die recently, treatment planning might not consider the grief as a core issue. Depressive episodes; emotional disturbances such as anxiety, low immune functioning, poor physical health, irritability, nervousness, apathy, restlessness or sleeping too much; and ruminating thoughts are all symptoms of grief (Breen et al., 2015; Finlay & Jones, 2000; Hambridge, 1990), though they may be unrecognized as such. Finlay and Jones observed that "complaints by prisoners of insomnia and symptoms such as pain are traditionally perceived as manipulation in order to obtain hypnotics or analgesics" (2000, p. 569). They noted that serious emotional stress and trauma in childhood or adolescence trends to maladaptive behaviors and criminal offenses. Offenders with unresolved grief often lack language and social skills to explain themselves, while incarceration intensifies their depressive symptoms (Finlay & Jones,

2000). With such hurdles for both the patient inmate and the treatment team, it is a challenge for grief to be identified, diagnosed, and treated properly (Kleinman, 2012).

Individuals who are serving time in a forensic setting have some unique factors to consider in how they might experience their grief as well. In such a setting they may not want to run the risk of being seen as weak by showing emotions that deem them as fragile by their peers. Such perceptions could make them vulnerable to physically stronger or emotionally manipulative patient inmates (Gussak, 2015; Lane, 2015). Often, they guard against disclosing their true emotions because they do not want them held against them by staff (Gussak, 2007; Hambridge, 1990; Schetky, 1998). For example, if they admit to feeling depressed, a staff person might put them on suicide precautions. At MMHI, that means that they will have a one-on-one staff with them around the clock. They will not even be able to use the restroom alone, and a staff person will be always at arm's length from them, including while they sleep. In a place where privacy is already scarce, having such precautions can be a burden and is intrusive to someone who craves privacy. According to Gussak (2007), "self-preservation is important in forensic settings for inmates to feel less vulnerable. Such defenses such as maintaining silence, lies and aggression may be resorted to, but at the same time they interfere with daily living skills and effective therapy" (p. 445). These defenses can become a barrier to treatment by hindering the therapeutic process. Additionally, there may be a mistrust of verbally disclosing personal information in the event it could end up in their medical charts or legal documents.

Other complications to the grieving process for forensic psychiatric patients include their mental illness and physical incarceration (Hambridge, 1990). Identifying

and expressing feelings of grief can be a challenge to people in general; for forensic psychiatric patients, expression of feelings can be hindered by symptoms of illnesses, such as blunt affect, poor concentration, or mania (Hooker & Park, 2002). Paranoia may prevent patients from expressing their true feelings (Arciniegas, 2015). Further confusing the situation are medications used to treat patients, which may exacerbate their ability to feel or to emote (Hambridge, 1990; Hooker & Park, 2002). Additionally, incarceration creates a physical removal from the patient's support networks. They cannot reach out to their families except during specific times and for some people, their families do not allow such communication to happen at all.

How Grief Affects the Body

The experience of grief is a whole-body process (Shulman, 2018). Evidence of a relationship between bereavement and medical consequences is well documented (see, e.g., Edmondson et al., 2013; Knowles, 2019; Young et al., 1963). Since the 1970s, the medical world has been examining biomarkers to explain the connection between bereavement and medical outcomes, specifically investigating the cardiovascular, endocrine, and immune systems (O'Conner, 2019). Bartrop et al. (1977) published a study that examined how bereavement grief affects the human immune system. They found a decrease in production of cells that fight off diseases not linked to any other physiological reasons or changes in the body. The Bartrop study was the first of its kind in providing evidence of how grief causes changes in the body, and it sparked others to research the effects of grief on the body (O'Conner, 2019).

Physicians and researchers have since found that the mortality for bereaved people increases in the first 6 months after the loss of a loved one, as compared to their

non-bereaved counterparts (Arizmendi & O'Connor, 2015; Fagundes & Wu, 2020; Parkes et al., 1969). This difference has become known in the medical community as "broken heart phenomenon" or Takotsubo syndrome (Boyd & Sohl, 2020; Fagundes & Wu, 2020; Knowles, 2019) and is linked to cardiovascular changes in the heart due to stress from grief or fear (Boyd & Sohl, 2020; Ghadri et al., 2016). There also is evidence that a person may have an increased risk of stroke in the months following a loss (Arizmendi & O'Connor, 2015; Tomita & Kitamura, 2002).

Changes in our brain chemicals have been linked to experiences of grief (Bosch et al., 2009; Knowles et al., 2015). Because balance of individual brain chemistry helps to stabilize mood and other processes functioning, if they get thrown off balance, it can play a role in a person's mental health (Olguín et al., 2016). Brain chemistry affects emotional regulation, ability to concentrate, and memory functioning (Shulman, 2018). These chemicals, such as dopamine and serotonin, also play a role in our limbic system, nerve network, and prefrontal cortex (Brisch et al., 2014). These reactions can affect many things, including sleep patterns and anxiety levels (Panksepp & Biven, 2012). If grief affects the chemicals in the brain that control all these vital processes, then one can infer that grief has the power to cause many bodily processes to malfunction if not treated in a timely manner. As previously noted, many forensic psychiatric patients may already be experiencing dysregulated emotions and moods or disruptions in sleep. If they are additionally harboring any of the various forms of grief as well, then there is the potential that untreated grief could compound and worsen their symptoms. Moreover, this could increase the risk of mistaking symptoms of grief for symptoms of their mental illness, interrupting the diagnostic process.

Why a Grief and Loss Program is Necessary

It is my position that grief and loss services are a vital part of treatment in the rehabilitation of patients living in a forensic psychiatric setting. The information I have laid out so far highlights the many losses that this population experiences. It also examines the benefits of managing symptoms of grief while not confusing them with symptoms of mental illness. The patients at MMHI (and in similar settings) only sparsely receive focused interventions to help them navigate the course of their grief. Consequently, they have not gained efficient coping skills to increase their ability to deal with loss (Hambridge, 1990). They may not even know how to ask for help with grief nor have the ability to differentiate it from other emotions. If their grief is not attended to, they will miss an opportunity to heal from their losses. Although I did find evidence in my research that *not* providing grief counseling can be harmful and can hinder a person's recovery, nowhere did I find evidence that there is harm in providing insights into ambiguous losses. Ethnically and morally, if we as therapists can expedite the healing process for one person, let alone an entire population, shouldn't we do so?

Art Therapy

Because of the unique ways that the forensic population experiences the grief process, it could be argued that there needs to be a unique way to treat it, with art therapy as a treatment of choice. Art therapists are master's level clinicians who work in a variety of settings with diverse populations (American Art Therapy Association [AATA], 2017). They work with individuals, groups of people, or families, and are employed in a variety of settings, such as in hospitals, private practices, or in community clinics and nontraditional venues. Due to the diverse beliefs and cultural backgrounds of their

clients, art therapists practice from a broad set of theoretical frameworks (Hogan, 2016). According to AATA (2017), “art therapy is an integrative mental health and human services profession that enriches the lives of individuals, families, and communities through active art-making, creative process, applied psychological theory, and human experience within a psychotherapeutic relationship” (para. 3). In other words, art therapy uses art and creative processes combined with psychology to aid clients therapeutically within a guided, supportive therapeutic relationship.

One of art therapy’s strengths is its ability to provide a positive emotional outlet through art making, which can be especially helpful to people who struggle with healthy emotional expression (Bailey, 2016). Considering the patients at MMHI, many found themselves in the corrections system because the ways they had learned to express themselves or deal with their situation were incongruent with social norms (Bartol & Bartol, 2017). For example, feelings of frustration may have led to rage and physical altercations in the past. Art therapy may provide a new outlet for that anger to be expressed—on a canvas rather through fists. Art therapy can be a mindfulness-based practice as well, as it allows the patient a space to reflect, slow down, and recognize how the mind and body are connected to their behaviors (Clark, 2017).

Another strength of art therapy is that its roots are embedded in psychoanalytic theory with respect to insight- and depth-oriented practice connected to the unconscious mind (Junge, 2016; Kramer, 1973). Insight requires a person to be aware of their core issues and emotions. Freud (1915) posited that the unconscious mind contained repressed images, instinctual drives, and memories that were a driving force behind an individual’s unique personality and behaviors. Jung (1916) theorized that all humans share in a

collective unconscious, inherited from past ancestors. Because art therapy developed from these theories in the mid-20th century, its earliest theorists connected human emotions to the unconscious—not in words, but through images (Kramer, 1973; Naumburg, 1973).

MacWilliam asserted that "most talk therapies are ego based, which means they rely on your conscious mind to have insight" (2017, p. 46). From the perspective of neuroscience, art therapy research suggest that it utilizes a "bottom-up" process in the brain (Albright, 2015; Hinz, 2009), beginning with sensorimotor functions and visual-perceptual processing before tapping cognitive functions, which is opposite from how most traditional verbal therapies proceed. Not everyone living with a life-disrupting issue can apply insights into their problems, of course; however, art therapy seems to bypass a lack of cognitive insight by using the creative process to make meaning of unconscious forces coming into awareness.

One of Wadeson's core art therapy ideas was that of meaning making. In the opening paragraph to her 1980 text, she stated, "Much of human striving, beyond mere survival needs, appears to me to be directed toward the creation of meaning in life"; that is, the "*creation* of meaning, not discovery of meaning" (p. 3; original emphasis). She noted that the difference between creating and discovering meaning lies in the interpretation. In recognition that humans have a shared knowledge, she examined how the creative process can foster a personal, yet unconsciousness, experience. She stated, "The artist has created an illusion, a separate reality, a personal vision that through transformation into an art object may be shared with others. The compelling nature of this communication gives art its power" (p. 4). Her view highlights the importance of art

therapy in a forensic psychiatric setting (or any other setting): art provides a language that does not need to be spoken to be real or shared with another. Art has the ability to bring unconscious driving forces to the surface in a way that can be explored safely and therapeutically.

Art therapy gives participants in a forensic setting an opportunity to work on identity formation, social skills, and problem solving (Gussak, 2020). Identity formation can be described as the process by which a person builds a distinct, secure perspective of themselves based on how they view their interactions with the world (Cote & Lavine, 2014). Erikson's (1968) concept of identity was the merging of all of the person's unique attributes—whether cultural, physical, physiological—in ways that forms a view of self. Sometimes these views may be in conflict with one another and sometimes they may be complementary (Cote & Lavine, 2014). An art therapy intervention that I use regularly at MMHI to examine identity formation is the creation of an "inside/outside" mask, where the inside represents how the person sees themselves and the outside represents how they believe others see them. This simple yet effective process can help both the patient and the art therapist learn about the person's self-views and hopes or fears regarding how others see them. Directives such as this can mobilize reflection on issues that the patients deem important about various aspects of their life, illness, or recovery.

An art therapy intervention produces not only a helpful process for creative expression, personal reflection, and problem solving, but also a tangible product that can then be viewed and contemplated (Malchiodi, 2016). By sharing with others what they see and feel when they reflect on their artwork, patients may find a freedom to externalize inner emotional turmoil (Malchiodi, 2016). In the context of grief and loss in the forensic

setting, patients draw on art therapy rituals of creating and sharing their reflections to express these feelings safely, containing them on paper, canvas, or other material. The final product can also serve as confirmation of a person's hard work and resilience in the aftermath of experiencing a loss (Isis, 2016). When introducing art therapy to a patient who has never been in my groups before, we discuss how the process is a deeply personal experience, and I often compare it to asking them to take a page out of their diary and sharing it with me. This idea not only prepares them in the event of a difficult emotion arising, but also lets them know their artwork will be treated safely and with respect, given the depth of personal disclosure that might be revealed to others.

Among other benefits, it also should be noted that art therapy fulfils many of the needs of those who have difficulty in verbal expression (Richardson et al., 2007), making it particularly valuable in the forensic psychiatric setting. This benefit is also germane to participants who speak different languages or in instances where the art therapist and the client may not share the same first language (Bird, 2008). Given that that language barriers can feed into the cycle of stigma that keeps people from seeking treatment (Breslau et al., 2017; Villatoro et al., 2014), art therapy is a means to bridge and share a common language (Bird, 2008).

Finally, due to few available resources that specifically apply to grief and loss art therapy in a forensic psychiatric setting, I found that art therapy's interaction with other fields or with similar populations may help bridge some gaps in knowledge relevant to my research. One interesting consideration is the intersection of art therapy and clinical neuroscience, including the application of the science of neurobiology to human psychology and how studies about structural, functional, and environmental factors

connect the body and the brain (Hass-Cohen, 2008). Using medical imaging, it is now possible to see the differences in brain structure that may help explain various disorders, including mental illnesses (Konopka, 2014). Neuroscientists and art therapists have begun to work together to explore how art making activates brain activities, areas, and patterns (Belkofer & Konopka, 2011; Knopoka, 2014) and the neural effects of emotion on art making (King et al., 2019), which could help art therapists in their work with forensic patients. Although there are no neuroscience studies specific to how art therapy affects the amelioration of grief, we may look forward to future research in this area.

Grief and Loss Art Therapy

Although I could not find much research on grief art therapy, and with forensic psychiatry populations or art therapy with ambiguous losses in particular, there is a rich body of information about art therapy with bereaved populations. MacWillam's (2016) book on grief and attachment in art therapy and personal correspondence with Johnathan Haag (March 13, 2019) were particularly useful when I was preparing to conduct my research study, as they helped provide a platform from which to start building a grief and loss program in my setting. The literature on grief and loss in art therapy and bereavement provided ideas for interventions and treatment for disenfranchised grief (MacWillam, 2016; Rutenburg, 2011). Art therapy's strengths of meaning making, safe expression of emotions, and reduction of stress all help with grief-related issues (Green et al., 2020; Haag, 2018; Hass-Cohen, 2016; Malchiodi, 2015).

Losses, regardless of if they are bereavement losses or other types of losses, can be life-defining (Harris, 2011). Neimeyer and Sands (2011) wrote about the challenges of having to reconstruct our worlds in the wake of losses. They noted that humans tend to

look for the meaning in these losses to begin a rebuilding process and constructing their new reality in their aftermath. In other words, following the death of a loved one, people tend to need to rearrange existing meanings to make sense of the world (Weiskittle & Gramling, 2018). Creating art offers a valuable ritual around the death and a way to memorialize the loved one (Potash et al., 2014). As one example, Rutenberg (2011) created plaster hand casts of dying patients in a palliative care unit of a hospital. The process provided an enriching experience for the patients and their families, offering enjoyment during an often bleak moment. After the patient passed away, the plaster hands were given to the families as a memento of their loved one. Many families later created rituals such as touching or holding the plaster hands during times of prayer or reflection. Such interventions help to create a bond between the griever and the deceased, despite the physical absence of the loved one (Haag, 2018; Neimeyer & Thompson, 2014; Potash et al., 2014; Rutenberg, 2011; Weiskittle & Gramling, 2018).

Grief and loss as an art therapy focus is beneficial, as positive and negative emotions can occur simultaneously during the grieving process (Stroebe & Schut, 2010) while art provides a means to explore these coexisting emotions in the same space (Malchiodi, 2016). For example, a person might paint an image of their favorite memory of the deceased person they are grieving. The canvas holds the image of a positive memory while it also contains the sadness or loneliness the art maker is feeling. The artwork can then become a physical object to be reflected upon, allowing for examination of all the emotions expressed on the canvas (Hass-Cohen, 2016; Malchiodi, 2016).

Cumulative grief can lead to stress (Marino, 1998). Rabin (2002) documented the many ways stress affects the body, including decrease in the immune system and a

change in hormone levels. He stated that hormonal changes can lead to lower ability to handle overwhelming emotions such as anger or sadness, as well as to increased depression. Haag (2018) found that the creation of art can help reduce such stress by providing a soothing activity for those who are grieving. Creating art also can help a person focus and become present in the moment (Muthard & Gilbertson, 2016), which can help the griever's presence to their emotions without becoming overwhelmed—a feeling often described by those who grieving (Shear et. al, 2013). Grief and loss in the context of art therapy treatment has been shown to be a powerful tool in aiding bereaved people by reducing stress caused by grief, expressing strong emotions, and providing meaning making and ritual around death.

Art Therapy in Mental Health

Most helpful to my research study has been the diverse and vast amount of information available about art therapy's applications with adults experiencing mental illnesses. From direct conversations with art therapy participants in need of mental health care, Spaniol (2003) found that art therapy provides connection to and for a population that is often isolated, strengthens selfhood in a time of low self-worth, and offers a tool to make sense of their experiences. Good (2006) identified the benefits of providing a way to safely identify, work on, and resolve life stressors through image-based and metaphoric communication. Art therapy can be a useful and enriching way to explore any problematic feelings or difficult life experiences within this vast population (Richardson, et al., 2007).

It has long been documented by sociologists and psychologists that people with mental illnesses often experience social isolation (Spaniol, 2003), a lack of intimacy

(Buckley et al., 1999), and feelings of incompleteness (Wright et al., 2006). Noted earlier, stigma in particular can increase depression, reduce self-esteem, and create a barrier for seeking help, further reducing their social interactions (Chronister et al., 2013; Perlick et al., 2001). In contrast, a nonjudgmental process of creating art can help build the therapeutic relationship by growing trust (McAlevey, 2016). Art therapists thus can model how to build and maintain relationships for their client (Spaniol, 2003). Over time, the patient begins to feel more confident in their artistic abilities, which helps build a sense of pride and grow self-confidence (Ciornai, 2016; Isis, 2016; Wadeson, 2010). The client may join art (or other) therapy groups, which can increase connections with others. Spaniol (2003) wrote that art therapy groups provide protected, creative spaces for people to connect to others, to feel less alone, and to develop empathy for others, taking these experiences with them beyond the therapeutic setting and into their lives.

People living with severe mental illness often have a low sense of self and wavering confidence (Chronister et al., 2013; Corrigan & Watson, 2004, 2002; Spaniol, 2003; Van Dongen, 1996, 1998). Spaniol (2003) stated, “Visual art as a therapeutic modality is especially useful for strengthening a fragile sense of selfhood” (p. 274). She noted that art activities can facilitate identity formation, whereas the final, physical product builds an artistic and personal identification. Moreover, by highlighting identities beyond their mental illness, their art can be an empowering tool that emphasizes the person as much more than a diagnosis (McAlevey, 2016). Art interventions serve to document the client’s values, fears, and hopes in a contained way, as a means for learning more about themselves (Allen, 1995). Thus, they have a physical representation of how

they have transformed and grown, which can act as an aid in rehabilitation beyond the walls of the therapy room.

As discussed above, art therapy provides abundant opportunities for meaning making. Lysaker and Klion (2017) defined meaning making as the ability to "form complex and integrated ideas about self and others" (p. 56) that can be used for guidance throughout life. However, symptoms of mental illness can sometimes disrupt a person's ability to form or understand complex ideas (Lysaker et al., 2018). When ideas are too complex to verbalize, art therapy's ability to bypass words and put ideas into an art form facilitates meaning making (Wadeson, 1980). Contemplation of the artwork and creating meaning from its interpretation can simplify these complex ideas, making them easier to structure as guidance for the self (Malchiodi, 2016; Spaniol, 2003). Allen (1995) pointed out that when internalized images are grappled with, as solidified in an art form, the art becomes a "way of knowing" for the person. Thus, interpretation and meaning making of the art can turn the artwork into a navigation tool for many client populations.

Art Therapy in Forensics

Building upon art therapy's core tenets, forensic art therapy also incorporates clinical understanding and judicial procedure (Cohen-Liebman, 2016). Art therapy has been used with incarcerated populations as well as with victims of crimes (Salmon et al., 2002), which may address the trauma that people who have survived criminal acts may be experiencing (Harvey, 2007). Forensic art therapists use art to attain facts about an alleged crime in a non-confrontational way (Teasdale, 1997). According to Cohen-Liebman, such fact-finding is a vital part of forensic art therapy (2016). Some of the patients I work with are survivors of a crime; however, I have never needed to collect

facts from a victim for legal purposes. However, because all the patients I work with have committed a crime, awareness of forensic art therapy research has been helpful to me.

For incarcerated populations, rather than expressing emotions in a destructive or negative way that may be harmful, art therapy provides an avenue for healthy emotional expression (Bailey, 2016; Gussak, 2020; Saunders & Saunders, 2000). Although there is little literature on art therapy with this particular population, Gussak has made a sound contribution on which to build future research. Based on his long experience as an art therapist in forensics, Gussak (1997, 2004, 2006, 2007, 2016, 2020) has documented how art therapy in forensic settings can be an asset for patients and their treatment teams. In particular, the nonverbal and symbolic discourse that art therapy facilitates can help patients and inmates feel less vulnerable when sharing their feelings, which is especially important among patients with a history of reluctance to verbally contribute to a group process (Bennink et al., 2003; Gussak, 2007). An art therapy program also deviates from an often-harsh setting through its focus on creative expression, which has been shown to be efficacious in decreasing various symptoms (Bennink et al., 2003; Gussak, 1997). Gussak (2007) has stated that whether someone is particularly talented or not, art is experienced by most inmates as a safe outlet and an arena in which they earn the respect of their peers, either for their artistic accomplishments or for their efforts. I have found this to be equally true for the patients I have worked with MMHI.

In their seminal book on art therapy with forensic populations *Drawing Time: Art therapy in Prisons and Other Correctional Settings*, Gussak and Virshup (1997) laid out multiple benefits art therapy can provide to this particular population that still hold true today. Gussak noted the ability art therapy has to reach all educational and cognitive

levels. Despite varying abilities to communicate among this population, most everyone has the ability to participate in art directives provided, even if modifications are needed. He examined how this population gains the knowledge to express convoluted emotions and themes in a simple, less complex manner through the art process. In turn, Gussak found that "art can diminish pathological symptoms without verbal interpretation" (p. 446). Consider the importance of this, both in terms of varying cognitive abilities of the population as well as the harshness of the physical environment they are living in. Gussak is asserting that art has the capacity to reduce symptoms of mental or physical illnesses, despite that the creator does not necessarily need to discuss their work to experience this benefit. In an environment where a patient may not feel safe sharing their true self with others, this is an enormous benefit of art therapy. Patients may be vulnerable to intimidation or violence by their peers; sharing emotions via art can be a safe way to express and disclose these feelings. Having this extra layer to buffer against that which could be deemed as weakness may encourage participation in further treatment. While patients may guard against disclosing complex emotions verbally, they may be more willing to identify and explore emotions through interaction with art materials and processes (Gussak, 1997, 2007, 2020).

Gussak (2007) has described how art can boost self-honesty by "circumventing unconscious and conscious defenses" (p. 446). Art therapy may help patients bypass their defenses that are no longer helpful to them, such as acting out violently or isolating, by providing a healthier way to identify and channel outdated schemas (Gussak, 1997, 2004, 2007). It is important for patients or inmates to engage in the creative process, in part because doing so allows for a diversion from the relentless forensic environment

(Gussak, 2020). It can also provide an emotion break by interrupting ruminating or intrusive thoughts (Spaniol, 2003). Finally, Gussak makes the point that artistic expression is acceptable across many cultures, including in forensic settings as well as outside prison walls (2004, 2020). For a population that may be used to employing detrimental or negative ways to express themselves in the past, art gives an opportunity for helpful, positive expression while working on ever-evolving identity formation.

Recalling that identity formation is the view a person may have of themselves, the world and/or how the world views them (Cote & Lavine, 2014), this view can include but is not limited to cultural, biological, or psychological attributes. They all blend to form a sense of self (Erikson, 1968). All of the patients I work with are someone's child, sibling, spouse, or father. Perhaps they used to be the income-earner for their family. Now they are a patient. They are incarcerated. Art gives them a way to look at all these identities in a singular, creative way. Gussak (2020) wrote an entire book dedicated to looking at the role art can play in helping incarcerated people recreate their identity. He concluded, "our identity as a clinician can be established by the institution or changed suddenly by an inconceivable event" (p. 169). Perhaps helping this population with identity formation through art is important to us because, in fact, we are not so different from the people we serve.

Conclusion

My review of the literature has filled in some of the gaps in knowledge about grief and loss art therapy services to people living in a forensic psychiatric institution. Examining how the systems that house this population were created as well as the role of myth, stigma, and marginalization, makes evident why offering such services has been

overlooked. This population has a unique set of losses, creating a unique type of grief. Clearly, we need to respond with a unique, powerful and effective treatment.

In discussing his research, Gussak wrote, “I wrote about what I know. I would hope that others . . . decide to expand the art therapy library by addressing and expanding these parameters” (2020, p. xi). Likewise, my research study evolved from what I was surrounded by daily: colossal losses layered atop one another with little means of being addressed. I started with what I inherently knew: the grief from these losses wasn’t going to disappea, and art was a safe way for it to manifest while providing containment. The patient volunteers expanded the depth of this research by adding to their identify formation: Son, brother, child, father, human, *griever*.

CHAPTER 3: METHODS

As an art therapist practicing in a forensic psychiatric hospital with offenders who have severe mental illness, I had observed a treatment need that was not being met. Through no fault of their own, the patients did not have the vocabulary or knowledge of how to address their disenfranchised grief from a cycle of ambiguous losses. Three years ago, I didn't have those tools either. Given the opportunity to examine the matter with them in doctoral research, I reasoned that art therapy would be an empowering means for the patients to learn about and address their grief. The need for information about grief and loss with this particular population is evident, given the numerous barriers to treatment and the lack of resources, as discussed in the previous chapter. The purpose of my study, therefore, had three objectives. First, I wanted to examine how patients in this setting use art therapy treatment to explore their disenfranchised grief from ambiguous losses and the ways it manifests. Second, I posited that grief and loss art therapy could contribute to more effective treatment planning. Finally, I aimed to humanize a marginalized population by providing an opportunity for patients to voice their needs through art and story sharing.

Multiple Case Study Research

Case studies are used within a real-life setting to study a research concern through the experiences of an individual or individuals; the information generated is used to interpret scenarios or to link and compare cases across broader, related populations (Gussak, 2016; Kapitan, 2018; Yin, 2012). According to Kapitan (2018), "case study research is a form of systematic inquiry that focuses on a particular entity to make sense of all aspects of it," resulting in "a holistic, clear sense of the client, the therapist, the

therapy, and its outcomes" (p. 123). Case studies use data collection from multiple sources, including but not limited to case notes, observations, interviews, and reports (Creswell, 2013). In art therapy research, data often includes artwork as well.

Creswell (2013) outlined several key features that distinguish the case study from other qualitative research methods. First is identifying a case, in consideration of the many types of cases that can be studied, such as an individual, a small group of people, a community, or a specific project. I aimed to construct a multiple case study by examining several cases of adults living in a forensic psychiatric setting, and a purposeful study in particular of two individuals who had committed a capital offense. Additionally, the case study method involves a clear intent that focuses on illuminating the unique qualities of the case. Thus, my research could be identified as an *instrumental* multiple case study (Creswell, 2013) because the intent was to look at the specific issue of how best to address grief in the setting. The rigor of the methods requires the researcher to present an in-depth understanding of the case by using multiple forms of data, which I designed into the study by using case notes, artwork, patient narratives, and peer feedback. The researcher must provide an accurate description of the data by highlighting themes or issues that have manifested. Finally, the research concludes with lessons learned and assertions of meanings found in the case that contribute to in-depth understanding (Creswell, 2013; Yin, 2012).

Mapping My Research

Practically speaking, I sought the participants' help in gaining mutual understanding of how to identify and treat problems associated with grief and loss. Having practiced in grief and loss groups with this population for 3 years, I noticed that

symptoms of grief were sometimes misidentified and instead attributed to the patients' mental health diagnoses. Additionally, I had collected insight into ways that grief can cause a patient to seem stuck in their process of recovery. My research purpose was to investigate how the patients used art therapy to interrupt the continuous cycle of unexamined grief from ambiguous loss that kept them from moving toward healing. I saw this research as a chance to document the effectiveness of art therapy in identifying these losses, highlighting feelings associated with them, and naming the types of grief they were experiencing, from which they could find relief and renewed agency. I provided accessible materials and a nonjudgmental space with the purpose of facilitating an opportunity for them to explore their complex human emotions. My research aimed to bring forth and center on the needs of vulnerable patients.

Among the participants in my grief and loss program, I observed that individuals who had committed a capital offense seemed particularly prone to being overlooked as people who suffered from disenfranchised grief. I sensed that the feeling of shame would appear in their narrative more often than other patients in the setting. I wanted to know whether this phenomenon might be part of a pattern among capital offenders, along with other distinguishing feelings or behaviors that might emerge while creating art. I asked, if these additional or divergent emotions are present with this subpopulation, what additional tools might be needed to help them in the healing process?

I proposed that a grief cycle may be overlaid with many aspects of a person's life and that art therapy may be an effective tool to properly identify grief, something this research would allow me to test with a small sample of participants. My research questions were:

- Why is there a need to address experiences of disenfranchised grief from ambiguous losses as a treatment with the forensic psychiatric population?
- How does art therapy provide an effective intervention in exploring ambiguous losses and disenfranchised grief within this and similar settings?

Research Design

I chose to conduct a qualitative research study using a multiple-case study methodology. The decision came from my practice experience, in which I have found that a major obstacle to treating grief and loss in a group setting within a forensic psychiatric hospital is the general unwillingness on the part of participants to disclose their emotions to their peers, despite the benefits of group peer support. This dynamic is especially pronounced with individuals who have committed a capital offense: although they may be willing to talk about their losses, in many instances they will not discuss their offense in front of peers. The only times a patient/capital offender has discussed their crime with me has been individually, which suggested that group dynamics may play a negative role in self-disclosure for this population. I also observed that in the presence of peers there can be a denial of the crime regardless of the type of offense. Therefore, collaborative case research conducted individually, rather than in a group, could circumvent some of the barriers and yield information on how to better address the treatment needs of patients in a group setting.

Case research is a methodology that focuses in-depth on a particular subject within its social world (Kapitan, 2018; Patton, 2002). Because the social–relational practice of art therapy with forensic hospital patients is complex, qualitative case research is an appropriate choice. According to Kapitan (2018) “case study research that sheds

light on a client's experiences of art therapy represents one of the most pragmatic, practice-oriented forms of art therapy research" (p. 123). Individual case studies would provide a structure for exploring with the participant their grief and losses narrative through art and verbal reflections; when multiple case studies are combined, theories and postulations can be reinforced (Gussak, 2016). McNiff (1998) affirmed that "the practice of case study research in creative arts therapy corresponds to the narrative mode of research" (p. 64).

Based on the above reasoning, I chose to conduct a multiple case study using art-based, exploratory processes with the patients as my research collaborators. By collecting individual case studies and then comparing them, I would be able to determine whether grief and loss in art therapy with MMHI patients all flows in a similar direction, regardless of whether the person had a capital offense. Differences in the losses and types of grief that manifest would indicate whether additional or differentiating treatment tools are needed for the patients.

Participants

A small convenience sample was recruited through patient self-referral and referrals from their treatment teams. The selection criteria were that participants were: (a) adults age 18 years or older, (b) currently a patient at MMHI, (c) had at least one consecutive year of incarceration prior to the start of the study, and (d) had no planned release set during the 6-week study. Although not identified in the inclusion criteria, important to note is that none of the participants had ever participated in a grief and loss groups with me prior to the study. However, 5 of the 6 participants in the sample had

participated in at least one art therapy group at MMHI. Therefore, it is possible that most of the participants were willing to volunteer because art therapy was familiar to them.

To recruit participants, I emailed every unit (14 in total) at MMHI, being sure to include the unit manager, rehabilitation staff, social workers, psychologists, and psychiatrists. In the email (Appendix B), I defined ambiguous loss, disenfranchised grief, and bereavement loss. I described the selection criteria, as well as details of the time frame and location. An additional point to mention is that the research study began during an unprecedented time: at the time that I was recruiting participants, MMHI had just ceased all patient programming because of the COVID-19 pandemic. My timeline changed multiple times as I waited on special permission to meet in-person with patients and because some of the units went on quarantine due to COVID-19 exposures. Therefore, timeline and location were still in flux at the time the email was sent out.

The sample aimed for six participants to consent, voluntarily, to be part of a 6-week individual case study. After I recruited and selected the participants, one was unable to be included in the study because quarantine in his unit was extensive. Although he was not able to participate in the study due timeline restrictions, I provided individual sessions post-study so that he could benefit from sessions equitably with the other participants.

To obtain informed consent, I sent out the informed consent form (Appendix A) to the units of interested participants. Because I had no knowledge of their reading abilities, I kept the language on the form to a 6th grade reading level, per MMHI's request. Each unit's treatment team printed two copies of the informed consent form, gave the participant a copy, and read the other copy aloud to them, per my instruction. I

then set up a time to meet with the participant individually to again go over the consent again and give them an opportunity to ask any additional questions they might have about participation. Only after they had fully understood the scope of their participation, they signed the informed consent procedure. Both the participant and a member of the treatment team signed and returned one of the copies of the form to me before the start of the study. The participant kept the other copy for their reference. For the one patient who had a guardian, the social worker contacted the guardian to receive their verbal consent (which was documented in the patient's chart) after which a photocopied copy of the consent form was sent to them, per MMHI policy. Participants also could discuss the study with their family or other support people prior to participating. Finally, at the start of the first session, participants reviewed and discussed with me their rights, protections, research purposes, procedures, expected duration of the participation, risks, benefits, and the voluntary nature of their participation.

Administrators of Mendota Mental Health Institute reviewed and approved all patient informed consent and study procedures. The Institutional Review Board of Mount Mary University also reviewed and approved all procedures before the study began.

Art Therapy Sessions

The sessions for the research study were planned to be conducted as 1-hour, weekly individual sessions in the area within MMHI where I normally held art therapy groups and sessions. However, the plan required further adaptation to proceed within the restrictions put in place at MMHI throughout most of 2020, due to the COVID-19 pandemic. As a result, sessions were held on each patient's unit instead, due to restrictions on patient movement on the facility's campus. Some sessions had to be

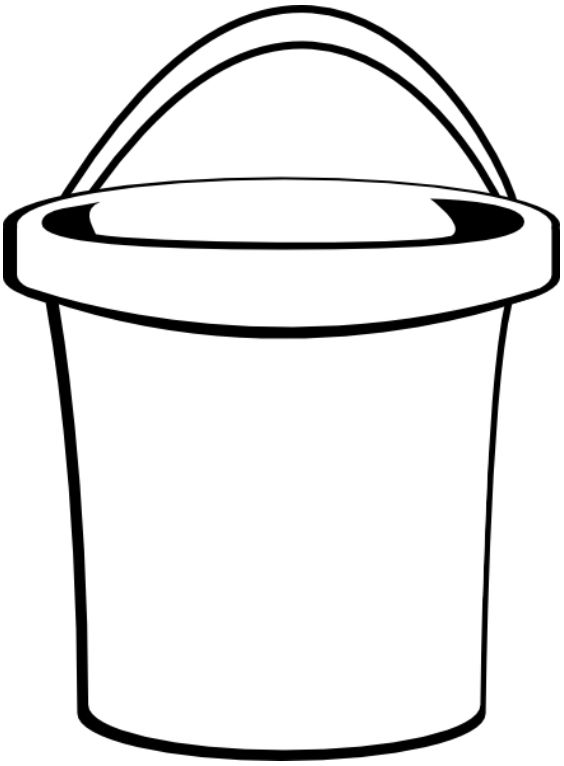

Figure 3. 1 Preprinted Bucket

scheduled twice weekly, in anticipation of future quarantine restrictions on the participants' units during various surges in Wisconsin of COVID-19 cases within the state's institutional settings.

Nevertheless, all sessions were conducted as individual art therapy within expectable procedures, ethics, and the current standards of care at MMHI, making the research aims of the study consistent with each participant's therapeutic aims. Participants engaged in art therapy, verbal processing, and education about ambiguous loss and disenfranchised grief. The sessions strived to provide some relief for the grief that participants were experiencing by offering tools and coping strategies. These included: (a) a vocabulary to ask for help, (b) an ability to identify and to describe various losses and corresponding feelings, and (c) increased self-capacity and expression through art. The art therapy sessions, described below, also sought to interrupt the cycle of disenfranchised grief and move patients onto a path of healing.

Data Collection

The data collection process was initiated in the first session with an art therapy directive I designed to help identify losses, called the "bucket of grief." I offered each participant a pre-printed image of a bucket (Figure 3.1) and a blank piece of paper should

they prefer to draw their own image of a bucket. The materials provided were black and white drawing papers, color pencils, permanent Sharpie® pens, Crayola® professional markers, oil pastels, chalk pastels, pencils, and erasers. I then asked the patient to first take a few moments and think about all the losses they had experienced in their life. I suggested that they write these down, perhaps in a list form, on the front or back of their paper. Next, I asked them to consider how much grief each of those losses had caused in their body. That is, if the bucket represented all the grief they held in their body, how much space would each experience take up. This imaginative process was a way of assigning a "weight" to the grief they felt with each loss. The purpose of the directive was twofold: (a) I could ascertain what the patient currently identified as losses in their life, and (b) I could gain an idea about how much mental energy they spent on the identified losses.

To provide an example, I stated that if someone's loss of both their grandmother and a pet dog were represented in a bucket, the grandmother might take up 50% of someone's grief, while the dog might only take 10% —perhaps because a person has worked through the grief of their dog or it is further in the past for them. I also gave the example that if a 90-year-old person was told they could no longer drive, the loss of that freedom might be on their list and given a spot in the bucket. The list could contain any kind of losses the patient could identify.

For Sessions 2 through 5, I directed the participants to create a visual timeline of their lives. I challenged them to think of their very first memory and then to add any memories or events they felt were important or significant to them. I told each participant that the significance was to be determined by them.

There were multiple objectives for this creative activity. First, I have always found that visual timelines are a nonintrusive way to learn about a patient's history. This directive allows them to add events that *they* determine are both important and safe to share. When working with a population that has had many freedoms and decisions taken away, this process is empowering, as they have control over their own narrative. Events or memories that are difficult to talk about can be added to their timeline with symbols, which for some people can feel safer than verbalization. Additionally, timelines can often provide information about the various losses the person previously identified. For example, the timeline might illustrate the loss and also give an idea as to how long ago the loss was experienced, as well as what other significant events were going on in the patient's life around the time of the loss. This was helpful to me as a therapist-researcher because I could see and assess possible secondary losses stemming from any of the identified losses that might not have been on the first directive (bucket of grief). Perhaps these secondary losses were not identified because the person did not know they were entitled to feel grief from these events or because they had not made the connection that one loss had created or emerged from another.

During these sessions, I engaged the participants in externalizing through their visual narrative and reflection as much family, health, and relevant criminal history as they felt able to reveal. I also used our time together to discuss the different types of grief that are common, as well as the concept of ambiguous loss, which informed and educated the patient about how they might understand and think about their various losses and disenfranchised grief. The final session (Session 6) repeated the bucket of loss art directive from the first meeting, which provided an opportunity to compare and reflect on

any changes over the course of the study. The purpose of repeating the directive was to visually capture whether the participant had any changes in what they identified as a loss after receiving some education on ambiguous losses. It also illustrated any changes in the amount of grief the participant allotted to the loss. Before the end of our last session, I asked each participant if they felt they had completed their grief and loss work, or whether they thought additional sessions would be beneficial. Finally, I brought the session to a close with some debriefing with the patient, as is typical for ending an art therapy course of treatment.

Immediately after each session with the individual participant (within 10 minutes and before moving on to any session or other work activity), I wrote up my case notes to document what had transpired. I documented post-session in lieu of audio or visual recording, in accordance with MMHI policies and procedures. In keeping with case study research procedures (Creswell, 2013; Kapitan, 2018), I focused my notes on the qualitative details, such as words and impressions, feelings, tone, and physical sensations that accompanied the participant's narrative, along with other observations. I also recorded, through separate analytic memos either immediately afterwards or later in the day or evening, my own impressions and insights from the session. My intent with these memos was to capture self-awareness and reflections that could have implications for meaning making when compiling the case study.

During the consent procedure, I asked each participant whether they would allow me to take a photograph of the artwork created during the sessions. Having obtained their consent, I was able to utilize the artwork as another qualitative source of data. Client's artwork, as well as their interactions with their artwork, have been recognized as a

valuable tool for information in case studies (Gussak, 2016; Van Lith, 2015). Finally, in the role of art therapy researcher, I found it helpful to synthesize the case by creating a visual portrait of my experience with each participant and their story. Kapitan (2018) wrote, "The artist's quest for coherence when painting a portrait parallels the research's construction of a case record that truthfully and authentically portrays the central information important to the study" (p. 128). As an artist doing art therapy research, combining both the data from the research sessions and my reflections in art helped me to construct a stronger, more authentic case record.

In summary, the data sources used in the study were the following:

1) **"Bucket of Grief" art directive** (pre/post Week 1/Week 6): "Using the pre-printed template (showing a line drawing of a bucket or pail), think about the losses you identify in your life. If you were to place each loss in the bucket, how much space would each loss take up? Use markers to fill in the template with these losses or a blank paper to illustrate your own bucket."
2) **"Visual timeline" art directive** (Weeks 2 – 5): "Using the art materials provided, please create a visual timeline of your life, from your first memory to present date. As you learn about types of losses, you will have an opportunity to go back over your timeline and add these losses."
3) **Case notes** collected post-sessions, which documented what occurred in the session verbally, behaviorally, and artistically. This was kept in an ongoing study journal.
4) **Artwork** created in the session, which was photographed before the end of each session, and art created by the researcher post-session.

Data Analysis

All data collected was de-identified in order to maintain confidentiality. For data analysis, I followed case study procedures described by Yin (2012) and McLeod (2010). Specifically, I first created a case record, which is a process of pulling together all relevant information that had bearing on the study topic (Kapitan, 2018). During this process, I made a copy of the study journal, as in this way I had an untouched original and one that I could use to arrange the progress notes into a coherent narrative of basic information. That is, as I went through the study journal copy, I eliminated minor, irrelevant, or distracting details in order to focus on significant patterns of meaning that ran through the data in each case.

I broke down each of the remaining case note information into seven categories relating to: (a) important background information; (b) index offense; (c) symptom/mental health; (d) artwork; (e) identified loses by the patient, either verbally or in their art; and (f) loses not identified by the patient but identified by me.

An additional category (g) involved setting up all the participants' artwork in a private space for viewing. I asked my peers at MMHI, which included a fellow art therapist, one social worker, one occupational therapist, and two corrections officers, to come and view the de-identified artwork. I asked them to use one or two words to describe their initial reactions to each piece. Those words were recorded in my study journal copy and added as the final category of information.

Next, after separating out all seven categories, I looked for correspondences between the cases and the larger study aims and research questions. Finally, I performed a cross-case comparison to identify linked results. Eisner (1991) compared researchers to

detectives in that researchers take small pieces of evidence and compile them to make a cohesive whole. Thus, the researcher seeks and finds recurring actions, behaviors, and images, while easily disconfirming contrary interpretations. Using this strategy, I studied the results and inferred possible benefits and challenges in engaging patients in grief and loss art therapy.

After the step of compiling the case notes into categories, but before I inferred final results, I created symbolic portraits of the participants. I felt that categorizing all the information was an important step in the data analysis, but I did not want to strip the participants' stories away in the process; I felt I was losing their voice. Therefore, as a means to keep their voices and stories central to the study, I used art to create "portraits" of each of the patients. These visual portraits provided emerging insights that were assets to my process of data analysis. They helped me capture what was special and unique about each person. After I was able to emphasize these aspects of the participants through my art making, I moved on to dispersing the insights gained into categories or areas where they overlapped each other. This process allowed me to keep the significant differences separated and contained in a portrait, and use them to look at all the participants' similarities in a way that maintained ethical integrity.

Kapitan (2010) defined art-based inquiry "as the creation of knowledge using visual means within a research perspective" (p. 162). Although not originally included in my research plan, art-based inquiry emerged as being essential to this multiple case study, not only because of its ability to add affective context to the narratives shared by the participants, but also for how it added depth to my own understanding of their stories through the portraits. I honed and maintained a qualitative researcher's reflexivity when I

examined my own artwork while comparing and contrasting it to the corresponding patient work. Additionally, I kept the portraits on a shelf above where I worked throughout the analysis. They were a constant visual reminder of who I was doing this for, and that it was their voices, their stories that needed to remain central to the study while examining benefits and challenges. As I worked, I would ask these portraits questions that were arising in my analysis and find a response from them that helped check potential confirmation biases and guided my direction. I also took the portrait to each corresponding participant and incorporated their feedback as part of my detailed analysis, described in the next chapter.

Ethical Considerations and Validity

Ethics of Working with a Marginalized Population

The study design presented unique challenges with regards to research ethics and the rights of human subjects. According to Schwenzer (2008), persons who are committed into an institution are considered a vulnerable population under the Common Rule. She wrote, "Vulnerable populations include people with psychiatric, cognitive, or developmental disorders, and are considered vulnerable if there are legitimate concerns about their capacity to understand information presented to them and to make informed choices" (p. 1343). Therefore, in choosing to conduct a study with the patients at MMHI, important ethical challenges had to be considered. First, building a trusting therapeutic relationship is stacked with challenges before adding a researcher/subject lens on top. Because I was their therapist, the research participants were well aware that anything they did and said could end up as a progress note in their medical record. This realization carried the potential to influence what the patient was willing to share.

Adding to the above dynamic was my role as a mandated reporter; that is, there is certain information that, if they share it with me, I cannot keep confidential. I am mandated to report thoughts of suicide, self-harm acts, or threats against self or others to unit supervisors and my direct supervisor immediately. These scenarios are immediately recorded in the patient's chart, which lawyers and the judge can see should the person apply for conditional release (CR). Thus, all mandated reports can potentially affect a CR decision for that patient. Threats against others triggers a duty to warn, in which all MMHI unit staff automatically alert those who were threatened by the patient. This means that people outside the therapeutic relationship will learn that the patient was discussing them in session and can lead a patient to feel betrayed by the therapist. Further, I am an employee of both the State of Wisconsin and MMHI. If the participant had any reason to not trust either of these systems—the system of MMHI being nestled inside the state system—they might view me as an extension of these systems and transfer their feelings, perspective, and assumptions onto me. This dynamic could hinder our relationship or give them pause in sharing their story with me.

Looking through the lens of researcher/participant, it is understandable that the idea of "being researched" could create anxiety or hesitation. With people who are living with a mental illness, their reactions in study sessions had potential to become paranoid. In addition to deploying my training to monitor their reactions and support them therapeutically, I used accurate, clear language to help resolve any misconceptions about the research and I constantly prioritized their personal needs over any research agenda. Nevertheless, were the idea of me as a researcher to trigger symptoms such as anxiety or

paranoia, it has been my experience that it would take a long time to rebuild the fractured trust that these symptoms can create.

Another ethical consideration in my research design was the power differential between the patients at MMHI and me. As discussed in Chapter 2, people with mental illnesses often must deal with stigma, especially in the form of authoritarianism (Corrigan & Watson, 2004). Recall that authoritarianism is the belief that people with mental illness need life decisions made for them. As an employee of MMHI and a therapist who is part of their treatment team, I am in an authority role with the patient. I am in meetings discussing treatment options and legal ramifications of not complying with treatment. If they see me as part of the system that is forcing therapy or medication onto them, it can lead to them feeling a breach in trust. It can also leave them feeling stripped of freedoms and decisions over their own body. If at any point a patient associates me with their loss of power, it highlights that my role at MMHI ultimately is one of having power over their role at MMHI.

In a group setting, I try to mitigate this reality by sitting at the same table as the patients and participating in the directive alongside them. Most often, we use art directives that the patients themselves have conceived and facilitated as a means of empowerment. However, even this can be a bit of a façade. If one of the patients stands up and begins to loudly express themselves, and I ask them to sit down, they do not have much of a choice but to sit down. I have the power to call a "code," meaning that I can call all available security staff to the room who, in a matter of seconds, will physically take down the patient to the floor, put restraints on them, and transport them back to their

unit on a gurney. The implications of loss of power, freedom, and choice are enormous in such a situation.

A third ethical issue that the research design raised had to do with ensuring that all participants would benefit equitably from grief and loss art therapy while considering the public impacts of their self-disclosures in my research report. I was aware of the "voyeuristic" potential of the patients' stories, given the content. In Gussak's (2020) writing about art therapy with the imprisoned population, there is an anecdote about a conversation he had when he was considering changing his clinical work and a work supervisor asked him, "but what about that art therapy in prison stuff? That's sexy" (p. vii). This, and other experiences I've had, have given me unease about my ability to safeguard the participants from people with voyeuristic intentions, while weighing the benefit to other patients in similar settings who may receive better treatment as a result of the study's dissemination. For this reason, I committed to a practice of "negotiated ethics" (Convery & Cox, 2012) to continually assess whether the benefits outweighed the risks of the research in each step of the design. The informed consent detailed confidentiality, including that no direct identifiers were used and original artwork or any copies were kept in a locked cabinet within a locked office. Digital images, transcripts, and other files were contained on a computer that had multiple password protections in place. The consent form and initial meetings with participants also assured that the patients understood their participation was voluntary, and the use of their stories and artwork would be used as a resource for others in art therapy and related fields. However, I continue to worry about if all the safeguards I put in place are enough to keep out the voyeurs.

Validity

Case study research design has been criticized for inadequacies toward validity, particularly when multiple perspectives on analysis are not designed into the study and/or inconsistencies exist between the data and the researcher's interpretations (Kapitan, 2018). When interpretations are not supported by the data, the study's internal validity can be called into question (Kapitan, 2018; Yin, 2008). Accuracy in how the information is gathered and used to represent the participants' realities is important to validity, as is whether the results are considered credible by them (Schwandt, 1997, as cited in Creswell & Miller, 2010). Similarly, Kapitan (2018) noted that research results must make sense "with the real contexts and perspectives of the people studied" (p. 137). Thus, the "quality" of the qualitative study supports validity and its accuracy is often measured by the very people who participated in the research.

Eisner (1991) identified standards that help art-based and qualitative researchers maintain validity in their studies. Construct validity (Yin, 2008) is enhanced by seeking out structural corroboration via various types of data collected, for example, artwork and case notes that are analyzed to either reinforce or disprove research interpretations. Another standard Eisner (1991) imparted is called consensual validation. Consensual validation uses the opinion and reflection of others to describe, interpret, and evaluate themes. In my design, I built in a consensual validation process by asking my peers to review and reflect upon the participants' art, as well as sharing my portraits with the participants and asking them to reflect upon them. Finally, according to Eisner, criticism can be used to highlight questions that may arise in the data and use this information for further insights and understanding. He refers to this as referential adequacy, which

furthers the strength of the study's credibility and validation. I sought referential adequacy using two valuable resources: my doctoral advisor and my fellow art therapist at MMHI. Both brought essential critiques that helped me to rethink and solidify research findings.

According to Marshall (1990), creative work in qualitative research builds upon exploration of the not yet known by exceeding current knowledge and challenging established thoughts. Although qualitative work is extraordinary in its ability to access creativity, it must also remain analytically rigorous and explicit (Patton, 2002). Because my study was structured completely within qualitative and art-based research paradigms, to reinforce validity I utilized member checking as well as triangulated the data with multiple sources. Member checking is when the final account of the study is taken back to the participants and reviewed by them to ensure accuracy (Creswell, 2013). Participants' input was used to check the accuracy of the results in order to validate researcher interpretations. The feedback to their portraits was also assessed and used for the final results. During the data analysis process, emerging themes were triangulated by searching for them across multiple types of data, including artwork, case notes, and participants' own narratives, providing an additional layer of validation.

Summary

Because this study aimed to investigate how art therapy provides a useful treatment intervention for grief and loss within a forensic psychiatric inpatient setting, a multiple case study was employed. A multiple case study design was warranted to provide an in-depth exploration of grief and loss art therapy with an overlooked group of individuals in the context of a unique setting. Each individual case was developed and

analyzed using appropriate methods that followed the logic of the design. Individual cases were then compared for commonalities and distinguishing differences. Portraiture aided in maintaining credibility by keeping the participants' voice central to the study. It was also used as a form of member checking. Finally, ethical practice was monitored throughout the sessions, creating adjustments to expected timing and procedures as necessary. I addressed validity at multiple points throughout, including the use of triangulation and member checking. In the following chapter I will provide a detailed report of the data and display the results of the study.

CHAPTER 4: THE CASE STUDY PORTFOLIO

This multiple case study investigated the various losses that patients in an inpatient forensic psychiatric hospital experienced and identified through art therapy. It sought to better understand grief in its different forms and how that grief might manifest within this setting. In this chapter I present the results in the form of a case study portfolio. I begin with the demographics of the sample, followed by each participant's narrative of grief and loss, analyzed first as a clinical case and then as a creative portrait of their words and imagery. The goal of portraiture as a research method is to reveal the person's inner world "within a balance of context, thematic structure, relationship, and voice that creates an aesthetic whole" (Hoffman-Davis, as cited in Kapitan, 2018, p. 128). Each portrait depicts the central information most relevant to the study, drawn from the participant's responses to the three art therapy directives, case notes, and my own synthesizing interpretation in art.

All participant names in the case studies below have been changed to pseudonyms. Following the portraits, the results from the cross-case analysis are presented, organized into the major themes that the cases had in common and their distinctive differences.

Demographic Snapshot

I endeavored to recruit a sample of six participants, which I reasoned would provide a range of forensic patient experiences with grief and loss for this in-depth qualitative study. Six patients consented to participate. However, only five patients were able to attend the study sessions due to quarantine restrictions placed on their activities

during a surge in COVID-19 cases that unfortunately was occurring in the surrounding community at the same time as the study.

The age range of the participants was from 26 to 40 years old. All had been a patient at MMHI or otherwise incarcerated for at least one consecutive year prior to the start of the study and had no planned release set during the 6-week study. Four of the five participants identified as male and one identified as female. The participants had various clinical diagnoses, including schizophrenia (3 participants), depression (3 participants), posttraumatic stress disorder (2 participants), and borderline personality disorder (1 participant). Index offenses included arson, illegal transport of a minor, domestic terrorism, and murder. Originally, three of the six participants in the sample had a capital offense; however, one could not participate due to COVID-19 restrictions. Of the five people able to participate, one was Black, one identified as a member of a Native American nation, and three were White.

Portraits of Grief and Loss

The individuals who participated in the study were highly motivated to engage with me in an exploration of their histories with grief and loss. As anticipated, within the protected space of one-on-one art therapy, they were more open to sharing their perspective on the events that brought them to the hospital, as well as a great range of emotional reflection. As they recounted these events and began to construct a narrative of their grief and loss with me in their art, they also described memories of their childhood and high school years. They each were willing to discuss any insights into their mental illnesses at the time they began to experience symptoms versus insights they had now. They were also willing to learn about ambiguous losses and disenfranchised grief,

gaining vocabulary and knowledge on this overlooked subject. The losses that occurred under the scope of mental illness shed light on the disenfranchised grief these participants harbor. Each individual's narrative is a portrait of their life before and after their diagnosis, as well as before and after their index offense. Finally, not only can we see their art as a portrait of the losses they have experienced, but also of their individual resiliency. They have endured and persevered. They continue to strive for new insights and tools that could be instrumental in their recovery process.

Neil

Neil is a 30-year-old White man who was at MMHI for a second time after having his conditional release revoked seven years ago. He was distinguished on the unit by the necklaces and bracelets he wore, hand-made from hemp and yarn, and his shaggy facial hair. Both staff and fellow patients always seemed to enjoy and appreciate Neil's kindness and sense of humor. His index offense was transporting a child across state lines when he and his friends decided to take a road trip. As he explained it, because some of these friends were not yet adults, the adults in the car were charged with a crime.

Neil has been creating art since he was child and excels in many art mediums. He is active in the art-based therapy groups offered at MMHI. Despite that I have seen him in a group setting for 5 years, the research study was the first time I worked individually with him. His diagnosis is schizophrenia, as well as cannabis and alcohol abuse. Although it was not in any of his medical records, he stated he suffered a brain injury when he was 4 years old.

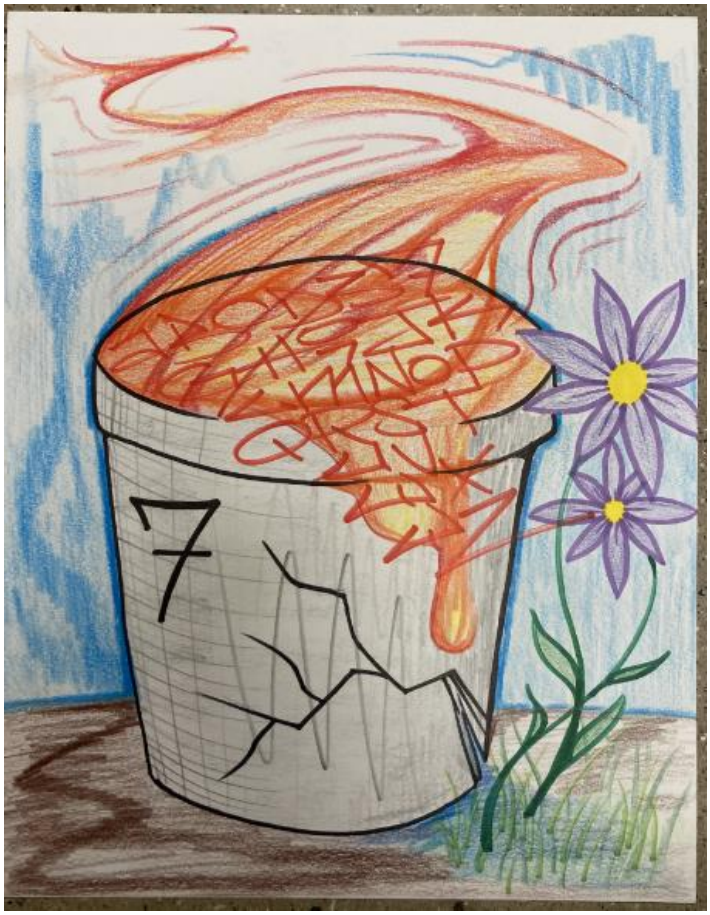

Figure 4. 1 Neil's Pre/First Bucket of Grief

Neil's Portrayal of Grief and Losses. During our first meeting, Neil did not start with the list of losses, and instead began to draw his "bucket of grief" on a piece of drawing paper using Sharpie markers and color pencils. He asked if it was acceptable to draw some things outside of the bucket, and then asked me whether I had a directive to work on. When I replied I had not thought of one, he said, "I have one for you: What holds you back from achieving what you want to do or where you want to go?" I obliged him and worked on his suggestion while he worked on the bucket. As he drew, he discussed family history, school history, and how COVID-19 had affected visits from his family. He disclosed that his symptoms first started when he was in his late teens; he did not offer insight as to his mental health at the time.

His first drawing of the bucket (Figure 4.1) was filled with the letters of the alphabet depicted as floating in reddish liquid. The liquid overflows the bucket while emitting what appears to be a strong aroma. The bucket rests on hard, dry ground. Along with a large, stylistic "F" on the side of the bucket representing his family, he drew a crack at the bottom, where water is shown as leaking out. The water nourishes a small

patch of green grass out of which two graceful purple flowers are entwined and growing upward. He explained,

> I had a head injury around age 4. At first, it really affected my thoughts and words. There was so much grief when I lost my words. The alphabet represents the words, and the orange around it are the thoughts. The crack represents the head injury. However, the crack allowed for creativity and art to enter my life so it's feeding the flowers. The flowers are the school colors for where I hope to go and get my art degree when I'm out of here.

After our first session was over, I noted that no bereavement losses had been depicted in his bucket of grief, nor mention of relationship losses or loss of freedom and his mental health. Dreams and rituals were also missing from his bucket. Instead, his artwork thoroughly centered on the loss of his physical health at an early age by including his head injury and all the complications that led from it. Although his loss had made his life hard and dry, he envisioned a new, greener place growing from it, addressed by his desire to go to college with the addition of the growing flowers. Neil was accepted into an undergraduate program in art the year before but had to decline because he did not get conditional release. While he drew the overflowing bucket, he described family losses in terms of missing his brother and feeling badly that he was missing out on his siblings' day-to-day lives. He also spoke of being close to his grandmother, that he missed her but talked with her on the phone regularly. However, he did not name these family relationships when looking at his art image.

Neil worked on his visual timeline in our next session. While he worked, he told me many stories of his life that the timeline seemed to prompt. He mentioned that his parents never married each other but had married other people instead, with whom they had other children. He loved his stepparents and siblings but also shared the memory of crying every morning in kindergarten because he knew that whenever he was with his father, his mother was separate and missing Neil. He told me about two of his family members who were killed in an accident when Neil was supposed to have been with them. Another experience he shared was being in jail while waiting to come to MMHI, and how difficult that was for him.

Figure 4. 2 Neil's Timeline

When Neil arrived for his fourth session, he viewed his timeline (Figure 4.2) and declared, "I think I'm done. Or almost done." When I asked him if he could think of anything else that should be on the timeline, he discussed the symbolism of some of the images and drew a few more things, such as being at the hospital (depicted by a red + sign on the left, center) and when law enforcement had used a Taser on him, which was also when he was first diagnosed with schizophrenia (about age 18). To the left of the

hospital symbol, representing his earlier losses on the lifeline, he had drawn a small green patch of earth from which two crosses were placed, as if repeating the visual vocabulary of the flowers in his bucket of grief. They are protected by a cloud from which a large sun is shining. Earlier still, to the left of the cursive, stylistic F —which he often used to represent family—are two trees, one small and another larger tree placed beside it. To the right of the hospital, he grouped several symbols, including the wall of his jail cell and a bird that holds MMHI. Contemplating his timeline, he added the Kanji sign for "hermit" in small blue and purple above the jail cell, followed by the Wiccan black star and a small sign of the fish in green, a symbol for Christianity. Finally, he stated that he wanted to add his siblings but could not think of a symbol to represent them. He reflected that he was closer to his siblings on his father's side, saying,

> That's something I feel bad about. My siblings on my mother's side do not even know me. And that got worse being here. When my brother was young, I was playing with him and he yelled at me saying I was not his brother. He really believed I was not his brother. My mom recently showed me a picture of him and a picture of me at the same age and I have to admit, we look a lot alike.

He decided to draw his siblings as apples (placed in the lower left-hand corner) because to him apples represented health and had seeds. He did not make a connection to the apples as representing his family tree, which I had wrongly assumed was the direction he was headed. Instead, he drew vibrating lines around one apple, saying, "because that's my sister, and we talk to each other in our minds. We don't discuss it out loud, but we can communicate telepathically. I can talk to her in my head and she can talk back."

When he had finished drawing the apples, I asked him to now look at his timeline and think about what was missing from it or what he wished was there. Thus prompted, he drew a tiny group of images along the bottom of the paper, consisting of a house, a college symbol, a Christmas tree, and a family. He reflected, “Time lost: possibilities that could have happened but instead . . . haven’t, because I’m here.” He explained that he wished he had a college education, his own home with a garden, and a family of his own. “I miss the holidays, so the tree is there to represent all the holidays I’ve missed.” When I asked him about the most positive thing on his timeline, he pointed to the house he had just drawn and said, “The things that haven’t happened yet.”

During one of our later meetings, Neil stated that looking at the timeline made him wish for forgiveness for all the things he missed out on. When I asked him who he needed forgiveness from, he reflected on how his own parents might have felt about him being ill or being at MMHI. He also brought up forgiveness from his siblings for being gone so long (a sentiment that came up regularly for him) and missing out on important things in their lives. He never discussed forgiving himself, and did not mention it on this day either.

Figure 4. 3 Neil's Signature Style

Figure 4.4 Neil's Post/Second Bucket of Grief

For our last session, Neil wanted to add his "signature style" to his timeline (Figure 4.3), explaining that filling the space with this intricate type of drawing was relaxing for him because it was easy and he "didn't even have to think." Now the timeline visually presented two distinct parts that balanced one another, with a past–future division between them. I told him there was just one more thing to do, and that was to create another bucket, like on the first day, that represented his grief. The second bucket image (Figure 4.4) was very different

than the first. In comparison, this drawing seemed very calm and organized to me. Where before he had an overflowing jumble of letters in red, he now drew a large cross; vibrating blues lines around a peace symbol replaced the noxious aroma. He included a symbol of himself this time, at the very center, represented by a large evergreen tree and with his family as smaller trees around him to depict all the memories he missed out on by being at MMHI. In the upper right-hand corner, above the familiar protective cloud with the shining sun, he placed a heart for relationships and circles on the left, near the large cursive F, to represent the family he hoped to start someday. His relatives killed in the accident were represented by the large cross placed inside the bucket. The sun represented his freedom, he said, and the peace sign was peace of mind. Unlike the first bucket, this bucket did not rest upon a ground line.

We ended this final session with Neil wanting to continue meeting and working on grief and loss in art therapy. A common theme that seemed to run throughout the sessions was his feeling of guilt about missing out on his siblings' lives, as well as missing his parents and grandmother. These guilt feelings were further reinforced when he described the dreams he lost by being in a forensic psychiatric hospital, such as missing holidays or starting a family of his own. Guilt and grief seemed to be tied together: he was not just grieving what had been, but also what could be, what could have been, and what now will never be, due to his incarceration.

A portrait of Neil. My drawing of our time together was the first of the portraits I made (Figure 4.5) after creating the case record and beginning data analysis. The very idea of Neil—who was already having a mental health crisis—sitting in a jail cell while waiting for a psychiatric bed to open for him was an image I could not let go. What emerged for me was a small, vulnerable person, curled up and isolated in the corner of a room. Paranoia and hallucinations are creeping in, advancing toward him. Seeing him as having no way to protect himself, my own desire was to provide something helpful, drawn as lines that surround and shield the figure of Neil. I wondered if perhaps his artwork was a guide that kept him grounded while working on difficult subjects. Behind him and to his side there are empty walls and floor. But if he were to look up, he'd see the bold, graphic designs in his own style that balance the white space, like a mural that wraps around the wall and ceiling.

Figure 4.5 Researcher's Portrait of Neil

My questions for the Neil portrayed in this drawing are: Do you still feel locked in a cell today? Does your love of art help you balance or fill this void . . . or get you out the cell? What does the cell mean to you? To me? What do you have to protect yourself, and become empowered in some way? How would you feel differently were I to draw a ladder on the wall or a trap door in the floor or ceiling?

Shortly after our last meeting, Neil was denied conditional release. He decided to stop taking medication and quickly became symptomatic. As a result, he was transferred to a maximum-security unit until he could get better control over his symptoms. Thus, it was only after several months that I had an opportunity to show him the case vignette and portrait and hear his feedback. He laughed at the pseudonym "Neil," joking that it sounded like a "surfer" alter ego. He told me he enjoyed reading the case vignette, as he had forgotten some of the stories that had come up for him. He found it useful to once again see the timeline he had drawn, looking at not only what he had overcome but goals for his future. He noted that before our meetings for the study, he had not realized how much grief he felt from missing out on family events. The loss of these rituals was really important to him. He also noted that COVID-19 had amplified this loss for him, taking away his in-person visits with family.

I then showed him the portrait I had made in response to our meetings. Studying it carefully, he said that the person in the portrait looked "alone, while deep in thought" and also "sad and ashamed," perhaps. The person looked like he was "reverberating," he said, adding that perhaps he was "trying to reach out telepathically." He very much appreciated the attempt I made at incorporating his signature style of art into the portrait. He liked that the person in the picture was surrounded by these familiar lines and shapes, because

for him they were calming and a means for meditation. He did not see the figure in the picture as trapped in a cell; rather, the figure was safe, surrounded by a calming presence of the art.

Robin

Robin is a 39-year-old White patient who identifies as a woman. She explained to me that she desired to have surgery to conform her body to her gender but has had no opportunity to do so. Because all her legal documents list her gender as male, she is living on an all-male unit at MMHI. She had a diagnosis of posttraumatic stress disorder (PTSD), which is the only diagnosis she had received that she agreed with. She also had been diagnosed with borderline personality disorder, major depression, and polysubstance abuse. She was at MMHI for threatening someone she knew. When the police arrived to talk to her, she barricaded herself in a motel room. Law enforcement found an arsenal of weapons in her possession.

Robin had attended a few unit-based art therapy groups with me; however, she had always opted to color pre-designed pages during the groups. She found it relaxing to color and had not found other art processes that she liked as much. Robin has a convivial presence—in fact, I have never seen her with a negative attitude. She always had a big smile, wore bright colors, and was ready with memorized jokes to bring humor to the room. On every unit she has lived at MMHI, her peers seemed to enjoy being with her.

Robin's Portrayal of Grief and Losses. During our first session, she started drawing her "bucket of grief" while telling me about her wife Jen (a pseudonym). About 15 years ago, Jen, who was pregnant at the time, was running errands when she became involved in a fatal traffic accident. Neither Jen nor the fetus survived. However, Robin

got to be with and hold Jen's hand when she died, which Robin said helped give her some peace around the loss.

As she continued methodically filling the bucket with layers of softly blended color, Robin shared her thoughts about a romantic partner named Dave (a pseudonym). Dave was in Robin's life before and during her marriage, and her wife Jen was aware of the relationship. Then Dave passed away, only a few years after Jen. Robin speculated that she still harbored a great deal of grief over Dave because she lacked closure for his death, due its difficult and odd circumstances. When I asked if she ever sought professional help for her grief, she replied, "Yeah, Dr. Daniels. Jack Daniels. For a long time after Dave died, I did not do anything, not even get out of bed, until I drank some Jack."

Figure 4.6 Robin's Pre/First Buckets of grief

As this first session was ending, I asked her at what age she knew that she was a woman. Robin responded that in 8th grade she told her parents that she "felt different,"

saying, “I told them and they told me I had a psychiatric problem. But I knew long before 8th grade something was different. It did not matter to them.” Robin then explained that they never wanted or referred to her as anything other than by the male name they had given her at birth.

Our second session began with discussing the items she had drawn in her two grief buckets (Figure 4.6). She had needed two of the pre-printed bucket images to include all her losses, and filled both of them in the same blended style. Looking at the bucket drawings, she began to talk about her father, which was a loss not ranked at the top of her written list but rather the sixth loss down the list. She stated that her father passed away about 5 years earlier and that she had lost everything because of his death. By Robin’s account, the family farm and home were immediately sold after his death and money she had inherited was stolen by relatives.

She described an uncle next, who was not a blood relative of her family but she grew up calling him as such. He had died of cancer 8 years ago. She explained that he was a positive male role model in her life growing up, and she even told a story of him standing up to her father when her father was verbally abusive to her. She disclosed her father’s mental and emotional abuse and her own mental health (“my mind/my sanity”) as losses in her bucket of grief. She said that she has been told she had PTSD and “manic depression” and that she started noticing “mood swings” and other emotional dysregulation around the 4th grade, stating she also remembered times when she felt manic. The PTSD, she said, was “from family abuse.”

Among her other losses, she listed “ability to drive” because driving had been an outlet for her prior to incarceration. Missing from her bucket was the loss of safety from

any of the abuses she had endured, as well as dreams, rituals, or any losses related to her inability to work. Physical health was also missing in her reflections, despite that she had been born with a severe spinal condition. She still has rods in her back from the surgery and has used a cane since her 20s. She also has injuries from a car accident and reports a hearing loss. These particular experiences were not included in her descriptions of her bucket of grief.

During our next session, she began to work on her timeline. After 20 minutes of writing, I asked if she was almost ready to begin drawing. She replied, "I'm only on second grade." I reminded her that she only had to write down significant memories or experiences, with significant being defined by her. "It's all significant," she stated.

During our next session as she was working on her list of what to include for her timeline, Robin verbally noted the different units she'd lived on during her time at MMHI. At one point, she had lived on a minimum-security unit, but only for a few months. Otherwise, she's been on medium and maximum-security units. She spoke about a feeling as if there were a "good Robin and a bad Robin" living inside of her, mirroring the need to have two buckets of grief to hold all that was a part of her. I told her that I had never seen "bad Robin." "No, you haven't," she replied; bad Robin had only shown herself once while in the hospital, she said. She elaborated:

> If you call me a "homo" and make fun of me to my face, and don't stop when I ask you to, you're gonna get bad Robin. I stood up and punched him in the head for calling me those things.

She compared these feelings to a movie she had seen about a girl who had good and evil living within her. That was part of the reason she chose the name Robin for

herself; the name reminded her of a poem from her childhood, and also that Robins are "smart." She also chose a new surname from what was on her legal papers, which she said was a term for "dark dragon" and a name she thought sounded powerful.

After some brainstorming, Robin figured out a way to make the timeline work well for her (Figure 4.7). She took a page from her notebook and wrote a line of text from

Figure 4.7 Robin's Timeline

which she could begin to construct her losses for the timeline. She worked on this for a while, trying to decide what to include. As she worked, she described her father's funeral. I asked her about her history of therapy (grief or otherwise) prior to coming to MMHI. "Just drinking," she replied, as she finished her notebook timeline. Then we discussed how to continue, as she was not confident in her artistic abilities. I suggested that she write down a word image that could be used for each significant loss she had included on her timeline and together we came up with organizing the timeline visually as a collage.

Robin wanted to listen to the song *High Cost of Living* by Jamey Johnson while she worked and also requested a printout of the lyrics. She wanted me to play it because, she said, she found the song "eerie" in its parallels with her grief, loss, and life. Robin mentioned that the refrain—about the cost of living high, playing like an old routine that cycled her through the same damn thing over and over, nott really feeling herself to be

alive, and living a lie—seemed as if the songwriter was telling her story. She mused that the song described her life "to a T." We ended the session by quietly listening to the song.

I started our next session by asking her what she missed about Thanksgiving, as the holiday was near. She stated that she did not do anything for the holidays. Usually on Thanksgiving she grilled and drank a lot, she said. She also did not celebrate Christmas anymore because it reminded her of the time her mother told her she was "too busy" to get together, and then found out that her mother spent the day with her sister. Her new "Christmas tradition" was to drink. When asked if she planned to drink when she was released, "it depends on the conditions of conditional release," she replied. "Once I'm off paper, I'll probably drink again." Off paper is a term that means when a person has completely finished all legal obligations, such as commitment or conditional release, from their index offense. Robin often deflected such inquiries with humor and joked that "the best choices she made were when she was drinking."

During our last session, Robin reflected on her completed timeline with me (Figure 4.8). She had arranged it chronologically starting with her first memory of riding in her father's orange pick-up truck. A red cross represents her mother's medical abuse of Robin as a child. Above the grade school and high school images are pictures that represent the abuse from her family, as well as being bullied at school. There is also an

Figure 4.8 Robin's Timeline with Future

image of the logo for transgender pride, which she placed around 8th grade. After the high school image, she placed cut-up blocks of the song lyrics and images that represent her drug and alcohol abuse. Continuing her timeline, there are some images that represent her feelings of depression, including an arm with words “worthless, mistake, hate you.” Shortly after that was when she changed her name to Robin, which is represented on her timeline by a redacted image. There is an image that represents a period of homelessness in her life, followed by a hand in a cuff to symbolize her arrest. The loss on her timeline that she wished she could take away was the abuse she had experienced when she was younger. Her favorite part of the timeline, she said, was the future, marked by the word “free” in bold block letters: when she gets out, she wants to get her truck back and hoped to live in a tiny house in the woods of northern Wisconsin.

Figure 4.9 Robin's Post/Second bucket of grief

In the final session she created her second bucket of grief drawing, which this time was only a single drawing (Figure 4.9) accompanied by a shortened list of losses. In comparison to the soft, blended colors of her first drawings, she drew this bucket with thick, boldly colored lines in markers. As she colored in these layers, she began to cry, saying,

"my dad was such an **hole, but I really miss him and I don't know why." When I asked her if she could share a favorite memory of him, she had many to share. I wondered aloud whether she might want to work on some artwork that honored his memory, and she seemed interested in the idea. Because this was our last session in the case study, we planned to meet again and continue grief and loss art therapy.

A portrait of Robin. When I began the sessions with Robin, I had noticed that there was so much emotional material that was always present in the room with us. It seemed that she had so much to say and so very much to work on—so much so that it was hard to know where to begin, which is reflected in my portrait of her (Figure 4.10). However, I trusted the structure of the intervention protocol I had designed for the study and used that as my guide to stay grounded, centered, and focused with her.

I also reflected that her need to bring in humor or an unrelated story often diffused the focus of the session. I do not regard this behavior as intentional, only that Robin was a very outgoing, social person and it was easy for me to get caught up in the lighter moments she offered. Whenever a difficult subject arose for Robin, it seemed,

Figure 4.10 Researcher's Portrait of Robin

she had learned to deflect it with humor or a self-deprecating joke. After a few sessions, it became evident that I needed to challenge myself to welcome these moments into the room and stay with them for a while, and then clear them away to allow the focus to fall back on Robin. This insight became the focus of my artistic portrait of Robin .

The portrait shows her sitting at the table, waiting for me to come into the room. The words around her represent some of the words she often said, or subjects she brought into the room. There are also the lyrics from Jamey Johnson's song, which also always seemed to surround us. These words fill up the space around her, but there is a clearing where I have swept away all the stuff that takes up room and allows me to be in contact with Robin. Her artwork acted as the guide to keep the sessions on task and my artwork acted as a reminder of the best way to hold the space safely: for her to feel comfortable by allowing her deflections to come into the room and then clearing them away so I could find my place or role at the art table.

My questions for this portrait are: How do I clear the space for you? Or keep it cleared? Am I right to assume that the space even needs to be cleared? If your space cannot (or should not) be cleared, is there anything that can help to penetrate all your "stuff"? So many words—do they help or hinder you? Are they crowding you? Causing you pain? Or are they wrapping you in a blanket of protection? How can I find you in such a full and busy room? How can you find your own true self?

When I met with Robin later, after completing the case record for the study, she read the vignette and seemed pleased with it. She agreed with everything I had written. Then I asked her if it was complete or if there was anything she thought needed editing or adding. She thought for moment, and then said, "I forgive everyone on my timeline, but I

don't forget." She sat silent a moment longer, looked away, and said, "I probably need some forgiveness too. I can be an ass." I asked her who she would want forgiveness from, and she immediately said Jen, her deceased wife, feeling guilty about the car accident. She could not help but feel that, had she been with her, it would not have happened. She also mentioned her grandmother, whom she wanted to have helped more before she passed away. Thirdly, she said, "myself." When I asked her what she felt she needed to forgive herself for, she responded that had she transitioned to her authentic gender 20 years earlier, she would be 20 years happier.

When I showed her the portrait I had created after our sessions, she studied it, reading all of the words around the figure, for a long time. She stated that she liked it very much, and that her favorite aspect was that I had incorporated lyrics from the song *High Cost of Living*. She began to touch the pieces of paper that the words that were collaged on, flattening any pieces that had curled when the glue dried. She commented, which was really something of a joke between us, that the glue was holding correctly. In some spots the words curled, while in other spots the glue "worked too well." This was a metaphor I had not considered until we studied the portrait together. I recalled that while working on her timeline, she always seemed to find the one glue stick that was empty or dried up. I finally bought new, larger glue sticks, only to hear her then comment about how messy it was, or how she had accidently glued something down she did not intend. Indeed, her artwork always had its problems with the glue, to the point of being comical. Perhaps the tools that Robin needs most in her life is "glue" and the ability to pick up and adhere together all the lost pieces. Perhaps the future portion of her timeline is the guide for how to put the pieces back together in a new way.

Carson

Carson was in his early 30s, and in his second incarceration at MMHI, having had his CR revoked after getting into an argument. His index offense was arson. He had been diagnosed as having depression and PTSD. Although he had a history of drug use, he said he had "been clean since 2014." I had worked with him in various groups during both his times at MMHI, as he is very artistically inclined. He had always been pleasant and very talkative. As a member of a Native American nation, he regularly referred to various aspects of his beliefs and culture when talking with me. He would bring newspapers from his Nation to group sessions and teach his peers words in his Native language.

Figure 4.11 Carson's Pre/First Bucket of Grief

Carson's Portrayal of Grief and Losses. During our first individual session for the case study, Carson talked about some of the losses on his written list while he worked on the "bucket of grief" (Figure 4.11). While he spoke, I began to fill out a timeline of my own, as his history was too complicated for me to follow without a visual to orient me. We discussed his parents and siblings, which included who he was closest with

and the fact that he had siblings he had never known. The event that precipitated this was having been taken from his home at 6 months old by federal drug enforcement agents when his parents "got busted" for drugs. Carson described to me a childhood lived in multiple foster homes, then returning to live with his family only to be placed back into foster homes again. On his 9th birthday, his mother died of cancer. He recalled that he found out about it while he was playing at a park down the street from his house.

We did not make it very far in his story of grief and loss before our session was over. I later reflected that the only losses he identified on his bucket of grief were deaths—and there was a significant number of people he had lost. No ambiguous losses, such as that of a stable home, a bond with his siblings, safety, or security were identified. I was left to wonder: did Carson ever have (now or when he was younger) a sense that his needs were being met? Despite such a rich and detailed background that he was able to reveal, like the interrupted quality of the overall image and its cut-off colors floating in the empty space, there seemed to be so much more that was missing. Stability was what stood out for me as a big loss for him. Also omitted were the many losses of safety, family connection, freedom, dreams, and rituals. At the end of that day, I was still thinking about my session with Carson. He was the person in the study who orally recalled the most losses (bereavement and otherwise) while finishing the art directive the quickest.

When later I studied his bucket of grief, the emptiness I saw in it served as a haunting reminder to me of what he lost or never had. Did he feel loved growing up? Who showed him the most love? He was moved around frequently as a child through no

choice or fault of his own, and I wondered how loving relationships form in the midst of the chaos he described.

Over the course of the next few sessions, he told me many more stories about his childhood—memories that were triggered by working on the timeline. He recalled going to a concert as a child and then, on the way home, one of his friends took his own life in the back seat of the car. As Carson explained it,

> He was high or tripping. I don't think he meant to do it, I think it was the drugs. I was only 12. I went with some friends who were older. It was just a mess. The whole thing was really sad.

As an art therapist studying the unmet needs of patient suffering from grief and loss, it is hard for me to imagine all of the implications that witnessing this traumatic event could have produced for Carson. The story contained many more upsetting details than recorded here. This situation would have been difficult for most adults, let alone a 12-year-old child.

Towards the end of the session, Carson discussed his feelings of guilt. He had been molested as a child by a step sibling. He wondered whether, had he spoken up, it would have protected his little brother, who later was molested by the same offender. He also wondered how his life might have been different had he gotten help when he was younger. He questioned whether he had a severe mental illness and felt that he should not be the one who ended up in MMHI, saying, "Instead, I'm locked up in here and [the offender] has never been arrested. He's out there free somewhere. I guess I feel grief from choices I did—or didn't—make."

During one particular session, I noticed that Carson, who is normally talkative, had become very quiet. He stated that he was fine, just tired, and then said, “This weather makes me depressed, I hate the cold. And it makes my jaw hurt, so then I can’t sleep . . . which makes me even more tired.” About 10 years ago, Carson was attacked by a group of strangers with a tire iron. As a result, he was left with a long scar down the side of his face and a severe under bite. When his jaw hurts, his speech sounds forced because he clenches his jaw. Although he had a medical appointment to address the pain, it was cancelled because of COVID-19 restrictions. Neither physical health nor the losses from the pandemic were included on his original bucket drawing.

Carson had a guardian who was assigned to him through the legal process, now going on almost 7 years. The guardian controlled where Carson lived (when he is not at MMHI), his money, and many of his life choices; “It’s like having a parent.” I also had to get the guardian’s permission for Carson to be in the study. This loss of choice also was not on his bucket of grief. He connected that he did not have much of a stable parental figure/guardian while growing up, yet ironically, he said, “I have one now, when I’m an adult and don’t need one. Go figure: it’s God’s way of making a joke.”

Carson completed his timeline and talked about the symbols of each image (Figure 4.12). The timeline is organized as a geography of events, places, and people along the many roads that he has had to travel. His first memory was of the Los Angeles riots in 1994 and seeing a semi-truck burning on the highway on the way home from a doctor appointment (lower left on the timeline). Moving left to right on the timeline, he also symbolized his Native American roots with the teepee structure, followed by images of drugs, flat lining, and being brought back to life. Next, he illustrated a mountain on fire

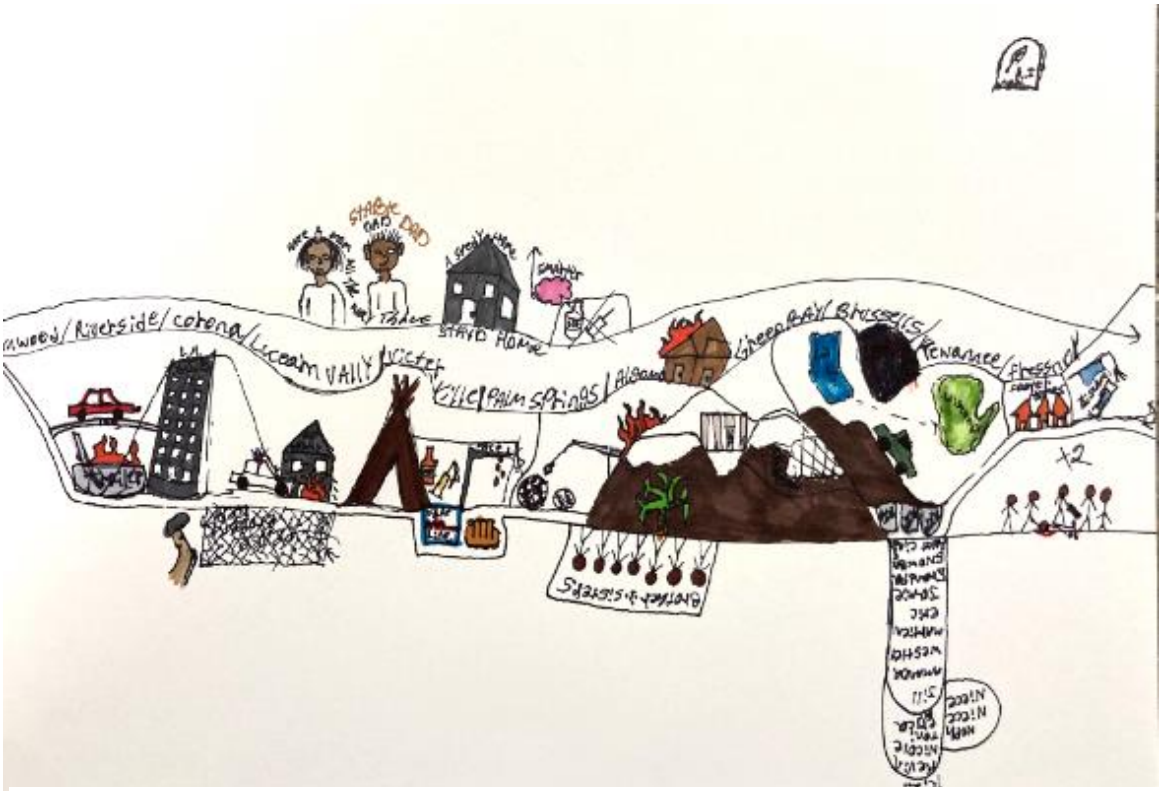

Figure 4.12 Carson's Timeline

with a Joshua tree below it in the dark soil near where his siblings are depicted (center, below the timeline). The fire image repeats, this time as his index offense of arson next to the jail bars. On the far right of the timeline, he drew himself laying on the ground with blood on his head, for when he got jumped, leading to his injured jaw. Lastly, he listed all of his deceased relatives and friends below the timeline, placed underneath several tombstones at the side of the mountain. Then he drew an image of his mother's tombstone, which he placed above the timeline (upper right corner), floating in the sky or perhaps in place of where a sun would be. Across the top of the landscape is a line of cities, in the order that he could best remember them as he moved from one to another of his many foster homes.

I asked him to consider what was missing from the timeline, or what he wished was on his timeline. He thought for a moment, then worked quietly. Now he drew his

mother and his father, a home, a brain, and an image of drugs with an "X" through them, placed near the center and at the top of the landscape. He reflected,

> I wish my mom would have been here the whole time. I wish my dad was stable [in his health], I wish I had had a steady home, that my brain was smarter, and that I had never used drugs.

He told me that he had drawn his siblings at the bottom of the timeline simply because there was not much room to place them elsewhere. He drew them upside down to illustrate how dysfunctional their relationships were. He said he wished they were closer, had been there more each other, and again mentioned that he wished he would have done a better job at protecting his little brother.

His PTSD and depression were diagnosed sometime around age 18. I asked him why he chose to leave any part of his illness or diagnosis off the timeline, and he replied, "I just forgot." MMHI was also left off, I noticed. He stated, "I don't want that on my timeline. I know it's part of it, but I live it, I don't need to see it." Then I asked him whether the timeline continued and did he know what he would put on it to represent the future? He began to draw his idea for a restaurant that would give money back to reservation for better education for the children. Then he discussed what a proper family

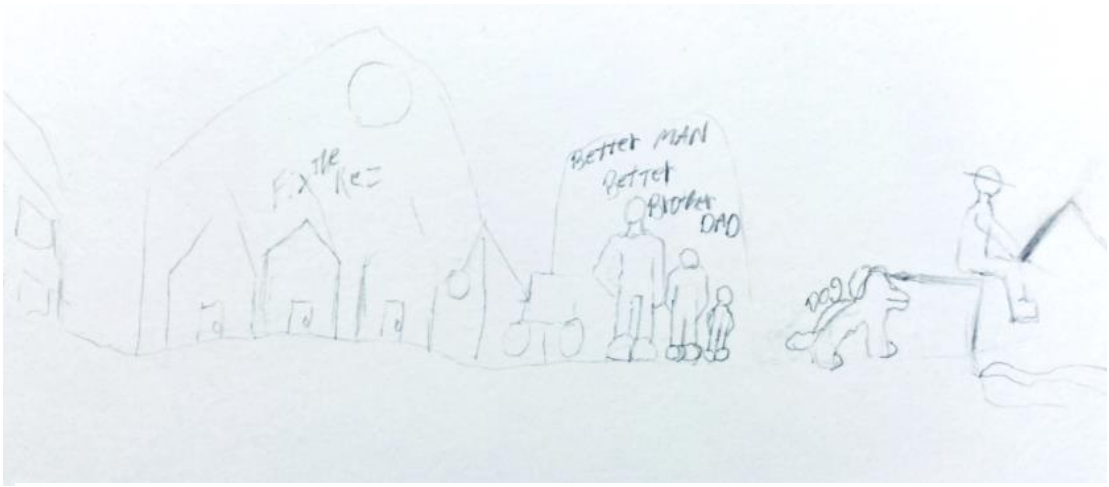

Figure 4.13 Carson's Future Timeline

looked like to him and reflected on his pattern of self-sabotaging relationships. When I asked him why he thought he did this, he stated that he knew he could not provide them with the life they would want, though having a career would help. His timeline ended with a picture of him as an old man with a dog, fishing off a pier (Figure 3.11).

To me, Carson's timeline is a visual representation of the journey of chaos he had endured throughout his life. Seen from a distance, however, the many smaller, colorful illustrations come together as one, and remind me of his personality in the way that he was always social, always colorful, and freely giving so much information that, in contrast to his bucket of grief, served to flesh out the many interruptions and vacancies in his life. However, just as Carson did for himself in this process, closer inspection of the images reveals a great deal of pain and loss. Many of the losses in Carson's life were brought to him by others—often other adults—whose decisions greatly affected him. He carries both his own grief and the grief of others with him wherever he goes. It is hard for me not to wonder about "what could have been if only . . ."

Figure 4.14 Carson's Post/Second Bucket of Grief

When we met to complete Carson's second bucket of grief (Figure 4.14), a number of weeks had passed because his unit had been quarantined due to a COVID-19 outbreak. He drew the second bucket without saying much and in a hurried manner. Although he wrote a shorter list of losses, the imagery of the second bucket captures more of Carson's losses, compared with having only illustrated bereavement losses on the first bucket. Now the bucket recorded Carson's insights into other types of losses he had experienced, such as family, relationships, opportunities, finances, and freedom. Where the bands of color once were positioned as lines and fragments in a sea of empty space, now the bucket appears more complete, integrated, and ordered.

A portrait of Carson. My portrait of Carson represents my perception of him as a person who must always carry the weight not only of his own grief but that of others as well (Figure 4.15). So much weight, in fact, that there is great physical pain as well as mental anguish. The figure in the portrait carries the large, heavy bucket on his back and across a bridge that is not sturdy. Thus, every move must be well-thought out because there is no support underneath him. Even as he moves forward, the bucket keeps filling

Figure 4.15 Researcher's Portrait of Carson

up with new things landing into it. This artwork acts as a guide to remind me that behind his colorful and kind disposition is a man going through life under the crushing weight of generations of losses.

My questions for this portrait are: Is there a creative way to take the heavy burden from your shoulders? With all these losses, can you put that filled-up bucket somewhere safe? As your art therapist, can I take some of the load for you? What would it feel like if you had solid ground beneath you instead of a janky bridge that has provided nothing to support you?

When we met to review the case vignette, Carson listened to what I had written and began to cry. I asked whether there was something in particular that had moved him to tears, wondering if hearing it "all at once" instead of having processed his losses over the course of weeks was overwhelming. He stated that the thing that bothered him most about his history was the sexual abuse. He wished he could have handled it differently. We discussed the possibility of him forgiving 9-year-old Carson for not knowing how to handle a situation he should have never had to deal with in the first place. We planned to continue meeting to work on his grief, starting with the loss of safety and grief from subsequent trauma. He seemed to ease somewhat with a structured plan in place for

continued art therapy and felt that drawing would continue to be a safe way to unload his bucket of grief and loss.

Liam

Liam is a 27-year-old man who has been at MMHI for 5 years and is under a life commitment for a capital offense in which he killed his father during an untreated, delusional event. He was subsequently diagnosed with schizophrenia. He stated that before the offense occurred, he had never received mental health care despite experiencing increased paranoia at the time. Liam also had a history of alcohol and cannabis abuse.

I had worked with Liam previously in a group called Blank Canvas, which is a 2-hour, open studio program in which the patients gather to have unstructured time to work on their choice of art projects. The group could not meet after March 2020, due to the pandemic. However, prior to the shutdown, Liam rarely if ever missed a Blank Canvas group. I had experienced him as always friendly to peers and me, but he was quiet and tended to focus more on his art. His choice of projects alternated between drawing, painting, and creating in sculpture. No matter what he chose to create, his work was always very detailed. Although he was allowed to have art materials on the unit, he explained that "no brushes were small enough for the detail work," and he would create paintings by using just a few strands of his own hair taped to popsicle sticks. He always worked in very small detail on large paintings and drawings.

Liam's Portrayal of Grief and Losses. During our first session, Liam was quiet and focused on completing the bucket of grief (Figure 4.16). Because I knew him as typically detailed in his work, I was surprised by the straight-forward way he chose to fill

his bucket, by creating thick lines. They bleed into each other in some areas and are not filled in completely. He mentioned that he had never used oil pastels before and decided to give them a try.

As he began coloring in the bottom layers of the bucket, we discussed his family tree, including his mother, with whom he speaks regularly although she lives in the southwest of the U.S. Liam explained that he was the youngest of three children, with an older sibling who lives out of state but only a few hours away and with whom he speaks weekly. He had not spoken to his oldest sibling since his offense. Liam stated he knew very little about this sibling as a result, and was unsure if they were married or had children. I asked whether he would have heard such news from his mother or other sibling and he replied, “I’m not sure.” About halfway through the hour-long session, he became frustrated by the smeary aspect of the oil pastels and decided to start over, redrawing his bucket. However, he again elected to use oil pastels and in the same, hurried manner as his first bucket. We did not get to discuss the art work, as it was the end of the hour by the time he created then recreated his bucket.

Figure 4.16 Liam's Pre/First Bucket of Grief

During our second session, Liam reflected on his bucket of grief and discussed the losses he had identified. His list included the death of a cousin in an accident, his dog's death, the divorce of his mother and father, the loss of his siblings when they moved away after the divorce, his "relation-shi*s" with his parents, and the loss of his father. He then added "freedoms" and "more freedoms." Although Liam can read above a high school level, he has been working on his spelling with staff. The misspelling of "relationships" was not intentional but it was an interesting mistake.

Liam's parents divorced when he was 7 years old. The three children were allowed to pick with whom they wanted to live. His two siblings went to live with his mother and Liam chose to live with his father, explaining that at that age, he "didn't really know" his mother because she worked the night shift and had to sleep during the day. He added that even after the divorce, the weekends he went to his mother's house were always "awkward" because they did not know or talk to each other. The image of 7-year-old Liam feeling "awkward" around his mother struck me as very sad. He also associated "covid" with the loss of having "more freedoms" in his bucket, given that the virus had taken away so much at MMHI, such as having visits, receiving packages, ordering out, and leaving the unit. He was the only participant to identify losses related to the pandemic during the study.

Liam identified the murder of his father as the biggest loss for him; not only the loss of life but the fact that it led to all other losses, such as freedom and family. As Liam spoke of this painful event, he became tearful and quiet. I reminded him that one of the goals for the research project was to better support those who, during a mental health crisis, had taken a life, and the impact of that event in the context of disenfranchised

grief. I understood that having a severe mental illness can create many losses for people; those who have committed a capital offense while in the throes of a mental health crisis may have further losses that clinicians sometimes fail to recognize. I let him know that although the research study would be no magic wand to give him some relief from the grief, my goal was to help. I told him we could continue to meet long after the study if he thought it could be helpful. That is, I was not going to leave him alone in his sadness, but would try to help him through it as best I could.

Over the 2 years that I have worked with Liam, he had always been quiet but also pleasant, flashing an occasional smile and even making a joke at times. However, I had not experienced him sharing his feelings. I had never seen laughter, let alone tears, and therefore this was an unexpected moment.

During the next few sessions, Liam created his timeline. At first he sat for some time, staring at the blank piece of paper. Then he took a ruler and used it to draw a straight line on which to write the words that would comprise the timeline. Except for some discussion about current events and music, he was quiet as he worked and proceeded in his usual, focused manner. He did not speak unless asked a question or when he brought up something about the paintings he was working on in his room. Because he had opted for fine-tip markers to draw with, and because Liam always worked in fine detail, I assumed he was drawing small details on his timeline when I noticed him hunched over working.

At one point, I asked about his oldest sibling, and Liam replied that he doubted he would ever talk to them again because they wanted nothing to do with him. I asked him if he thought it would be helpful if his family understood mental illness better. “Yeah, probably, but [the oldest sibling] would never bother to take the time.” Then the topic of forgiveness came up. Having caused the death of their father, Liam did not believe his sibling would ever forgive him. When asked who he needs or wants forgiveness from, he said “no one.” After a minute or so, he reflected that maybe he would want forgiveness from his father, but did not think that was possible, as “he’s gone and it wouldn’t change anything, so forgiveness doesn’t matter.” Liam had always been forthcoming when asked, but in this instance there was something in his tone that made me not believe him. His stated “not caring” about receiving forgiveness seemed like a façade; however, I did not push the matter further.

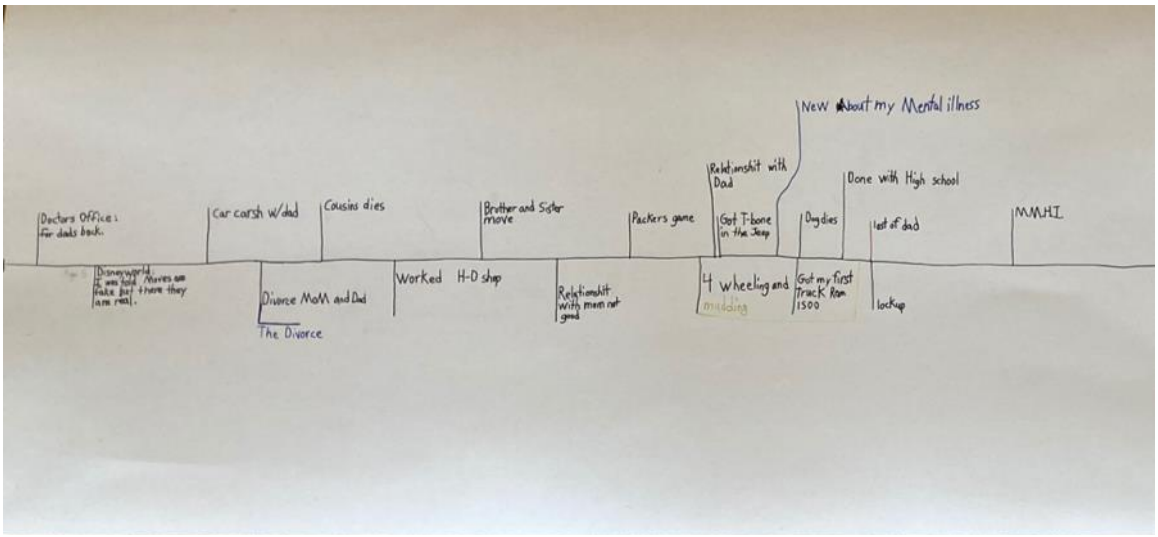

Figure 4. 17 Liam’s Timeline

He then told me he was done with his timeline (Figure 4.17). My initial reaction was actually a little surprised. The timeline had no images, only words. It had a very straightforward organization: the content is displayed in straight lines, with a few off-

shoots and words to name a given event. When I prompted him to tell me about the timeline, he stated that he could not remember dates for any of it, but had put things in the order he remembered. He said that his favorite thing on his timeline was "four-wheeling" to which he added the word "mudding" in yellow. The worst part was "loss of dad," which he drew with a red line leading to it, the only other color on his black-and-white timeline at this point. Between that event and the next, his incarceration at MMHI, there is a large space, with another large space leading beyond it.

I asked him, apart from what had happened to his father, was there anything that he wished he could change? He replied, "the divorce." When I prompted him to add anything that he felt was missing from his timeline, such as things that did not happen but he wished were there, he added "[k]new about mental illness." With this addition, he reflected that had he known about mental illness or been aware of why he was having paranoid delusions about his father that led to taking his life, his father would still be alive and his life would be vastly different. There was nothing else he would add to his timeline. I told him I was surprised by the fact that, because he enjoyed drawing and painting so much, he had created no art imagery on his timeline but used words instead. He explained that because of the hour-long time limitation for the session, and knowing he would want to add more detail, he decided not to add any art at all, feeling that he would not have time to get very far. I asked how he felt looking back over his timeline. Without emotion in voice, he simply stated, "it's fine."

When I challenged him to add a future to the timeline, he was hesitant at first, from feeling that he would "be here forever" at MMHI. However, after some encouragement, he added the words "get out," "sell artwork," "get a good job" (in red),

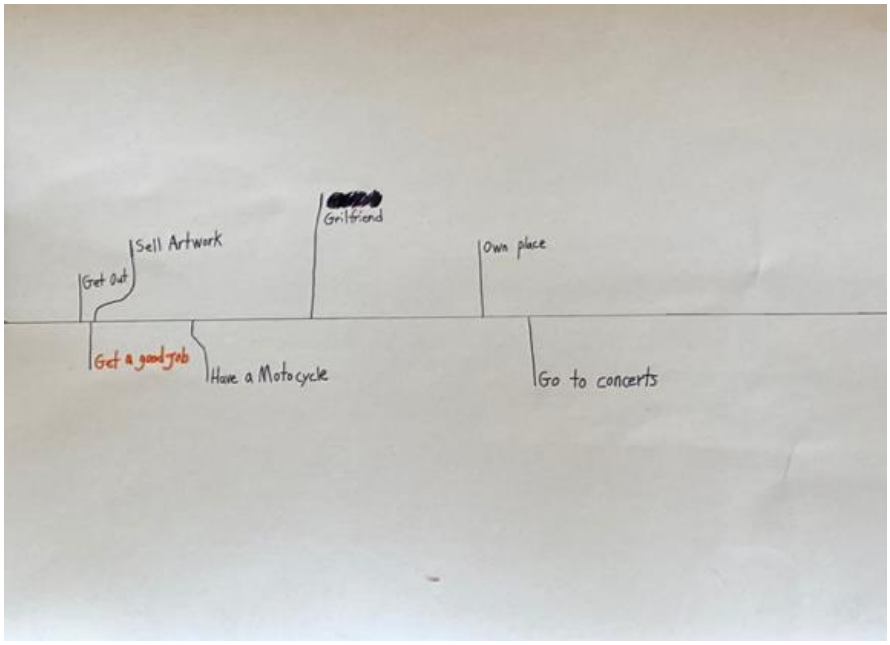

Figure 4. 18 Liam's future timeline

"own a motorcycle," "girlfriend," "own place," and "go to concerts" to the right side of the timeline (Figure 4.18). When I noticed there was no reference to family on the future timeline, he said that he used to want kids, adding "but now I don't because I don't want to pass along my mental illness. I won't get married. I can't commit to someone for a lifetime when I could end up back here at any moment."

I noticed he was really set on "coming back" to MMHI after he gets out, to the point that it kept him from thinking of any sort of future life. He described his feeling that even were he to leave on conditional release, he would only end up coming back, even if he did nothing wrong. He said, "people could just . . . not like me and make up something to get me turned back in. They won't believe me, and I'll be right back here." Having worked with Liam for 2 years, I find it hard to imagine someone turning on him in this way, given my experience of him as a soft-spoken, pleasant person. But then I must remember that, in the context of both self-stigma and public stigma, Liam had a valid point. He had no control over what others may perceive or feel about him, given the gravity of his index offense. Others who feared him could keep Liam from living in their

neighborhood or apartment complex, joining their work site, or whatever situation he might find himself in. Liam was the only participant in the study to bring up potential losses stemming from stigma.

Liam created his second bucket of grief at the end of the study (Figure 4.19) and I noted that it omitted the loss of his freedom and his dog's death that were on his first bucket. However, now he included "mental illness," which was not on his first piece. The grief from his severe mental illness takes up the largest portion in dark pink, over half of the bucket, whereas the loss of his father is proportionally less, placed below it at the bottom or base of the bucket in blue. He stated that even though the study had ended, he wanted to continue meeting to process his losses. I asked again which loss he thought caused him the most grief/discomfort internally, to which he identified the loss of his father. He reflected that usually when the loss of his father bothers him, he lays in his room all day, unable to paint and not wanting to be around people. He did not sleep, he just laid on his bed. In response I asked him how he

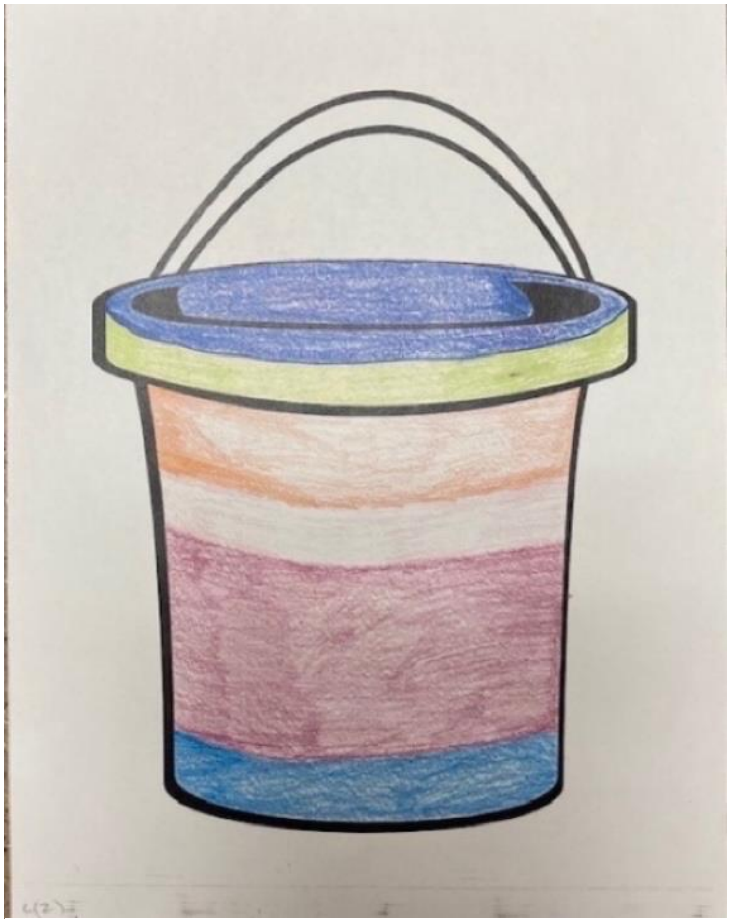

Figure 4. 19 Liam's Post/second Bucket of Grief

would feel about doing a piece of artwork that honored his father, such as a portrait. He replied that he did not think he could do that just yet. Then he recalled his favorite memory of his father, which had to do with a car he had built. Liam thought he could perhaps do a portrait of the car.

As I looked again at his second bucket of grief, I noticed that he had used colored pencils instead of the smeary oil pastels that had frustrated him in the first session. I considered whether he felt he had somewhat more control now that he had a plan for feeling some relief from his grief.

Liam's timeline presented his story of grief and loss in a way that was devoid of art, emotion, story, or memories. However, even without the details I was so used to coming from him, his timeline helped create treatment plan of sorts for his grief in a creative manner. It also gave me insight into his life before his offense, which he rarely discussed in group. While Liam created it, I was honored to hear his stories of his childhood or his favorite memories. The timeline even provided the opportunity to teach me about what life growing up in a rural area was like, or what "mudding" is (which is riding around in big trucks through muddy trails).

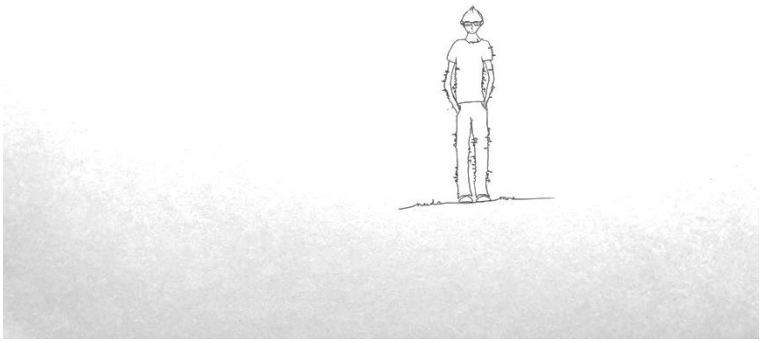

Figure 4.20 Researcher's Portrait of Liam

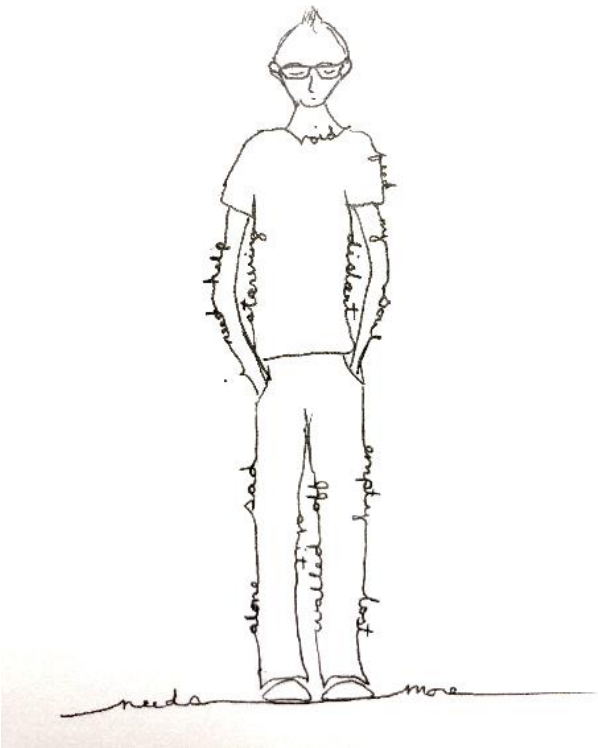

Figure 4.21 Portrait detail

A portrait of Liam. My artistic portrait (Figure 4.20) of Liam reflects that initial feeling of the void I felt: the figure stands with his hands in his pockets, alone in a vast, empty space. I did not add any other images. I purposefully used a very fine-tipped pen as a way to better understand Liam's process of working in such fine detail. It is a time-consuming process, which reminded me that Liam felt he would be here for life, which must seem like a very long time. At first glance, the portrait might seem empty or alone, but closer inspection (Figure 4.21) reveals details that might otherwise be missed. The lone figure casts his eyes downward; he stands upon a line formed by the words "needs . . . more." The contour line that forms the figure is comprised of words to illustrate emotions that might prefer to stay hidden, such as the desire be forgiven or to feel better. Also used are words that described his artwork and stories, such as "void" and "empty."

My questions for this portrait are: How might art therapy or the MMHI staff fill in some of the gaps of support that seems to be missing for you? What would that support look like? Should I add people around you, or color inside your lines? As your art therapist, how do I fill in the distance between you and me so that you are not so far away and seemingly untouchable? Why is there so much distance between us?

When I met with Liam to read the case vignette, he sat quietly listening. I would stop every few sentences to check to see if it sounded accurate to him. About halfway through, I looked up and saw that he was crying. I stopped and checked in with him. He said he was missing his father and his life before his mental illness, which had caused such loss. We discussed his feelings of being so far away from feeling any relief from his pain and went over our plan for continued meetings for grief and loss-based art therapy. He eased somewhat then and told me I could continue reading. We finished the vignette and then studied the portrait. I explained the symbolism of being distant from the viewer and he agreed that he did not ever discuss his offense or the circumstances around it. He remarked that he always guarded that part of him out of fear of being judged by others. He acknowledged that the thing he kept at the greatest distance was what had caused him the most pain. Perhaps over time, the art will provide a safe way for Liam to explore that distant part of himself.

Keith

Keith was initially hesitant to participate in the study with me. He expressed wanting to do some grief and loss work, but was unsure about art therapy, having "never done art before." After talking to him about the art therapy process, he decided he would give it a try. I had not worked with Keith before, but had met with him a few times. He is a Black man in his late 20s with a diagnosis of schizophrenia. He had been at MMHI for 3 years. He had a capital offense for killing his father while experiencing a psychotic episode.

Keith is someone who seems quiet upon first meeting him, then opens up and becomes quite talkative. His peers and the staff enjoyed him. Even with a face mask on

(required by COVID-19 protocols at the hospital) one could tell when Keith was smiling. His eyes radiated warmth and he always seemed to have a smile. He had a laid-back demeanor and engaging sense of humor.

Keith's Portrayal of Grief and Losses. During our first session, I explained the bucket of grief directive and he asked several follow-up questions about it. He then began to work on it very quietly, except for when I asked him a question. He told me that before his offense, he had worked at a cancer clinic. "You know the machines that people get hooked up to for chemotherapy? That's what I do: I get the patients set up on those." He explained that his mother had passed away due to cancer, which motivated him to become interested in learning more about it. Keith hoped to go back to working the same job upon his release. He then described his family tree: both his mother and father had passed away, and he had three sisters whom he talked to regularly and a brother who had not spoken to him since the murder.

Figure 4.22 Keith's Pre/First Bucket of Grief

Keith was the participant who was most hesitant to work with me while taking the longest to complete the art directive (Figure 4.22). Although his list of losses only had six items, his

bucket is very detailed and precise. He filled the bucket with three rows that each had eight swirls, and he was careful not to let any color fill in these swirls. He explained that the swirls represent the loss of freedom, which he said took up 50% of his grief and was his biggest loss. There also are two wavy lines that cut across the middle of the bucket, separating the swirls from a pattern of six bold, vertical lines. He did not state what these lines at the top represented to him, nor did he identify his severe mental illness, which had led to his crime, as the root cause of his loss of freedom.

Over the next few sessions he worked on his timeline using the metaphor of a city skyline. His list of events to include on the timeline sparked a number of conversations. He discussed his love of all kinds of music and he referenced the many concerts he had gone to. I asked what concert he would see today if he could and he said Kevin Gates, an artist I did not know. He proceeded to educate me about him. His list of events and memories had many items on it, including the "night Tupac died" and when Keith got his first car. Although he did list going to jail, he did not include the murder or his mental illness.

When I asked him about a car he was drawing, he told the story of buying his first car and how much he loved it. He was unsure where it was today or who might have it. There seemed to be much emotion tied to this car but he did not explain it further. He was very engaged when drawing the car and when he was finished he exclaimed, "I don't think I've ever drawn anything this good before!" He smiled with pride for his work.

Figure 4. 23 Keith's Timeline

When Keith finished his timeline during our fifth meeting (Figure 4.23), he enjoyed pointing out all the details he had added, such as the basketball hoop and the road for the car that rises behind it on the timeline. He had organized the events along a ground line placed in the center of the paper, holding up the skyline of Milwaukee on the left and the basketball hoop, car, and a key with the jail on the right. He then took a blue marker and filled in the bottom left half of the picture with blue water below the cityscape and drew his name in block letters below on the right (which has been redacted in Figure 4.24). These water and the name elements were added seemingly impulsively,

Figure 4.24 Keith's Finished Timeline

as if he felt he needed to scribble out a mistake. However, there was no mistake; it had been a blank space in the picture before this addition. Keith said that it simply did not look finished to him. It was interesting to note how detailed he was with the buildings, having taken so much time working on everything, only to complete the timeline in such a rushed manner at the end.

When he was finished with his timeline, I ask him what was missing that he wished was there. He replied that he wished he had added school, such as high school or college. After a few moments, he reflected that he realized his family was not represented anywhere on the timeline and that perhaps they should be. Then he said he wished he could remove the water he had added at the end, saying that he did not swim, did not like water in general, and did not like how it looked on his drawing. Finally, he said he wished he could take the image of the jail off his timeline, but did not talk about it further.

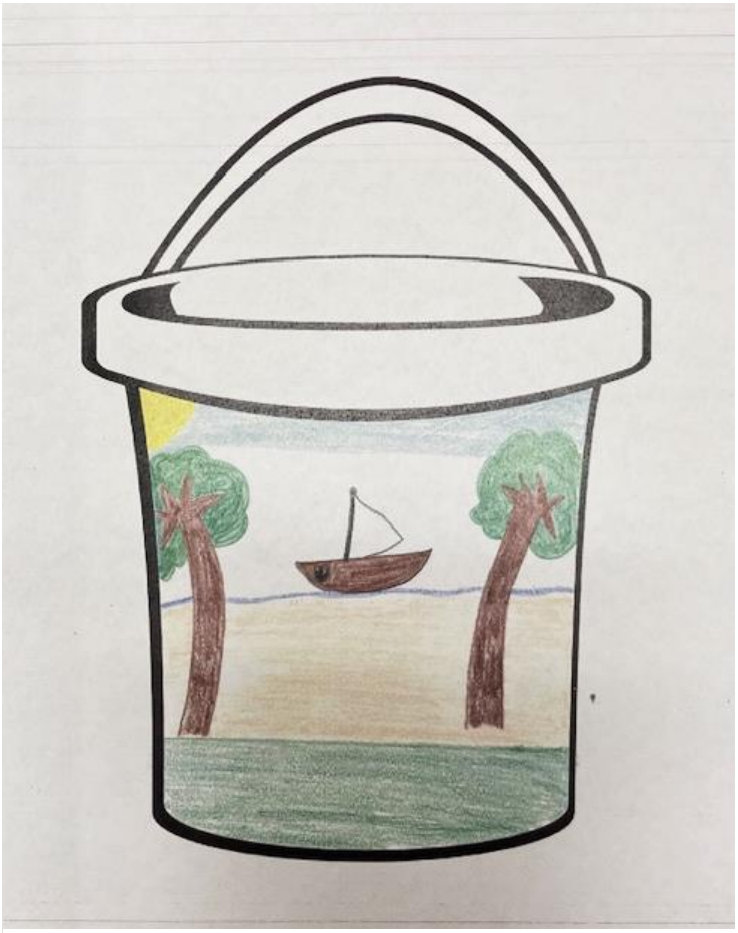

Figure 4.25 Keith's Post/Second Bucket

During our last session, he created a second bucket of grief (Figure 4.25), again taking time to create a list of his losses as he did before. Then he flipped the

paper over and began to draw. He worked with the same detailed and focused engagement as he had previously. Within the image of the bucket he created an entire scene, placing a sailboat in the center, enclosed by two trees in the foreground. Keith explained that the boat was floating out in the water. I asked him who was driving the boat and he replied, “No one. It just has to go where the wind blows its sail.”

I felt Keith’s image of the boat profoundly, considering that he did not like the water. Here he had expressed his loss and grief as a lone boat with no captain. The boat is framed by the two trees bending away from it. Perhaps they represent his family tree, which was missing from his timeline, or his deceased parents. The viewer sees the boat from very far away, as if viewing it from the shore while standing on solid ground. I shared the feeling the image evoked for me, saying, “If someone doesn’t like water, it must be scary to be a boat with no captain and have no control over where you’re headed.” He took this comment in and grew very quiet. We noticed that he did not use much blue to make the water in this image, rather it is just a thin line. This thinness added to the feeling of distance from the viewer.

Continuing our mutual contemplation of the image of his grief, I ask him how he felt about forgiveness and he stated he would like forgiveness from his father and family but was unsure of “how to get there.” I pulled out his timeline in response and asked him, “If you could add to it, and add a future, what would it look like?” He replied that when he gets released, he planned to go to church and Bible study, as reading the Bible had been a source of comfort and distraction for him since being “locked up.” He also would want a decent job—hoping for his old job back at the cancer clinic—and an apartment. He added that he wanted to get to know his nieces and nephews. At the

close of our final session, he asked if we could continue meeting. He wanted to work on the idea of forgiveness from his father but was unsure how to proceed. We discussed the idea of making a painting to honor him and scheduled future sessions.

Keith's artwork reveals that there was much more going on behind his kind smile. His two art pieces of the bucket of grief give insight into the time his grief took from him inwardly and detail the losses that have piled up one on top of another. His timeline shows the viewer a solid and loving foundation while it illustrates all that was lost to his mental illness. The solid patch of water, which Keith mentioned several times that he disliked, was added in haste after the detailed timeline was complete. Perhaps this impulse represented the onset of mental illness with its power to erode his foundation, as well as the unknown or fear and misunderstanding that his illness caused in his life.

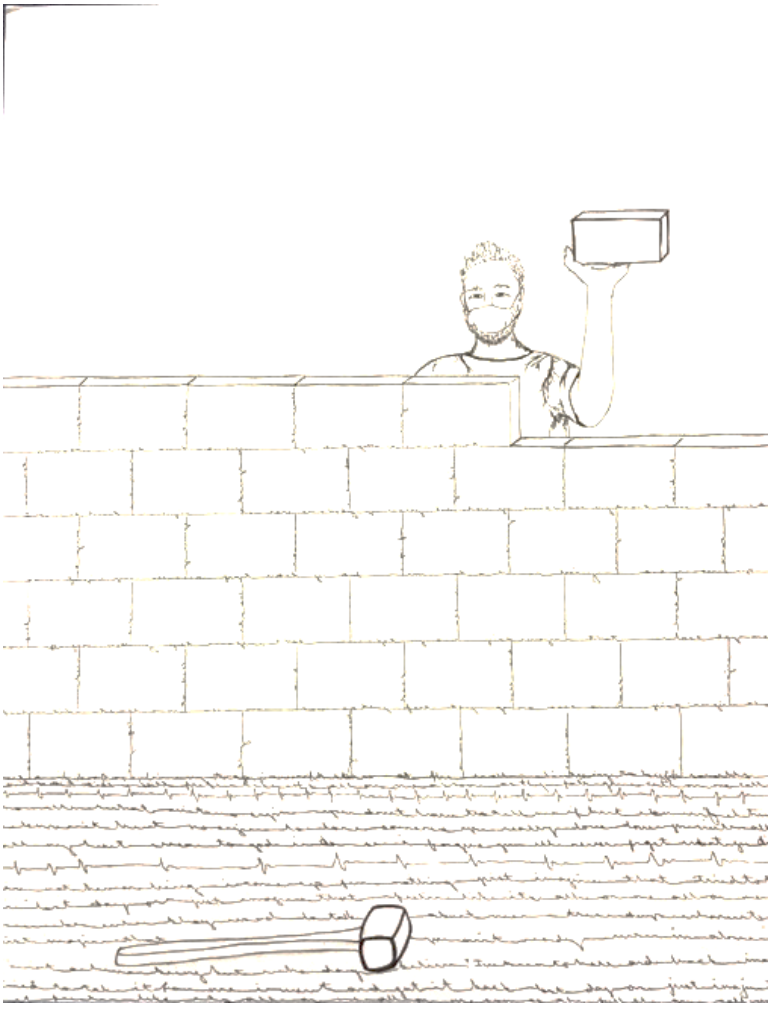

Figure 4.26 Researcher's portrait of Keith

A portrait of Keith. My artistic portrait reveals an image of Keith building a wall (Figure 4.26). The bricks are made of lines from the lyrics from a Kevin Gates song

that often could be heard in the background while Keith was working on his art. The song discusses the ideas of forgiveness even though wrong-doings can never be forgotten about. It also hits on the idea of missing someone who is still alive. Keith seemed to struggle with the idea of forgiving himself for taking his father's life. He also seemed to grieve one of his siblings who is still alive but has not contacted or communicated with Keith since the offense. In the years since he has been living at MMHI, he has never once discussed his index offense or the pain and losses it created in his life. He rarely mentioned schizophrenia or talked about what it was like for him when he first felt symptoms. I drew a wall that he has been meticulously building up around him. There is a tool in the foreground that could be used to break it down. But it is unclear if he or any other person or intervention has the power to wield the hammer and start knocking down the wall.

My questions to this portrait are: Does the wall built up around you need to be torn down, or built up even more? What benefits would tearing it down have for you? What if I'm wrong in my assumptions and it shouldn't be torn down? If you want to stop building it and to tear it down, what is the best tool for you to do that?

When we met to review the case vignette to ensure its accuracy, I showed Keith the portrait and read these questions aloud. He agreed that he had built up a wall, as he never openly discussed his offense, not even with the peers he considered as friends who live on his unit. He did not know what it would feel like to take down the wall because he had never considered doing so. It was at the end of this meeting that he looked at me and said, "I guess we have an idea for what my next painting should be." We have been

having individual art therapy sessions since the study, and he has started a painting of what forgiveness from his father looks like.

Analysis of Grouped Artwork

Individual case studies offer an in-depth look at each participant's history, story, and artwork. However, when I compared and grouped the work into subcategories, additional insights emerged that could be considered for the study findings. Most evident were the three individuals (Neil, Liam, and Keith) with schizophrenia whose timelines included large areas of black and white. As a thought disorder, schizophrenia is characterized by thinking disturbances involving "loose and indirect associations, overly abstract or concrete responses, illogicality, inappropriate intrusion of personal material, and unusual word usage" (Subotnik et al., 2006, p. 85). In consideration of how such symptoms could affect treatment in grief and loss art therapy, the areas of black and white could reflect concrete thinking. In contrast, the two participants whose mental illnesses were not schizophrenia did not have areas of black and white on their timelines.

Additionally, the three individuals with a schizophrenia diagnosis used very bold colors for their first buckets, whereas for their second buckets they all opted to use fewer colors. Their second images radiated a sense of calm when compared to their first images. It is possible that working with the concrete, orderly structure of a timeline helped them to organize their feelings around their disenfranchised grief and aided in creating some internal stillness that came through in their second bucket drawings.

As for my portraits, I noticed that I unintentionally mirrored some of these same elements. For example, the many black and white brick buildings of Keith's timeline also appear in the image of the wall I created between us out of black and white bricks. Both

Liam's timeline and my portrait of him look sparse at first glance, until a closer look reveals many details. Additionally, I placed the image of Liam standing on a line, which mirrored the foundation of his timeline. I purposefully included Neil's artistic style in my portrait; however, I noticed that he is in a cell, and this and other geometric shapes are repeated in his timeline. Finally, the portraits for these three individuals are rendered purely in black and white. In comparison, for the two individuals who did not have a diagnosis of schizophrenia, I had added color: lightly on the clothes of Robin and prominently in Carson's image.

The most striking thing I noticed when I re-grouped the art to compare the works was that the two participants with a capital offense had a number of similarities. Both had very bold colors for their first bucket and very soft, almost pastel colors for the post-intervention bucket drawing. Neither participant had much to change on the written list they made for each of their buckets, however the before and after buckets were very different from one another. My sense when viewing these pictures together as a sub-group is that these men did not feel they were allowed or had the right to grieve their losses, despite several weeks of meeting with me to explore that very possibility. Their lists of loss were simple and almost unchanged. I wondered if, despite now having the vocabulary and insight to identify their ambiguous losses, they were still feeling the disenfranchisement of their grief. Perhaps internally they were recognizing the losses created by a history of mental illness but externally were still unsure if they were allowed to list these losses. The boldness of their first buckets suggests to me a need to grieve, whereas the softness of the second buckets could indicate a feeling or start toward

acknowledging and experiencing their losses and corresponding grief, despite their unchanged lists.

When the two men's timelines are compared, one sees different drawing styles but very similar compositions. Even the evenly dividing ground line matches up almost perfectly. Interestingly, the tallest point on Liam's timeline, where he wrote "Knew about my mental illness," is about the same spot as Keith's tallest timeline point. Other than the solid block of blue added at the end, Keith used very little color. Likewise, Liam's timeline is composed mostly of black and white with a few words written in color: blue for what he wished he could change; yellow for his favorite thing; and red for the worst thing on the timeline.

When I invited other staff members to view all of the participants' art, the two images created by Liam and Keith evoked a similarity of sentiments, including: "empty," "incomplete/blank," and "black/white versus colors." The concrete thinking that can be associated with schizophrenia may account for the line through the middle of the paper the men created when tasked with drawing a timeline. The flow is also interesting in that the highest point of each timeline seems to come at a similar point, precisely where the capital offense had happened for both.

My portraits also reflected some similarities that I did not realize until after I studied them next to each other. Both have an obstacle between the figure in the portrait and the viewer. Similarly, in the art of Liam, there is a great distance between the viewer and the image. I created a wall of bricks for Keith in my portrait and a tool that does not seem accessible to him. This reminds me of the sentiment I have heard from other patients with capital offenses: in addition to not feeling worthy of receiving treatment or

recovering, they do not have access to the right tools or may purposely block their access to the tools that could help them feel better. As someone with such an offense once said to me, “I deserve to sit and wallow in my own pile of sh**.” It is important to offer them tools that could help them find their self-worth, and once they feel worthy of feeling better, have the tools in hand to help them break down the wall, bridge the distance, and/or process their grief.

The artwork of the participants in the study served multiple functions. It provided a platform for discussion of the many stories or memories evoked, which might have gone unsaid without the opportunity of creating a visual timeline to initiate the conversation. The artwork helped tell these stories in a contained and private way: they were not being scanned into a medical chart and were only shared with the participants’ permission. Even though viewers can see the timelines, the participants’ identities and many details of the stories are nevertheless safely contained in the multiple meanings of each image or symbol. The viewer sees these images and symbols, of course, but without hearing the background story of what the artists were depicting, the viewer cannot decipher exactly what the image is about. Importantly, the artwork also furnished some freedom and control around the narrative of the artist’s history. The artists’ chose what to put on their timelines and chose what, if anything, they wanted to share about it. In an environment such as MMHI that can at times be harsh and restrictive, where the patients cannot go outside for fresh air unless it is scheduled, having such an opportunity for control can be empowering.

Creating portraits in response to the participants’ stories had benefits for the research study as well. This process emerged from my research structure; coming about

organically as a way for me to make sense of what I was experiencing during this journey, thereby functioning as a valuable structure for data analysis. In parallel with the participants, my artwork provided containment for the overflowing data of their stories, memories, pain, loss, grief, and evocative imagery, along with my own thoughts and reflections from our sessions that contained tacit knowledge that was relevant to the multiple case study.

Additionally, the metaphors that came into the portraits helped guide me to better hold the therapeutic space for each participant. The questions that arose from the portraits were valuable as an aid in my future grief work with these participants by providing goals to work on or a matrix to follow. All the participants validated the case vignette I wrote and viewed the portrait I had made of them; all had positive reactions that affirmed the presentation of their grief and loss as residents of a forensic psychiatric hospital. Moreover, they each had their own ideas of how to best help the person in the drawing/corresponding portrait. Robin suggested "organizing and regluing" the words; Carson thought it would be best and easier to carry his bucket of loss if all of the losses it held were redistributed into smaller buckets; Neil thought of connecting telepathically to the person in the image to let them know they are not alone; Liam wanted to bring the person closer, to be able to read the words better; and Keith wanted to explore feelings around building the wall taller versus tearing it down completely. Each gave me permission to use the portraits in the dissertation, an additional choice over sharing of their stories.

Cross-Case Thematic Results

The results that emerged from the case studies, the participants' artwork, and my own artwork were rich and insightful. It seemed that once the participants gained knowledge and vocabulary around the different types of losses and corresponding grief, their ability to identify these losses in their lives was less of a challenge. For example, severe mental illness was only listed by Robin in the first bucket directive, however everyone but Keith addressed it in their timelines. In their post-intervention buckets, again everyone except Keith included mental health as a loss they grieved. It is possible that before being introduce to the term ambiguous loss or the consideration of the grief these losses created, the participants were not aware they could include it as one of their losses.

None of the participants mentioned loss of dreams or future plans. This theme continued throughout the study, evident by the fact that none added a future to their timeline until it was suggested. However, while working on this part of their timelines, they all discussed hopes and hesitations for getting released from MMHI and that the feeling that having severe mental illness would hinder these plans. These discussions arose from the art directive, suggesting that these rich moments would not have occurred without the timeline providing the platform.

There were other prominent themes that followed this same pattern of omission (of their losses) that then manifested on their timelines, in session discussions, and post-intervention bucket directives. For example, none of the participants listed safety or a sense of security with their first buckets; however, as their stories unfolded during the timeline-making process, all revealed various forms of loss of safety beginning in childhood. These losses were brought about by such things as divorce, trauma from

physical or sexual abuse, moving, or losing a parent to a terminal illness. As adults, diagnosis of severe mental illness, incarnation, and loss of their permanent homes was the case for each participant, which I wrongly assumed they would identify as a loss or losing a sense of security. Although Keith, Liam, and Robin identified loss of freedom on their buckets, they did not associate this with safety, neither in their art nor in discussions with me. Similarly, Robin, Neil, Carson, and Liam all addressed their mental health diagnosis on their timelines, but again they did not connect it with a loss of the sense of safety.

Additionally, none of the participants noted loss of rites or rituals with their pre-intervention bucket images. However, each discussed both minor and major rituals they missed. Going grocery shopping, eating dinner at a restaurant, going to concerts, and taking a dog for a walk were common themes from all the participants. One participant even discussed a protein powder they had enjoyed daily before coming to MMHI and wished they could drink again. More significant losses also were mentioned in common across the case studies, such as missing out on holidays and birthdays. Carson noted different powwows he had missed, along with other rituals specific to his Nation. All of the participants had either experienced a bereavement loss or were anticipating one soon, due to an ill relative, and noted that they could not attend the funeral or related ceremony. Keith and Liam both discussed being in jail at the time of the funeral for the parent they had killed, and that they had not done any kind of ritual in honor of their loved ones' deaths. Additionally, neither felt they would have been allowed to attend, due to their families' wishes.

Connection to family emerged across the cases as a theme in a number of other ways as well. On their pre-intervention buckets, Robin, Carson, and Liam listed family

members who had passed away. Neil, Keith, and Liam all noted that they missed various members of their families. During the creation of the timeline, all the participants told stories about past and current family dynamics, their relationships with living relatives, and relationships they had with relatives who had died. The topic of siblings was a constant during the entirety of the study with all the participants. Each of the participants used the time creating their timelines to examine sibling bonds. Robin has one sibling from whom she is estranged; however, she discussed her sibling in almost every session during the study. Carson often discussed his weekly contacts with his younger siblings while pondering what life would have been like had he bonded with his older siblings whom he had never met. Missing out on the chance to grow a bond with his siblings seemed to be a regular source of anxiety for Neil, which he integrated as a feeling of "telepathy" with the sister he is closest to. That is, he communicates with her in his head daily so as to not lose that bond. Keith and Liam often discussed their weekly correspondence with siblings which was a highlight for both participants. Each also has one sibling who has not spoken to them since their offenses, which was topic that came up regularly for both of them.

Finally, the idea of forgiveness was a theme that emerged unexpectedly across all of the cases in the study. Although not specifically represented as a symbol in any of the participants' artworks, each participant brought it up in our discussions while they worked on their art, during the member checking process, or both. At the point in the process when each individual identified the loss of their mental health, they all examined how it had caused many other losses, such as the ability to trust themselves, their credibility with family or others, their freedom, and in two instances, the life of a parent.

Enright (1996) identified what he called the "forgiveness triad" in which forgiving others, receiving forgiveness from others, and forgiving oneself intersect. When a person believes that they have failed to meet standards put forth by various systems, such as a society, a workplace environment, or even a family system, they may feel shame and guilt so intensely that they become debilitating unless and until they receive forgiveness from others and themselves (Leach, 2017). Presumably, then, the desire for forgiveness stems from shame and guilt. When working with this population, exploring the ideas of forgiveness, shame, and guilt could be beneficial to include on their treatment plan.

The results of the cross-case analysis suggest that the guilt the participants felt grew from losses created by their severe mental illness. The most obvious example would be Liam and Keith's guilt for killing their parent, which happened during severe psychosis. However, it is possible that all the participants felt some level of guilt for the behavior that led to their offenses and for becoming so ill that they require long-term hospitalization. They may have harbored guilt for not being trustworthy while ill, for losing employment, losing their housing, not being a present sibling, missing holidays and events, and so forth. Having their artwork act as a visual aid in order to see how the loss of mental health led to other losses could be a valuable tool in the process of forgiveness. The art process could allow them, firstly, to lift some of the guilt by seeing severe mental illness' role in their lives, and secondly, to capture that guilt within a piece of art so they no longer have to carry so much of it within themselves. Art also may trigger a conversation about forgiveness. This result allowed me to recognize that guilt and forgiveness were a large part of what was unseen in the art but still present and in

need of addressing. The conversation led to the possibility for the patient that forgiveness was still possible and provided a plan for exploring this through future art.

The Art of Identifying Grief: Take-Aways

Looking back over the artwork and case notes from the study, there were a few important take-aways from the multi-case results. Firstly, with the exception of Keith, the participants' lists of losses changed from the pre-intervention to the post-intervention bucket directive. They were able to identify losses more specifically post study, in comparison to the general, broad losses pre-study. Importantly, by the end of the study, each could tell me how their identified losses fit into their life stories and what secondary losses or new growths arose from the initial loss.

Secondly, all the participants were able to identify and discuss how their grief from these losses manifested in their daily lives. When feeling grief from his identified losses, Liam stated he doesn't sleep or eat, but just lays in bed. Keith also noted that he lays in bed on days he's feeling grief, and imagines conversations with his father and sibling who no longer speaks to him. These conversations "play like a movie on the ceiling" while he lays in bed watching for the outcome. Robin admitted that when she's feeling her grief, she wakes up in the middle of the night and binge-eats. Carson becomes increasingly tearful and self-deprecating. Neil noticed that he isolates and punishes himself through self-sabotage. The particular way that each of the participants' grief manifests could easily be misidentified as sleepiness, depression, or a form of acting out. However, if the participants, unit staff, loved ones, and the participants themselves were more aware of feelings of grief and how these feelings can manifest, it could lead to

intervention and recovery from these moments by enfranchising the grief and treating it as such.

Thirdly, at the conclusion of the study, each participant knew how they wanted to proceed with their grief and loss treatment after creating the visual timeline. They each wanted to continue to meet and work on their grief, and they all seemed relieved to have a tangible plan in place for treatment that they themselves created. Each person seemed excited by the prospect of enfranchising and then healing from their grief.

Conclusion

In the next chapter, I will discuss the creative portfolios of the participants by putting these results into context and within a model of the grief cycle. I will review insights that emerged from what I assumed would be learned from the study in contrast with what actually arose as new information. I will investigate validity and the limitations of the multiple case study, and implications for future research and art therapy for grief and loss with forensic psychiatric patients.

CHAPTER 5: DISCUSSION

In my research, I sought to learn through case research how grief and loss manifests in a sample of people living in a forensic psychiatric setting, and particularly for those who have experienced ambiguous losses (Boss, 1999) and disenfranchised grief (Doka, 1989). I had discerned their effects in my clinical experiences working with the patients at MMHI, which led me to examine what grief and loss resources are available to art therapists working with this population. My review of the conceptual frameworks of both grief and loss theories and art therapy with psychiatric forensic patients provided only a partial explanation of what I had observed. Many art therapists and forensic psychologists have skills for grief and loss therapy; however, their respective professions lack the kind of hybrid inquiries that could produce effective tools to treat this population. By disseminating the results of this research study, I hope to provide the research community and other practitioners with a map of how art therapy that is centered on grief and loss could be a helpful intervention that recovers patients' empowerment and enfranchises their feelings of grief.

When I began planning my research, my intention was to examine the efficacy of art therapy in treating grief among forensic psychiatric patients with capital offenses. It quickly became clear that I needed to broaden my focus and explore how art therapy may be used to abate grief for this population in a more generalized way. There was no research available that looked at grief and loss art therapy with forensic psychiatric patients; therefore, nothing was available for me work from or compare with the subpopulation of capital offenders in this setting. Thus, my first step was to examine the

needs of grieving forensic psychiatric patients. I sought to build upon existing research and theories, including that of Boss (1999), Doka (1989), and Gussak (1997, 2004, 2014, 2016, 2020), by conducting a naturalistic case study that explored the area where contributions from these three researchers might overlap. The results of the multiple case study suggested that the participants had not perceived non-deaths as losses. However, once they were given permission, so to speak, to classify their severe mental illness as an ambiguous loss, they could order and put their life experiences into context, as well as identify their future dreams and feelings of safety and security as important losses in their lives. Finally, perhaps due to the many losses created by their mental illnesses, the significance of family and forgiveness emerged as very important factors to consider when treating their grief.

In this chapter, I will discuss these results by placing them into context, first by presenting a model of the grief cycle on which the results can be mapped conceptually. I then will discuss what I assumed would be learned from the research and the useful information that was actually gained. Next, I will explore the extent to which the study answered my research questions. Finally, I will discuss validity and the limitations of this study, and conclude with implications for further research and practice.

A Grief/Loss Model for Art Therapy Intervention

When I started my research, I had already begun to develop a tool that helped to illustrate a person's "cycle of grief" as it seemed to function in my clinical experiences with the population. Based on my review of the literature for how art therapy can be a uniquely successful intervention for many populations including forensics (Gussak, 1997, 2004, 2014, 2016, 2020) and for people dealing with grief (MacWilliam, 2017), I

postulated that art could be a valuable intervention. I prepared for the study by completing a pilot grief and loss art therapy program at my work site from which I began to map out how grief is conceived and could stem from ambiguous losses that built upon one another. I envisioned how the introduction of an appropriate intervention might help break or interrupt the cycle and move the person to a path of healing. I found it useful to sketch the model on a piece of transparency paper as a way to visually explain to others what I suspect happens when this cycle is overlaid across various contingencies in a person's life, such as severe mental illness, addiction, sexual offenses, or other challenges. Considering this model with the multiple case study, I now have a greater understanding of the cycle of grief; however, I also am aware that the tools for intervention will vary for each individual. The Cycle of Grief model (Figure 5.1), as I

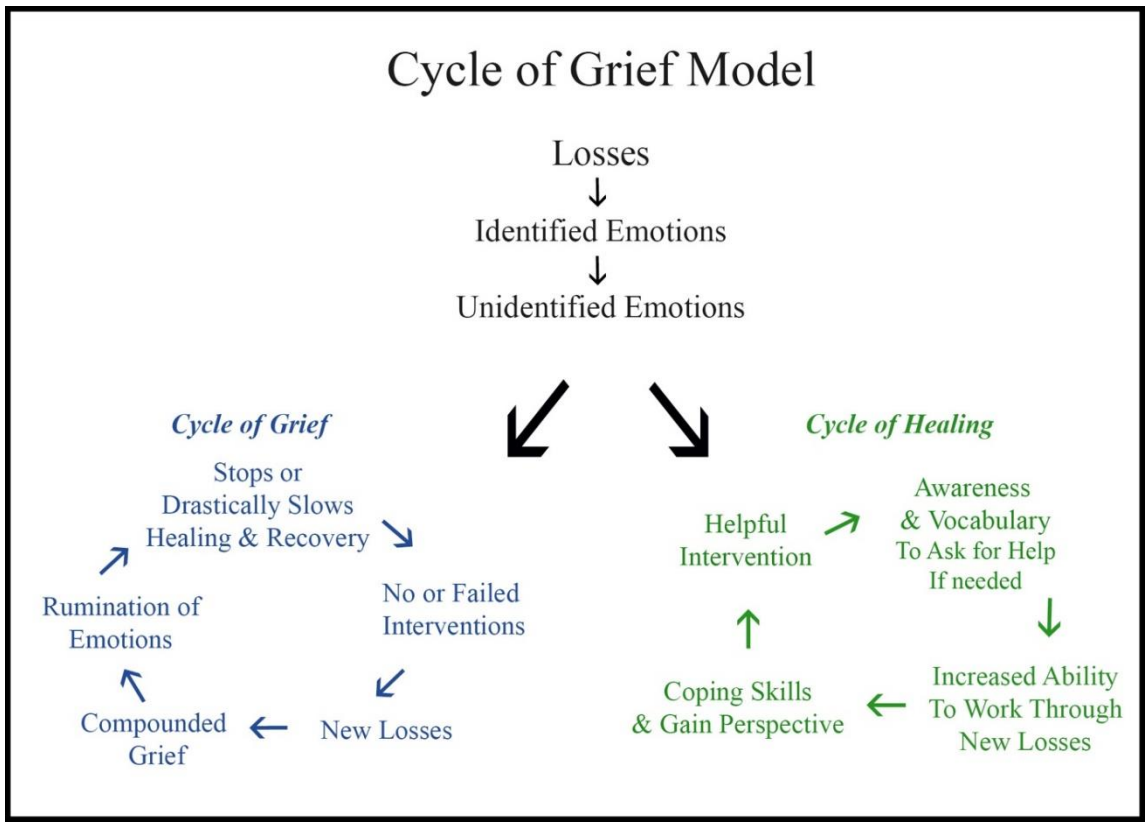

Figure 5. 1 Researcher's Cycle of Grief Model

have conceived it, highlights the likelihood that areas connected to earlier losses may be linked to or produce new losses and subsequent grief. Additionally, it maps out how a successful intervention can break this cycle. The results from the multiple case study appear to accurately reflect this idea. Specifically, the pre-intervention bucket of grief directive captured the participants' baseline knowledge and recognition of identified losses. The visual timeline functioned as a helpful intervention by providing the participant with a platform to explore how the losses they had identified at baseline were part of a larger picture. Through the process of working on the timeline, they explored what other, secondary losses grew from these memorable events. The participants also learned that these less obvious or ambiguous losses (Boss, 1999) have a name, which can create feelings of grief that are unacknowledged or disenfranchised (Doka, 1989). Because grief can manifest in many ways, it is possible that a grieving person can be overmedicated and misdiagnosed by medical professionals, most commonly as depression (Doka, 2017). Additionally, failure to properly diagnose can lead to unresolved grief, which halts the grief process, causing it to become chronic until treated (Doka, 2017). As Boss wrote, "ambiguous loss is typically a long-term situation that traumatizes and immobilizes" a person due to the nature of how these losses go unrecognized and untreated (1999, p. 7). Therefore, an intervention that properly identifies losses and recognizes the corresponding grief is vital for healing.

The model and the study both highlight a need to gain perspective. The visual timeline is a way for the participant to view their losses from different perspectives, such as when Carson discussed his sexual abuse from a child's view and then from 30 years later. Doing so created a potential for him to be able to forgive his 9-year-old self, which

has been shown to decrease anger and depression and improve overall mental health (Graham et al., 2017). Additionally, the timeline can illustrate what has grown in the void of a loss, such as when Neil noted that in losing his freedom, he broke a drug habit and his mind now feels clearer and his memory has improved. Gaining such insights could lead to new ways to treat current and future grief (Doka, 2017). The finished timeline and post-intervention bucket directive provided a picture for what an individualized grief and loss treatment plan for each participant could entail. The plan allows for future opportunities to work through the losses. It also gives structure to emotions that may have previously felt messy or out of control.

Analysis of Researcher Expectations

The Art Directives – Development of an Individualized Treatment Plan

I had expected that the art inventions I had employed (i.e., the pre- and post-treatment "bucket of grief" drawings and the visual timeline) would serve as the intervention needed to break the cycle of grief for each of the participants in the study and move them onto their path of healing. I did not expect that the directives would have any other role.

Where my expectations proved to be inaccurate led to major insights gained from this study. I had expected that the sole purpose of the art directives would be as a tool for dislodging the repeating cycle of disenfranchised grief. I learned that this was too narrow an expectation. The art directives were only the beginning of a much larger process of breaking the cycle. Rather than solely a tool to help interrupt the cycle, their larger purpose, I now believe, was the creation of a visual treatment plan for the participant's grief therapy. That is, the combination of the three directives created an effective,

accurate structure for treatment planning that provided both the therapist and the client with insight into what should be addressed as an immediate need versus what felt stable or supportive to them. Through creating and rank-ordering the list, assigning visual weight to each loss and in proportion to the whole, and evoking and talking through the surrounding stories of each loss, the patient gained the agency to define what was most important to start with in their grief therapy, from which a coherent narrative eventually emerged and became available for integration into their life story. Every participant reviewed the portfolio of their artwork at the end of final study meeting, asked for future sessions to continue the process, and came up with their own plan for what their first post-study artwork would address in therapy. I found that in each of these meetings the participant felt relief in the discovery that their often-chaotic losses were now organized and clear to them, contained as they were in the safe format of the art, and that we had a plan to tackle what they identified as their biggest cause of grief still residing in their body causing them anguish or pain.

The Empowerment of Co-Researchers

I no longer assert that art is the sole mechanism for dislodging the participant from their grief cycle. Instead, I found that the member checking component of the data analysis proved not only valid but very insightful and advantageous. Instead of a case study in which the researcher constructs and presents an abstract representation of its subjects, here the participants heard their story reflected back to them, often in their own words, and were asked to listen to ensure accuracy. This process was experienced as empowering: they had an important role in the research, as well as a say into what I included in story and what they wanted to be omitted. There also seemed to be a sense of

pride from being involved in the research process this way, which made them feel like the co-researchers they were. Further, it was an emotional experience for each of the participants to hear their condensed story juxtaposed with my own thoughts and insights as their creative witness. This added component, which Eisner described as the powerful "all-at-onceness" of art to convey a recognizable truth (as cited in Kapitan, 2018, p. 215), aided in bringing their grief into clear focus. It solidified the need for additional therapy in this area and confirmed our continued plan for treatment. The thought of relief from even some of the pain they harbored brought a few of the participants to tears.

The above point brings me to another expectation I held at the beginning of the research: that the length of the study would provide the participants with sufficient time to complete their grief work. Perhaps due to my own needs to conduct a doctoral-level study within time limitations, I naïvely assumed that the entirety of the study I had designed would be enough to mitigate the participants' grief. It should be noted that the original timeframe was 12 sessions; however, I had to amend the study length due to COVID-19 restrictions that affected my ability to meet individually with the participants. When I began formulating my research questions, COVID-19 did not yet exist. Despite that 12 sessions would have provided more time than the amended 6 weeks, based on the study results I must conclude that the longer timeframe also would have been insufficient in helping the participant move from the cycle of grief to the path of healing. This conclusion suggests the value of additional research to explore whether a particular timeline is needed or even determinable.

The Grief of Capital Offenders

I brought expectations to my sub-focus on the grief and loss experiences of capital offenders as well. First, I reasoned that because they had volunteered to participate, they would be willing to openly discuss and explore their offense, particularly in regards to additional losses the crime had created in their lives. I also assumed that trust between us would be established in the same manner as the other participants. For example, three participants discussed their index offense in the first or second session, without any prompting from me, whereas the two capital offenders never disclosed their offense to me. Although I knew their history before the study (as it is part of their medical record), I left it up to the participant to discuss what they were charged with and its circumstances. Neither participant with a capital offense told me why they were at MMHI, only referring to it as "the incident" or "my offense," and only Liam included it on his timeline.

Second, I had assumed that my overall expectation that art and art alone would be the tool that moved participants to their path of healing would be particularly true with those with a capital offense, given my experience of their hesitation to verbally discuss their losses in group settings. I expected that their relevant losses would appear in their art. Instead, I found that neither Liam nor Keith used the art directives to identify the loss of their loved one and corresponding offense. Liam did not apply his preferred, art-based skills to the directive, opting instead to create a starkly linear timeline and descriptive words. Keith used art but did not address the loss of his parent on his timeline. Moreover, family was not on his timeline at all, which was something he noted after completing it. Instead of the art-making process, member checking seemed to function as the more beneficial tool for both of the capital offenders. Certainly, it was a poignant process for all the participants; however, Keith and Liam were particularly moved by hearing their

story read back to them, evident by their tears, silence, and broken voices. It appeared that they became open and vulnerable when hearing their losses highlighted in the condensed format of the case vignette and portrait. Perhaps hearing their story mixed with my personal reflections on whether and how their offense may have caused losses illustrated in their art modeled a missing connection that they could take in as insight and with relief. Thus, I found that the validity structure of member checking was a more effective tool than the art directives in terms of interrupting their grief and shifting towards healing due to the evidently cathartic process of hearing their story reflected back to them in such a way.

The Importance of Portraiture

Finally, I had expectations for myself as a researcher that interacted with my clinical skillset as an art therapist. Creating art as a process of reflection and discernment is something I do regularly in my practice. In fact, I created response art during our sessions throughout the study. As the participants worked, I would take one of the bucket printouts and fill it in for myself, thinking that these images would be valuable in the study's data analysis. However, when I created the case record and began analysis by writing the vignettes, the response art I had created was not much help to me. The data collected from weeks of individual meetings, case notes, evocative narratives, and evolving artworks, left me with abundant information to sort through. It reminded me of when Robin, while writing every detail of her childhood she could remember, told me, "it's all relevant." What if I omitted something that was glaringly important? The only strategy that could shift me was the creation of the artistic portraits. They gave me a focal structure and an accurate, centering lens from which to capture the most salient aspects

and information from the stories they shared with me. I now realize that the images I created are not a portrait of the participants; rather, they are a portrait of each of the participants' current reactions to their grief. Creating these images allowed me to clearly see how the patients' carried themselves in the midst of their pain as well as the tools they have developed to cope with that pain. Having discussions with the portraits tapped my tacit awareness that I had absorbed from our meetings and provided insight on how the participant's defense mechanisms both aided them and could be a detriment in coping with grief.

The participants' artwork and narratives served in creating a treatment plan, but my own artwork sensitized me to how I could approach the participants as their art therapist. For example, Carson's narrative and art reflected his primary need to work on his grief around the sexual abuse he experienced. My portrait of him enlightened me to the heavy, multigenerational burden he carried, for which he had little support. As we continue to work together post-study, I plan to help him explore how to strengthen the support network he already has in place. Additionally, increasing his self-efficacy could help the portrait change from an image of a large bucket crushing a small Carson, to a large Carson holding smaller buckets. Exploring ways for him to take back control of certain parts of his life, while boosting his autonomy, could further change the portrait: He might choose where to put or what to do with his smaller, more manageable buckets. Perhaps these ideas would have come to me regardless. However, as with how member checking was a concentrated form of feedback for the participants, the portraits were a concentrated examination of focus and strategies for supporting each participant in the therapeutic relationship.

What Did This Study Accomplish?

This study accomplished many of the goals I set forth. First, it answered the initial research question: Why is there a need to address experiences of disenfranchised grief from ambiguous losses as a treatment with the forensic psychiatric population? The answers to the first research question are summarized in Table 1 below.

The art therapy directives were effective in multiple ways in that they were not complicated and, regardless of education levels, cultural backgrounds, diagnoses, or offensives, the participants understood what to do and seemed to feel safe working with them. Secondly, the art created by the participants provided a safe means to contain and tell the story of their life beyond the limiting story of their diagnoses, illnesses, or criminal offense. Their art included tragedies and triumphs, while allowing their histories to be told in their own style and voice. Importantly, the timelines gave a glimpse into their lives before severe mental illness. The art therapy directives were evocative structures for perceptions, thoughts, and feelings, as the participants shared stories of their childhood, their favorite memories, and their worst experiences. While they worked, my mind easily imagined 6-month-old Carson being picked up out of his crib by a federal agent, or 7-year-old Liam talking to a mother he felt was a stranger. I could imagine Robin trying to tell her parents that she was female, Keith driving around in his car that he loved, and Neil in tears in his kindergarten class missing his mother. Taken together, the study results broke down stigmatizing stereotypes and reinforced the reality that people living in forensic psychiatric hospitals are not a collective “them” and readers of this study are not an “us.” We are all just people trying to figure out how best to navigate life.

Table 1:Research Question One

Why is there a need to address experiences of disenfranchised grief from ambiguous losses as a treatment with the forensic psychiatric population?
• Ambiguous losses and disenfranchised grief are not readily being addressed, evident by the lack of resources available to clinicians/art therapists. • Non-bereavement losses may not be addressed in forensic psychiatric settings. Participants in this study were unaware of or did not feel "allowed" to identify non-death losses as losses, and therefore unaware these losses may cause grief • Classifying their mental illness as a loss helped participants put their life experiences, including their index offenses, into context. • This classification, in turn, "gave permission" for participants to grieve the lost ability to trust their own mind, the loss of feeling safe or secure, and loss of dreams for the future. • Ambiguous losses in this study fell into a category of losses stemming from mental illness; they felt "allowed" to grieve them once identified as such • The art therapy intervention provided exploration of the grief around their family or lack there of • The art therapy intervention led participants to an exploration of feelings of forgiveness and guilt • Participants who identify experiences of disenfranchised grief from ambiguous loss may obtain proper diagnosis and treatment of grief

The second question I sought to answer was: How does art therapy provide an effective intervention in exploring ambiguous losses and disenfranchised grief within this and similar settings? Summarized in Table 2, evidence for this question includes the result that the art directives can be used to create of an individualized, art-based treatment plan, noted earlier.

The study revealed some feelings that were common to all of the participants. In particular was the pervasive feeling of guilt: for missing out on their families' lives, for

their victims, for their actions or lack thereof. Another sentiment that was shared by all was that of forgiveness. Each participant expressed a wish, unprompted, to be forgiven by someone else. Self-forgiveness, however, was not mentioned until the end of the study, if it was mentioned at all. The two capital offenders wished for forgiveness from their victim. They also both felt a distance—both from me their therapist and from their grief itself—manifested primarily as a guardedness against revealing their feelings of grief or their biggest losses. When they did mention anything related to their offense, the feeling in the room reminded me of telling a secret that we were not supposed to share, as well as the relief to finally be able to share it.

Table 2: Research Question Two

How does art therapy provide an effective intervention in exploring ambiguous losses and disenfranchised grief within this and similar settings?
• Participants were able to tell their story in a safe way, within a contained format • Participants used their own symbols and images, and chose whether to share the story of the symbols • Participants used art to control their narrative, giving them power and choice • Art provided a gentle, nonintrusive format for increasing participants' knowledge of various forms and manifestations of losses and grief • The art directives were accessible and functioned across various education levels, diagnoses, cognitive functioning, and forensic security levels • Via the "bucket of grief" directive, participants were able show and discuss losses that they deemed "weighed" the most to them • Participants had created a visual grief and loss treatment plan at the conclusion of the study

From these results, it appeared that the study was successful at enfranchising the grief of the participants. Art therapy provided a structure and an environment to explore their losses. They often were able to investigate how one loss had an energy that fueled additional losses, like branches spreading from a tree trunk. The ability to identify the losses and name them "ambiguous" validated the weight the losses had caused. For example, I mentioned to Carson that, despite his chronic pain from his jaw injury, he had not identified his physical health as a loss. He stated, "I always thought losses were from living, breathing things. That once they stopped breathing, then I could call it a loss. I did not know I could call anything else a 'loss.'" Bringing to light what they had lost so that they could correctly mourn it allowed for their emotions to be identified for what they were: grief. This process fostered the participants' ability to properly identify feelings of grief when it arises, giving them the ability to tell treatment providers what they are experiencing. In turn, it is possible that by correctly identifying these feelings, they could reduce instances of misdiagnosis.

Furthermore, because they held paradoxical experiences and made them visible, the three art directives offered a way to examine any possible benefits from the losses the participants experienced. They could look over the timeline and see that sometimes where a loss occurred so did an opportunity for growth. For example, when Neil told the story of losing his grandfather and cousin in an accident, he was able connect his stronger relationship with his grandmother as a subsequent, positive development. He did not feel close to her before the accident and now they speak daily and she is one of his strongest advocates. Similarly, Liam was able to connect the loss of his mental health, father, and relationship with his oldest sibling with the beginning of stronger relationships with his

mother, middle sibling, and grandparents. Although the study purpose for the art therapy directives was to explore losses, the benefit of exploring growth was an important, emergent outcome of the multiple case study as well.

Validity and Limitations of the Study

Whereas quantitative research uses reliability and generalizability as determinants of validity (Kapitan, 2018), qualitative research seeks to demonstrate the trustworthiness of a study's findings (Leavy, 2017). Validity in case study research is defined by its sense-making properties, particularly with respect to whether results may apply to other people in like situations (Kapitan, 2018; McLeod, 2010). Triangulation of data is utilized to increase validity by using more than one data source, theory, or method to provide evidence that reveals a theme or new perspective (Creswell, 2013). According to Kapitan (2018), when the researcher's experiences and intuition, reflections from the research participants, and feedback from supervisors and peers align with each other, substantive significance has been achieved. Substantive significance, as well as member checking and triangulation of data, provide rigor and validity that solidifies the findings in a case research study.

Table 3 presents the strategies I used in my research study to ensure validation of the results. The case study results derived from prolonged engagement that allowed for in-depth observation, having spent uninterrupted time in a non-group setting with each participant. I was able to thoroughly investigate every story or reaction to a memory that arose, which allowed triangulation of their self-reported experiences with my direct observation. Case notes, journaling, the patient's medical chart, and their timelines created methodological triangulation. Feedback from my doctoral advisor as well as

another art therapist at MMHI provided investigator triangulation. Additionally, I asked peers for reflections on the de-identified artwork. Member checking proved to be a powerful experience for both the participants and myself. The participants' emotional recognition of their experiences as recorded in the case study vignettes and my portraits, as well as pride of accomplishment, seemed fill the room during this process. Finally, I reflected in this dissertation my own background and where my biases might have presented themselves during the study.

Table 3*: Validity Strategies*

Strategy	Qualitative Research Goals	Method Utilized
Prolonged engagement/ Participant observation	Building trust with participants, learning participant culture, checking for misinformation	• Multiple individual case study over 6 weeks • Work experience in the setting for 5 years prior to the study • Confirmation of data accuracy during individual sessions
Methodological triangulation	Corroborating evidence via multiple data sources	• Direct observation • Case notes • Reflexive analytic memos • Biographic and Autobiographic information from participants
Investigator triangulation	Reviewing interpretations for comparison and to gain perspective	• Peer review by an art therapist within the setting and an art therapist outside of the setting • Feedback from members of the MMHI Rehabilitation Team
Member checking	Reviewing researcher interpretations and findings to ensure accuracy	• Case vignette read aloud to the corresponding participant • Opportunity for participant to add, clarify, or omit information in their personal story
On-going reflexivity toward research bias	Creating transparency of researcher positionality and biases	• Research background and positionality included to introduce the dissertation and as part of the discussion of results

Limitations

There were several limitations that became apparent during the course of the research study. Certainly COVID-19 created complications that I had not anticipated. The plan was to have the individuals work in the designated space of the art therapy room. This could not happen due to new and continuously evolving restrictions on patient movement. Thus, the participants missed out on having access to a plethora of art materials, benefiting only from any portable art materials I had that could fit into a tote bag. These materials had to be approved by security captains for the various units I had to enter.

The limit of art materials was not the only loss from COVID-19 restrictions. Because the patients were not allowed off their units, all art therapy sessions were facilitated in the same area where the participant lived. This possible intrusion into their unit space could have affected the participants' level of comfort and willingness to share. Rather than meeting privately in a separate space, we had to meet in dayrooms on the unit, with large windows where peers and staff could potentially see in, limiting privacy.

Relatedly, because the study was conducted in a clinical setting where I am employed as an art therapist, the study results may be limited by my ability to manage and negotiate researcher and therapist roles. Although I prioritized the therapeutic needs of the participants, I did wonder to what extent the role of the research played into the participants' responses. I am still a state agent and the participants could see me as part of the system that failed them or keeps them at MMHI. Down to my core, I felt the participants were telling me their stories in truth and as best they could recall events in their lives. I believed—and still do—their willingness to participate in the study grew

from a desire to manage and understand their grief. However, at the end of the study I met with the treatment team of one of the participants (who identifies as straight and male) to let them know he wanted to continue seeing me for grief and loss art therapy. The unit manager said, “Really? Or does he just want the one-on-one attention from a woman?” I had not considered this point as a limitation and never felt that any of the participants’ commitment to the study was from a desire for female attention. However, because four of the participants identified as straight and male, it is a point that cannot be dismissed.

Limitations in the sample also were evident. All five participants were about the same age. A diverse age range could have added depth to the findings, such as youth offenders whose narratives would not have the same arc of time. Additionally, the participants for my study were predominantly men. Replicating the study with other genders would provide a valuable means of comparison. Finally, although I had sound reasons for limiting the case studies to individual sessions, facilitating the art therapy process in a group setting could prove beneficial. For example, the participants in this study did not benefit from hearing insights from their peers or experiencing the healing realization they were not alone in their grief.

Because I both collected and analyzed the data to create the case studies and distill their results, the model of the grief and loss cycle and other results are limited at this time to my own firsthand observations and therapeutic-artistic sensibilities. I believe that I have presented a coherent argument for the results and benefits, and worked to triangulate them with multiple sources and member checking. However, the results were still arrived at through my particular lens on art therapy within my particular place of

employment that may have limitations when considered for other similar settings and art therapy participants. My hope is that others will apply and test the model to lend further credence and even to refute results that may not be viable.

My final point is one that straddles both limitations and implications for future studies. A comparison study would have been beneficial to observe outcomes of this population in the same setting but without art therapy directives. Such a study could highlight the benefits of art therapy directives while also exploring traditional ways of expression in this setting via verbal therapy. It could also clarify the shortcomings of these methods. Additionally, offering grief and loss art therapy to non-offender psychiatric populations in the same manner as this study could reinforce benefits of art therapy while allowing for emerging themes to be compared and contrasted. These comparison studies were not part of this study for a few reasons. First, I could not find any research that looked at grief and loss art therapy with forensic psychiatric inpatients. Therefore, I felt it was a crucial step to first exclusively explore the intersection of this population in order to scrutinize emerging outcomes. Second, I wanted to examine themes from this population while also considering and contrasting the subpopulation of capital offenders. Having this as a secondary goal provided a small comparative exploration within my established study parameters. I also wanted to ensure this important subpopulation would not be overlooked by the addition of more information. However, now that outcomes have been established from this study with forensic psychiatric inpatients, it builds the possibility for future research.

Implications for Future Research

This multiple case study built upon research in the area of forensic art therapy by Gussak (1997, 2014, 2016, 2020) and grief and loss theories established by Freud, Bowlby, Doka (1989), Boss (1999), and others. However, to my knowledge, there is no research that combines these areas to examine art therapy as a means for dealing with grief and loss in the forensic psychiatric setting, which I have argued omits a significant need for treatment. Replications of this study would be useful to help validate the outcomes with other samples from similar settings. Additional study samples and research designs also could examine and validate manifestations of grief among participants with other mental health diagnoses or index offenses. I intend to disseminate this study to peers in the field of art therapy in the hope they find it useful in increasing their knowledge of grief and loss while treating similar populations.

Additionally, I hope the study reaches professionals in the fields of grief and loss and forensic psychology who may not only be exposed to the benefits of art therapy but to the narratives of grief and losses that art making can contain. Perhaps such interdisciplinary exposure would encourage co-research with art therapists who can implement the directives for the study. Field research becomes more feasible when each co-researcher takes responsibility for processes that fall within their unique skillset (Kapitan, 2018). Further, because grief and loss research trends towards types of bereavement losses, it is possible that certain other questions and concerns may be overlooked. As Doka wrote,

> As the myriad circumstances of loss become more recognized there is a pressing need for research that really describes the particular and unique responses to different types of losses, compares reactions, outcomes, and problems associated

> with these losses; assesses possible interventions and describes the critical variables affecting each loss . . . most critically it will offer a foundation on which to acknowledge, assist and enfranchise the disenfranchised. (2002, p.19)

Therefore, examination of the various forms of loss and corresponding grief is important in the area of grief and loss services, and art-based research could offer additional data. Additionally, as already mentioned, comparison studies with varied populations, such as those in non-inpatient settings or people with no criminal offenses could provide insightful information to examine.

Conclusion

During my time as an art therapist at Mendota Mental Health Institute, I have tried to better understand how to help the patients by reviewing the art therapy literature, grief and loss resources, and literature in the forensic or criminal justice discourse. While providing grief and loss art therapy groups, it became apparent that the population I work with and their unique losses were missing from most research available to me. I could find information on each of these topics individually, but none overlapped in a way that was helpful to the population I serve.

With this dissertation research, I explored how grief manifests when providing art therapy to adults in a forensic psychiatric inpatient setting. I examined the types of losses described by the participants and provided terminology for their grief. Finally, I showed how art therapy gives patients a means to express their feelings in an area where words and a lack of vocabulary have traditionally failed. This process unexpectedly created an art-based treatment plan to aid the participant in future sessions and a model of the grief and loss cycle that may benefit other professionals and their clients and patients.

This research was important for a number of reasons. It aimed to bring knowledge to fields of art therapy, grief and loss, and forensic psychology by helping to properly identify symptoms and providing interventions that focus on coping with the disenfranchised grief caused by ambiguous losses. As a practitioner-led, pragmatic research study, it can be used as a tool for other art therapists in their practices. Perhaps it will serve as a springboard for them to add on to what I uncovered. The research will start to fill in the gap of resources available to those working in similar settings with similar populations.

Finally, the study and its structure aimed to humanize a marginalized population by giving them a means to find their voice and platform for self-expression. In some instances the participants had committed notorious offenses—so much so that it can easy to forget the role that mental illness played. My research showcased these patients as just people who are capable of experiencing and identifying emotions, and gave a glimpse to the life they led prior to the loss of sound mental health. Corrigan and Watson (2002) discussed that one of the best ways to break down public stigma around mental health is interpersonal contact. While this study cannot bring the participants physically outside of MMHI, it does allow them to be introduced to any reader who sits down to read this dissertation. Although I feel that this population has been overlooked, nevertheless this research centered the importance of focusing on the needs of vulnerable, stigmatized patients. Additionally, exploration of the differences in how grief manifests in people with a capital offense has just begun. I hope there be more research with regards to their grief, and I plan to be part of that new research. I will take insights uncovered during this study and use them educate and inspire other researchers in similar settings. Finally, the

course of my research produced a structured method to implement grief and loss art therapy services throughout Mendota Mental Health Institute, creating an art-based treatment plan for patients' grief.

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Appendix A: Informed Consent Participant Form

The following is to be read aloud with the patient participant:

Title of Study: Grief and Loss in a Forensic Inpatient Psychiatric Setting and How Art Therapy Can Enhance Treatment

As you may know, I am currently a student at Mount Mary University. As part of my schooling, I am working on a research project on the use of art therapy with patients in an inpatient, forensic psychiatric setting. The following is a request for consent for you to take part in my study.

Invitation to Participate and Purpose of the Research

The purpose of this study is to look at and provide treatment to patients who may be feeling something called "disenfranchised grief" from the many losses that have happened before and during their time in a hospital. We will be using art to help identify your feelings of grief and learn to cope with them. Examples of the types of losses you might have include loss of your health, freedom, friends and families, and even your dreams. Disenfranchised grief means something that feels like it cannot be openly talked about, which can damage your health.

I am inviting you to join in this study to give you and me an opportunity to properly identify your losses and find relief from feelings of sadness and grief that many patients in this setting experience. We will learn about loss and grief and use art to explore ways to cope.

The study will take a total of 6 weeks and will require meeting with me every week for one hour. The sessions will be like a regular individual art therapy session. We will start with a brief art task to help identify some losses that you remember in your life. Then we will work on a visual timeline while learning about grief and loss. For the last session, we will do the art task from the first meeting again and answer a few more questions.

I will write notes about what we discuss in the sessions to help me remember later what you shared about your art, but these notes will be kept in a locked file and locked room, and will not include any information that could identify you to others. All information will be kept separate from your regular Protected Health Information (PHI). I also will ask your permission to take pictures of your artwork for the study. All information will be kept private and I will be the only person who can access your information. Information will be stored electronically and will be password protected. After 3 years I will destroy the study files by shredding or deleting them. I will not include any recognizable information about you in my final research documents or any publication.

Benefits and Risks: This study will help me and other art therapists by learning how we can help patients identify and talk about their grief and loss. While the goal is to better understand how grief affects patients in this setting, it is possible that you might not benefit personally

from being in this study and there will be no monetary reward. There are no known risks from participating.

The subject of grief and loss can bring up some discomfort, such as feeling embarrassed, uncomfortable, or frustrated with your art making, and memories that can stir up unpleasant feelings. You can ask me any questions or issues of concern before we begin or at any time in the study.

Possible benefits that may occur are the same as what you would experience in your usual therapy programs at MMHI, and how you might feel following regular therapy sessions with other providers. You also might gain understanding of yourself and your relationship with losses that have occurred in your life.

Your participation in the study is completely voluntary, meaning that you can refuse to participate or completely withdraw from the study at any time, and will not affect the services normally provided to you at MMHI. Even if you give your permission, you are free to decide not to participate at any time.

It you have any questions or need more information, please call me in the Learning Center at [number redacted] and I (Janine) or your treatment team will set up a meeting with me. You can also ask questions to my advisor, Lynn Kapitan by calling Mount Mary University at [number redacted]. You will be given a copy of this letter for your own records. If you have any questions regarding your rights or privacy as a participant in this study, please contact Dr. Tammy Scheidegger, Mount Mary University Institutional Review Board Chair, 2900 North Menomonee River Parkway, Milwaukee, Wisconsin, 53222-4597, telephone [number redacted] or email [address redacted].

Signing below means that you have read this consent form, know that you can ask any questions, and have agreed to voluntarily participate. You may stop participating at any time, or refuse to answer any question, without penalty or loss of benefits that other participants may experience.

You may request a copy of this page for your records. Thank you for your participation.

Signature of participant_____ Date _____
Please print your name_____

The above patient's treatment team has reviewed and discussed this research study with the patient, and are assured that the patient understands and is consenting freely to participate. The treatment team will monitor the patient throughout the study to answer questions and ensure the patient understands their rights around participating in this study.

Signature of treatment team staff_____
Occupational title: _____ Date _____

Appendix B: Recruitment Email to Units

Hello Teams,

I'm writing because I'm looking for the units' assistance in finding patient participants for a study I'll be conducting for my school requirements. I hope to explore disenfranchised grief from ambiguous losses, and how that grief might manifest in our patients. What does that mean? *Ambiguous loss* is a term that refers to losses that cannot be easily identified or clearly defined (Boss, 1999). Examples include loss of mental or physical health, loss of freedom, loss of relationships, rituals or rites of passage; of culture or of dreams, etc. Disenfranchised grief is defined as grief that has not been or cannot be "openly acknowledged, publicly mourned or socially supported" (Doka, 1989). Because ambiguous losses are much harder to identify than a bereavement loss (i.e., a loss due to the death of a loved one), often people aren't even aware to identify them as a loss. The grief that manifests from these losses is often overlooked due to common misunderstandings about them.

The purpose of my proposed study is to explore these subjects with the patients in order to contribute to more effective grief and loss treatment in forensic settings such as MMHI. An additional objective will be to humanize a marginalized population by providing an opportunity for patients to voice their needs through art expressions of basic and complex emotions.

Who can participate?

1) Participants willing to engage in art therapy, verbal therapy and education about ambiguous loss and disenfranchised grief.
2) I'm hoping for 6 participants who each consent, voluntarily, to be part of a 6-week individual multi-case study. The sessions will be 1-hour per week for six weeks. **The sessions will be individual sessions, not a group**.
3) Participants must be 18 years of age or older, have been a patient at MMHI for at least one consecutive year, and have no planned release during the 6-week study.

When this taking place?

Pending IRB approval which is (hopefully) in its final stages, I hope to start the 6-week sessions at the beginning of November. Due to time constraints of school, I am currently only able to accept six participants. If I get more than six people who wish to receive

G&L therapy for ambiguous losses, I will work with overflow volunteers' teams to set up sessions at a later time for those who don't get to participate.

Where will the sessions take place?

I'm hoping to have the sessions in the LC pending approval, however it is possible that I will need to travel to participants' units, and will need unit space for the time listed above.

Please speak to or share this with your teams and let me know if you might have patients willing to participate who may benefit from the proposed study.

Thank you so much for reading all this (I know it's wordy), and I look forward to hearing from you!

Janine