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ART THERAPY TREATMENT WITH INCARCERATED WOMEN

by

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A dissertation submitted in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
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ABSTRACT

This study examined the effectiveness of art therapy in decreasing symptoms of trauma and psychological distress in women who were incarcerated in county jails in the Southeastern United States. In order to protect the integrity of the study, control subjects were in different dormitories from the treatment subjects. While the dormitories were randomly assigned to treatment or control, the subjects were not. The dependent measures were paper and pencil tests, the Outcome Questionnaire (OQ-45.2) and the Trauma Symptom Inventory (TSI) given at pretest and posttest. A demographic questionnaire was completed in the first session to better characterize the participants. In addition, a post study evaluation with open ended questions was completed at the end of the study that allowed participants to share their feelings about the treatment experience. Additional qualitative information was obtained through observation data collected by the investigator who served as the provider of treatment.

Art therapy group participants attended six sessions of art therapy over a three week period which was administered using six standard art projects. Like treatment subjects, control participants had access to the treatment available in the jail to all inmates, and were offered art therapy treatment after final data were obtained.

Though the statistical data gathered in this study did not provide empirical evidence that the group art therapy treatment was effective in reducing symptomatology, the qualitative responses indicated that the treatment was rated very positively by the participants. No statistically significant changes were found in overall scores, however, some significance was found on some individual treatment scales. Scores measuring psychological distress and trauma symptoms generally decreased over time for all study participants, however, treatment

participant scores improved at a greater rate. The study was limited due to small sample size (N=26). Nearly half of the original participants were lost to attrition associated with administrative actions in the county jail system. The measurement instruments used were not specifically adapted to incarcerated individuals and may not have provided adequate measurement for this population.

Responses from the participants were overwhelmingly positive. Inmates responses to the post study evaluation indicated that they had enjoyed the experience and would recommend the group to others. More than 75% stated that they felt that the treatment had helped them deal with difficult experiences in their past. The most frequent suggestion for the future was that the groups needed to be continued, and should be longer and more frequent.

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LIST OF ABBREVIATIONS

IRB	Institutional Review Board
OQ45.2	Outcome Questionnaire
PTSD	Post Traumatic Stress Disorder
SSPS	Statistical Package for Social Sciences
TSI	Trauma Symptoms Inventory

CHAPTER ONE: INTRODUCTION

The number of incarcerated women in the United States are increasing at an alarming rate. A closer look reveals underlying issues influencing this trend. Approximately three quarters of female inmates in local jails in the United States meet the criteria for a mental health diagnosis and co-occurring substance abuse diagnosis (James & Glaze, 2006). In addition the majority of incarcerated women have a history of trauma including sexual, emotional and physical abuse as children and adults and have a co-occurring mental health diagnoses at the time of incarceration (Mageehon, 2003). As many as two thirds of women newly admitted to jails suffer sufficient psychological distress requiring mental health services (Singer, Bussey, Song & Lunghofer, 1995). This suggests a need to review current treatment issues and the potential need for development of alternative, efficient, effective options for this population.

Incarcerated women report a high incidence of traumatic experiences prior to their arrests. Singer et al. (1995) found that 81% of the female inmates interviewed reported having been sexually victimized at some time in their lives and three fourths reported having been threatened with physical violence over the previous year. In addition, nearly half of female inmates reported that they had experienced trauma within the year before their incarceration (Wellisch, Anglin, Douglas, & Pendergast 1993). These included rape, assault, domestic violence, and being a witness to violence (Pomeroy, Kiam, & Abel, 1998). According to Wellisch et al. (1993) nearly half of the incarcerated women surveyed had experienced physical abuse, frequently at the hands of their husbands or boyfriends, while 36% had been subjected to sexual abuse. Many experienced life disrupting traumatic experiences at an early age that led to discontinued educational pursuits, substance abuse, and deviant behaviors, that in turn, contributed to their subsequent incarceration (Wellisch et al.).

Because of the overwhelming occurrence of mental health disorders, trauma and substance abuse issues in female correctional facilities, mental health staff are often unable to provide adequate treatment for inmates. (Singer et al., 1995; Pomeroy et al., 1998). Treatment modalities for trauma that are currently used successfully are impractical in an incarcerated setting. Most of these treatments require one-on-one counseling, intense group work, and in some cases, specialized training. While cognitive behavioral therapy, exposure therapy, and others are considered to be effective treatments for trauma, inmates are seldom able to receive individual treatment considering the ratio of counselors to inmates (Pomeroy et al. (1998). Much work needs to be done to find alternative treatments that can be delivered to this underserved population (Ferszt, Hayes, DeFedele, & Horn, 2004).

Art therapy techniques have also been found to be effective in relieving a wide array of physical and psychological symptoms experienced by children and adolescents. In studies with children, Gross & Haynes (1998) found that art therapy can be used to tap the body's relaxation response which, in turn, reduces anxiety, strengthens client-therapist relationships, increases memory retrieval, helps clients to organize narratives and encourages more detailed disclosure than in a verbal interview (Gross & Haynes, 1998; Malchiodi, 2001). Art therapy has been used to help children cope with loss (Finn & Pearson 2003), divorce and family upheaval, physical illness, loneliness, trauma, (Hanney & Kozłowska, 2002) autism, developmental issues, learning disabilities, and abuse. Adolescents have also been effectively treated with art therapy for a variety of symptoms including the traumas of September 11 (Pressman, 2005), physical illness, substance abuse, trauma, sexual and physical abuse (Gladding, 2005).

Art therapy has been used successfully with adults in family therapy, individual and group therapy addressing a wide array of problems (Gladding, 2005; Kwiatowski, 2001;

Malchiodi, 2003; Rubin, 2001). Collie, Backos, Malchiodi and Spiegel (2006) advocated utilizing art therapy with veterans who have been traumatized by war. The use of art therapy allows each person to address his or her own issues while in the supportive confines of a group (Waller, 2003).

Several facets of prison life and culture render art therapy a good treatment for inmates. For example, verbal expression of extreme emotions while incarcerated sometimes leads to negative consequences. However, expression through art facilitates intense expression in acceptable and appropriate ways (Gussak, 2006). Art therapy can be effectively administered in group settings making it possible to provide treatment for a broader population with limited resources. Art therapy treatment work provides a tangible record of psychological processing which can be valuable as treatment progresses (Ferszt, Hayes, DeFedele, & Horn, (2004). The positive anecdotal effects of art therapy use with incarcerated individuals have been reported by many clinicians (e.g. Cronin, 1994; Eisdell, 2005; Wilson, 2000).

This study offers an opportunity to address trauma related outcomes while providing needed treatment in order to reduce symptomology, alleviate individual distress, and increase the likelihood of functional life changes for participants. More effective treatment options and methodologies need to be developed and made available in order to raise client coping skills and facilitate reduction in recidivism (Pomeroy et al. 1998). Art therapy techniques used in group settings provide a practical, efficient, economic, and effective way to provide treatment to incarcerated individuals.

Trauma

In order to better understand trauma, we must first understand how it is defined. Trauma is defined by the American Psychiatric Association as “an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others” (DSM-IV-TR, 2000, p.424). Psychological trauma occurs when an individual experiences some event that overwhelms their ability to cope and they fear death, annihilation, mutilation or psychoses. The circumstances of the event commonly include abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion and loss. The definition of a trauma is fairly broad, ranging from powerful one-time incidents like natural disasters, or accidents, to long-term repetitive experiences such as combat, battering or child sexual abuse (Giller, 1999).

Most recipients of mental health treatment have experienced trauma in some form. In fact, two prevalent psychological conditions described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM IV TR, 2000), Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD), identify trauma as an etiological element in the diagnostic criteria (DSM IV TR, 2000). Trauma is found at the root of many mental health disorders including anxiety disorders, personality disorders, substance related disorders and dissociative disorders, as well as eating, sleeping, sexual, and behavioral disorders (Giller, 1999). Trauma is believed to be both a psychological and a physiological experience. PTSD has both psychological and physiological symptoms. Because the core of traumatic experience is physiological, the expression and processing of sensory memories of the traumatic event are essential to successful intervention and resolution (Rothchild, 2000).

Theoretical Background

Expression of emotions related to trauma is crucial to client recovery (Frattaroli, 2006; Malchiodi, 2005). According to Young & Bemak (1996) individuals who have difficulty expressing themselves verbally are more likely to benefit from expressive treatments. Expressive arts offer a unique, effective avenue for expression and catharsis (Gladding, 2005; Malchiodi, 2003). Art therapy and expressive writing have both been found to be effective in relieving traumatic symptoms and improving emotional functioning (Gladding, 2005, Malchiodi, 2005; Pennebaker, 1990). Gussak (2005) suggested that the use of expressive arts therapies can bypass the resistance that is often present when working with inmate populations, enabling them to address and express experiences that are difficult to verbalize.

One of the most important contributions to the use of expressive modalities is evident in Pennebaker's research based on his theory of psychosomatic inhibition. This theory assumes that individuals who are reluctant to express thoughts and feelings related to traumatic experiences have increased stress which leads to physical illness and impaired psychological functioning (Pennebaker, 1990). He posits that psychological pain is often exhibited in the form of physical pain, leading the individual to seek help, and that this behavior is linked to difficulty in disclosing upsetting memories. Traumatic memories are thought to be stored in a unique way, and are not as readily accessible to verbal disclosure. Pennebaker (1990) stated that they are more readily accessed through writing or visual therapy techniques. Pennebaker's work with trauma identified physiological benefits when participants expressed their feelings about traumatic experiences and related emotions. He concluded that the benefits derived were three-fold. First, when an individual is able to express strong emotions related to trauma it leads to an

awareness of deeper unconscious emotions. Second, expressing emotions helps the individual realize that he has some responsibility for his emotional experiences and can do something to resolve them. And third, through expression, the individual gains insight and understanding into his experiences and is able to begin to resolve them (Pennebaker).

Art Therapy

Many therapists concur that because memories of trauma are stored in a visual form, it is a natural and effective practice to encourage visual representation of those memories prior to verbal disclosure (Rubin, 2001; Gladding, 2005). Throughout history creative expression in many forms has been employed to process life experiences (Malchiodi, 2005). From the earliest attempts to help individuals deal with past experiences, imagery and verbal expression have been used (Malchiodi, 1998). Specific drawing tasks can be effective in tapping sensory memories and generating narratives. There are two kinds of memories implicit and explicit (Rothchild, 2000). Explicit memories consist of facts, concepts and ideas. Implicit memories are sensory, emotional ideas. Rothchild posited that art expression may help to bridge between implicit and explicit memories by facilitating the creation of a narrative through which a person can explore memories. Developing a sense of why they are upsetting, which, in turn, helps the client to think and feel concurrently while examining difficult experiences.

Because the field of art therapy is a relatively new field, possibilities for its use are constantly expanding. It is seen as a “modality to help individuals to verbalize their thoughts, feelings, beliefs, problems and world view” (Malchiodi, 2003, p.2). It is considered an adjunct to psychotherapy that can be used to enable verbal expression through making visual images. In addition, the process of making images itself, is viewed as the therapy; the creative process

involved in creating art is life enhancing and therapeutic. Most therapists who use art in practice agree with both of these perspectives and that its use does assist people in expressing things that may be difficult to verbalize. It works in a way that verbal interviews and interventions can not (Malchiodi, 2003). Art therapy draws upon the creative process within every individual to promote growth, self-expression, emotional reparation, conflict resolution and transformation (Malchiodi, 1998).

Purpose of the Study

The purpose of this study was to evaluate the effectiveness of art therapy interventions when treating female inmates experiencing trauma related issues to determine if symptoms were reduced and psychological outcomes improved through its use. This study compared expressive therapy methods with existing treatment offered to female inmates. This study contributes to the body of knowledge about art therapy and treatment options in an incarcerated setting.

Women in jail report a high incidence of trauma and mental health issues. Because, those who are incarcerated have limited access to mental health treatment, traditional therapies such as cognitive behavioral therapy, EMDR, and exposure therapy which require intense and individual counseling attention are not practical in a prison setting. Counseling personnel in a county correctional facility have a large client load. Individualized, consistent treatment is difficult to provide due to the extreme need and the transient nature of county jail populations. Most often, counseling services are limited to mental health status assessments, psychiatric referrals, and individual counseling to limited clients, usually on a monthly basis.

The art therapy treatment used in this study can be applied in group settings allowing more inmates to receive treatment than individual modalities afford. Art therapy use for brief

group treatments has the potential to provide additional effective treatment options for incarcerated individuals. Positive outcomes with the use of art therapy with female inmates who have experienced high instances of trauma may indicate that individuals who have experienced less severe trauma in other treatment settings would also benefit from its use.

Research Question

The research question is as follows: Are expressive arts treatments effective in decreasing symptoms of trauma and psychological distress in incarcerated women?

Research Design

A study was conducted with incarcerated females in two county corrections facilities in the Southeastern United States. Participants attended six sessions over a three-week period in the art therapy group, and the control group received only the treatment available through the correction facility. Pre-test and post-test measures were taken at the beginning and end of the three-week treatment period. Because of the living arrangement for inmates who live in separate dorms called *pods* it was not practical or desirable to randomly assign subjects to treatment groups. Due to the structure of the jail, and the interaction of inmates with each other in the dorm, in order to protect the integrity of the study, the volunteers were assigned to groups according to the dorm where they were housed.

Approval procedures included an application to the Director of Corrections, and programs staff at the John E. Polk Correctional Facility, Seminole County, Florida, and the Lake County Florida Correctional Facility. The study complied with all regulations set forth by the American Corrections Association and the National Commission on Correctional Health Care. IRB applications were submitted and approved through the University of Central Florida.

Recruitment and Enrollment Procedures

A flyer was displayed in pods where female inmates are housed describing the study asking for volunteers for the study and inviting them to attend an introductory session where they would learn about the study, trauma, and related symptomology. They were informed that participation was voluntary and that they had the option to drop out at any time without negative consequences. They were informed that their participation would have no affect upon their standing in the jail. They were informed of confidentiality issues regarding the study, and were informed that they would receive no tangible rewards such as money or goods for participation according to corrections regulations. Individual informed consent agreement forms were provided for sign-up and were collected by the Programs Director.

Participants were assigned a confidential identification number to identify treatment work and research instruments. Numbers coincided with a master list of participants kept by the primary investigator in a password protected file on a laptop computer at another location, and were used only to record pre-test and post-test scores appropriately. Participants were asked to refrain from adding identifying information to their drawings and any inadvertent use of names were blacked out before the work was viewed.

Treatment groups met twice each week for three weeks. Individuals in the control group participated in the pretest and post test at the same time as treatment groups, and were given the opportunity to receive art therapy treatment after post-tests were administered. Digital photos of client artwork were made for reference and further research. All original treatment work was returned to the participants.

Administration

In order to maximize the quality of care, the treatment was administered by the primary investigator who has experience working with incarcerated clients and has provided art therapy in an incarcerated setting. Approval to enter the correctional facility required an extensive background check and application process as well as security training provided by the facility. Specific intervention protocols were used for each session. Groups were held in a classroom inside the facility. Each session consisted of a brief introductory discussion to clarify concepts and describe treatment tasks, then participants were given time to complete treatment work. Each session concluded with a brief group discussion where each individual shared their drawing and their feelings and insights about the experience.

Materials

Materials required for the interventions were provided by the primary investigator. All facility regulations concerning appropriate materials for inmate use were observed. Materials included drawing paper, water-based markers, crayons and pencils.

Measures

Data was obtained through pre-test and post-test measures using four instruments. The Trauma Symptoms Inventory (TSI) (Briere, 1995) and the Outcome Questionnaire (OQ-45.2) (Lambert et al. (2004) both in wide use (Merker, n.d.; Fernandez, n.d.), were selected as measures to evaluate changes in psychological outcomes scores. A demographic questionnaire developed for this study was used to gather information about the participants which included age, marital status, education level, number of children and their custody status, incarceration history, substance use history, and mental and medical health history. At the conclusion of the

study, participants completed a short questionnaire with open-ended questions to evaluate their experience.

The Trauma Symptoms Inventory (TSI) (Briere, 1995) was designed to evaluate acute and chronic traumatic symptomology in adults. The measure consists of 100 items describing trauma-related symptoms that are to be rated on a 4-point scale of frequency of occurrence over the preceding six months. The test is written on a 5th to 7th grade reading level and requires approximately 20 minutes for completion. Scores reflect ten symptom domains: Anxious Arousal (AA), Depression (D), Anger/Irritability (AI), Intrusive Experiences (IE), Defensive Avoidance (DA), Dissociation (DIS), Sexual Concerns (SC), Dysfunctional Sexual Behavior (DSB), Impaired Self-reference (ISR), and Tension Reduction Behavior (TRB).

The TSI was administered by the test developers to a random adult sample from the general population (N=828) and with Navy recruits (N=3,659). Separate norms indicate that the TSI is appropriate for adults with combinations of age and gender. Built-in validity scales are: Atypical Response (ATR), Response Level (RL), and Inconsistent Response (INC). The average alpha coefficient for all clinical scales is .85 (Briere, 1998). The TSI showed reasonable concurrent validity when compared with similar scales, and data indicates overall psychometric soundness.

The OQ-45.2 (Outcome Questionnaire) developed by Lambert & Burlingame (1998) is a 45-item self-report questionnaire designed as a brief screening and outcome assessment scale that measures subjective distress as well as the effects on how they function in the world. (Lambert, et al. 1998). The instrument can be completed in approximately 10-15 minutes and is written at a sixth grade reading level (Hanson, 2007; Merker, 2007). The questions are rated on a

5-point Likert scale with responses of never to almost always. In addition to the total score, the OQ-45.2 measures how a person is feeling, getting along with others, and how they are functioning in important life tasks, with three sub-scores: symptom distress (SD), interpersonal relationships (IR), and social role and occupational functioning (SR). This instrument is sensitive to change and was designed for repeated administration, and has been found to be broadly applicable across ages, diagnoses, treatment modalities and clinician orientations. Both Hanson (2007) & Merker (2007) indicated that one strength of this instrument is its ability to identify potential treatment failure. Pfeiffer (n.d.) states that the reliability of .93 indicates that the OQ-45.2 is psychometrically sound, and that the Reliable Change Index (RCI) facilitates measures of change during the course of treatment.

Assumptions

The study was conducted in two county correctional facilities. The assumption was made that the populations were similar and that responses to the test instruments would be constant. Study participants were assigned to groups according to their living arrangements, it was assumed that the groups assigned to the treatment group and the control group had experienced similar trauma and would respond about the same to the measurement instruments. The instruments used were self-response, it was assumed that participants would respond honestly. One assumption made in this study was that a population who has experienced more severe trauma may produce more dramatic differences in psychological outcome scores. It is also assumed that a more intense treatment consisting of several sessions over a three-week period would provide enough time and intensity for the treatments to be effective and that the psychological outcome scores would indicate these results.

Limitations

Conducting this study in an incarcerated setting provides a group of individuals who have experienced extreme trauma therefore results may not transfer to a non-incarcerated population. In county correctional facilities the population is transient, attrition occurs for a variety of reasons including the early release of inmates, transfers, and other changes in jail housing. Establishing a trusting therapeutic relationship can be challenging with incarcerated participants. Even though they were informed that responses would not be shared with corrections staff and would have no effect on the disposition of their case, participants may not have responded honestly, in an effort to appear healthier than they are. Because of differing perspective on dealing with inmates, cooperation with correctional staff can be challenging and effects the administration of the study.

Conclusion

The women who populate the county jail system have experienced extensive trauma, addiction and related issues and are in need of quality mental health care. They often find themselves in a cycle of incarceration and dysfunction with little accessibility to treatment in the community or as an inmate. This study explores art therapy as an alternative treatment option that could be beneficial in alleviating distressing symptomology to clients while offering reasonable options for treatment in correctional facilities where treatment is currently difficult to obtain.

A discussion of this study follows. Chapter One addresses the organization and purpose for the study. It elaborates upon the theoretical foundations of art therapy. Chapter Two reviews literature relevant to working with incarcerated clients and explores the unique characteristics of

this population. A review of current research utilizing art therapy applications in correctional settings is also included. Chapter Three describes the methodology used to conduct the study and a description of treatment and data collection procedures. Data analysis and research findings are discussed in Chapter Four. Chapter Five discusses implications of the study and suggestions for further research.

CHAPTER TWO: LITERATURE REVIEW

Women are the fastest growing group entering the criminal justice system. Between the years of 1980 and 1995, female arrest rates grew at a rate of 200% (Pomeroy, Kiam, & Abel, 1998). They have tripled since; leaving about 1% of all adult females in the United States imprisoned (Covington, 2007). This rapid growth is complicated by the prevalence of recidivism, as nearly three quarters of inmates have been arrested two or three times previously (Alemagno, 2001). The explosion of this population has even wider social implications when its intergenerational effects are considered. Evidence has shown that families with incarcerated parents often lead to incarcerated children (Norton-Hawk, 2001). Even with a population of approximately one million, women represent only 11% of the incarcerated population (Bradley & Davino, 2007; Covington, 2007). Consequently, they are now frequently housed in facilities and enrolled in programs that were originally designed for men (Henriques, 2002; Radosh, 2002). The unique issues affecting women arrestees, and the growth of their population, reveal the need for a change in current correctional practices.

Special Concerns for Female Inmates

In one of the most important demographic studies of incarcerated women, Wellisch et al. (1993) found that most female inmates had one to three children and became mothers at or prior to the age of eighteen. Approximately 4% were pregnant when arrested and more than 75% of all incarcerated women were mothers with children under eighteen. The continuous involvement of mothers with incarceration, substance abuse, and unaddressed psychological problems has costly

implications for society in general and specifically for the development of children (Henriques, 2002).

Women detainees express overwhelming concern about the welfare of their children while they are in prison and their ability to care for them when they are released (Radosh, 2002). More than half lived with their children before entering jail and will return to live with them when they are released. In the meantime, children are left to be cared for, in the majority of cases, by the offender's mother or grandmother (Wellisch et al. 1993). Many female inmates have lost parental rights to some or all of their children. However, others were involved in ongoing child abuse or custody investigations to determine the placement of their children while incarcerated and after release. Due to their role as care-taker before coming to jail, women continue to be concerned about their family responsibilities, whereas most male inmates trust that these needs will be met by others (Grella, & Greenwell, 2007).

Female detainees are also more likely than their male counterparts to suffer from health concerns while incarcerated. They are more likely to suffer from chronic physical health problems and less likely to receive adequate medical care (Grella & Greenwell, 2007). Compared to other women, inmates demonstrate higher instances of many medical conditions including: toxemia, anemia, hypertension, diabetes, obesity and a higher instance of infectious diseases, sexually transmitted diseases, HIV/AIDS, hepatitis A, B, C, and tuberculosis (Covington, 2007). Women's health needs are further complicated by additional reproductive health care issues such as unplanned pregnancies and inconsistent use of birth control (Grella & Greenwell, 2007). Despite the increased prevalence of these physical ailments, women are less likely than men to seek health care services in jail due to fear of exposure or intimidation (Staton,

Leukefeld, & Logan, 2001). The lower health status of female inmates is related to high risk behaviors such as alcohol and drug use, smoking, prostitution, and histories of trauma (Covington, 2007). For many female inmates these behaviors constitute a cycle that will return them to jail repeatedly.

Causes for Recidivism

Unlike men, women are primarily arrested for non-violent crimes with an economic motive (Wellisch et al. 1993) such as drugs or drug-related offenses, prostitution, or fraud (Covington, 2007; Radosh, 2002; Singer et al. 1995). Drug involvement is often related to their relationships with men and their offenses are frequently tied to obtaining drugs. Women caught in a cycle of drug use, crime, and incarceration find it difficult to escape faulty life patterns. In a study conducted by Norton-Hawk (2001) women involved in prostitution claimed that they did not enter prostitution to finance drug habits, however, they admitted that they eventually used drugs regularly to make the job more tolerable. Drug use, in return, demands a large amount of money that is difficult for them to obtain through any other means. As many as 95% of prostitutes surveyed admitted that they were addicted to alcohol and illegal drugs (Norton-Hawk, 2001). Many incarcerated women have engaged in prostitution as a way to support drug use, and continued to use drugs to enable them to endure prostitution. This perpetuates a cycle that is difficult to escape. The cycle consists of repeated arrests and incarcerations with an eventual release to face the same problems they had before incarceration or worse resulting in their return to prostitution and other crimes (Radosh, 2002; Singer et al., 1995).

Much of the recidivism among women entering the jail system stems from a struggle to find and maintain adequate employment due to a lack of education and vocational skills (Hall,

Baldwin, & Prendergast, 2001). In general, incarcerated women have limited employment skills, poor work norms, and erratic work experience further complicated by practical and logistical problems such as transportation, housing and child-care. Less than 20% felt they were qualified to get the kind of job they would like (Grella & Greenwell , 2007). Radosh (2002) found that most women detainees had experienced financial difficulties before incarceration and that only about 40% were employed at the time of their arrest. Approximately 20% said they had been unemployed for three years before being arrested (Radosh, 2002). In one possible explanation, Mcgeehon (2003) concluded that some life-altering event had disrupted the education of many female inmates during adolescence. Frequently, despite early positive educational experiences, they failed to complete middle or high school. A study by Wellisch et al. (1993) revealed that only about 15% of incarcerated women had completed four years of high school and 24% had obtained a GED. According to Mcgeehon (2003), the events that had interrupted inmate women's education included ongoing difficulties at home, repeated rapes, physical abuse, sexual abuse, and early childbirth, resulting in disconnection from peers and teachers (Wellisch et al. 1993).

Domestic Abuse and Criminality

Women's incarceration stems from an array of domestic problems that affect women as a group and permeates many facets of American culture. Prior to incarceration, many of these women lived in poverty with parents who abused alcohol and drugs. A history of abuse is also believed to increase the likelihood of contact with the justice system and perpetuates a cycle of intergenerational violence (Henriques, 2002). A majority of women in the criminal justice system have a history of physical abuse, sexual abuse and interpersonal violence, often more

severe, frequent, ongoing, and beginning at younger ages than those in the general population (Alemagno, 2001; Radosh, 2002).

Studies have consistently found this to be true of female detainees. Wellisch, et al. (1993) found that 36% of the women surveyed reported they had been sexually abused as children or adolescents, 50% had been physically abused as children or adolescents and 50% had been physically abused as adults by husbands or boyfriends (Wellisch et al., 1993). A later study (Bradley & Devino, 2007) conducted in a New York prison found that 59% of women had experienced childhood sexual abuse, 70% had been physical abused by a caretaker as a child, 49% had been the victim of rape and 75% involved in interpersonal violence as an adult. Radosh (2002) found that extreme battering was the most consistent pattern of abuse endured by incarcerated women. Abuse occurred in higher numbers in instances where women had spent time in foster care or institutions, or in homes where parents abused drugs or alcohol (Radosh, 2002).

Singer et al. (1995) found that women, with histories of extreme violence and abuse, used drugs or alcohol as a coping mechanism. More than half of female detainees admitted that they had used drugs in the month previous to arrest, and 40% admitted that they had used drugs daily (Haywood, Kravitz, Boldman & Freeman, 2000). As many as 80% admitted to regular drug use at the time of arrest (James & Glaze, 2006; Wellisch et al. 1993). Increased substance abuse and involvement with drug dealing leads to more violent acts committed by women (Singer et al., 1995/ Sterk & Elifson, 1990). Haywood, Kravitz, Boldman and Freeman (2000) reported that the prevalence of drug use among female detainees translated to criminal offenses. Of women surveyed, 25% indicated that they had committed offenses to obtain drugs. They found that one

in three females were in jail for drug related offenses and 40% admitted to being under the influence of drugs at the time of arrest. An overwhelming majority of women in jail have histories of abuse and substance dependence requiring mental health treatment.

Mental Health of Female Inmates

In a statistical report conducted for the U.S. Department of Justice, James and Glaze (2006) reported that 75% of incarcerated females had a mental health problem at the time of their arrest, a figure nearly three times the rate of male inmates. This meant that they had reported a recent history or symptoms of a mental health problem or had received treatment or a clinical diagnosis by a mental health professional based on DSM-IV-TR criteria within the previous year. Teplin, Abram, and McClelland (1996) studied the prevalence of psychiatric disorders among a large sample of women offenders in a large urban jail and found that 70% of female detainees suffered from a major psychiatric disorder within six months prior to arrest, and 80% had at least one lifetime psychiatric disorder with 33% qualifying for a diagnosis of PTSD (Haywood et al. (2000).

Trauma from abuse plays a major role in resulting mental health, substance abuse, and physical problems (Covington, 2003; Pennebaker, 1990). Traumatic experiences result in a variety of symptomologies and dysfunctional behaviors. Trauma is a factor in a number of mental health disorders such as mood disorders, personality disorders, anxiety disorders, dissociative disorders, eating disorders, sexual disorders and substance abuse disorders. Abuse experienced during childhood has been linked to a variety of problems in psychological functioning and dysfunctional behaviors (Messina & Grella, 2006). Childhood abuse and

traumatic exposure have been associated with adolescent conduct problems, adult psychological distress and specific types of criminal behavior (Grella, Stein, & Greenwell, 2005).

Co-occurring mental health disorders and substance abuse disorders are prevalent among women inmates. Of those female detainees who are diagnosed with a mental health disorder, 75% also met criteria for substance dependence or abuse (James & Glaze, 2006). Co-occurring substance use disorders were more prevalent among jailed women with severe mental disorders (72%) than among psychiatric patients (30%-50%) (Haywood et al. 2000). Singer et al. (1995) observed that women with co-occurring substance disorders were more likely to be arrested and served longer jail sentences than those who had not. In a general population of female inmates, 49% were found to have co-occurring disorders (Covington, 2006). The special mental health needs of women have presented a difficult challenge to correctional institutions.

Mental Health Services in Correctional Institutions

Correctional institutions have the primary purpose to “protect society by confining offenders in controlled environments that are safe, humane, cost-efficient and secure” (Federal BOP). Though the system was designed to isolate criminal behavior, it is also necessary for correctional institutions to provide help with mental health and physical needs (Covington, 2007). According to Blitz, Wolff and Paap (2006) women offenders may be more likely to receive mental health services than substance abuse treatment while incarcerated, and may be more likely to get treatment in jail than in the community before incarceration. Substance abuse treatment programs are not able to address mental health issues associated with co-occurring disorders. Both forms of treatment must be available to inmates in order to reduce the number of them returning to jail. While treatment accessibility presents a challenge in correctional facilities,

needed help is also limited in the community (Wellisch, 1993). Lack of access to integrated treatment within the community and minimal treatment in correction facilities leads to recidivism among offenders with co-occurring disorders, who are disproportionately women (Grella & Greenwell, 2007).

Incarcerated women have a higher instance of substance abuse, mental health, and health problems than their male counterparts (Alemagno, 2001; Covington, 2007; Grella & Greenwell, 2007). By most accounts, the special needs of female inmates are met with “sporadic, inconsistent, inappropriate, or inadequate programming” (Radosh, p. 301) and fails to address the issues that are most important for humanistic reasons that are most likely to enable individuals to cope and reduce recidivism (Radosh, 2002). Haywood et al. (2000) found that many larger jails were providing mental health screening and evaluation, suicide prevention, crisis intervention, limited therapy, and some substance abuse treatment but recognized that these programs fell short of meeting the needs of female inmates. According to Wellish et al. (1993) a large percentage of jails and prisons were not providing women with adequate medical, psychological and substance abuse treatment options in the majority of jails and prisons. Many programs neglect some areas of treatment altogether. Teplin, Abram, and McClellan (1996) observed that most incarcerated women with psychiatric disorders were not receiving treatment.

Once incarcerated, women face a multitude of problems requiring mental health and substance abuse intervention and medical care. Limited institutional funding is available to address the needs of this complex population (Radosh, 2002). Changes are needed so that the correction systems, ill-equipped to supply the needed treatment, can develop low-cost, brief, and effective treatment options (Covington, 2007). Henriques (2002) called for the development of

integrated, gender-sensitive treatments for incarcerated women, designed to address mental health issues, trauma, and addiction. Comprehensive treatment programs are needed to facilitate real changes in the system and in the lives of individuals and families (Covington, 2007). The American Corrections Association has established standards for mental health treatment in the jail setting, describing essential treatment components. However, little research has been conducted to examine treatment efficacy for incarcerated women making it difficult to develop treatment solutions for women in jail (Haywood, et al. 2000). Within correctional institutions, counselors must adapt to special challenges that are less likely to be found elsewhere.

Counseling Inside a Correctional Facility

Professional counselors working with incarcerated populations face extraordinary challenges. Inmates' treatment needs are extreme, time is limited, and prisoners are resistant and distrustful of the therapeutic process. Detainees are influenced by the social structure in jail and perceived expectations of fellow prisoners. Often they demonstrate a reluctance to address emotional issues and an automatic distrust for those associated with jail administration. A heightened resistance to verbal disclosure coupled with the tendency of inmates to take advantage of others' weakness and vulnerability often interferes with effective therapeutic interaction. Disclosure may be perceived as dangerous or threatening if inmates fear being perceived as vulnerable by others. Inmate perception is often one of basic survival leading to the use of rigid defenses for self protection. Inmates often feel judged by others and are reluctant to address sensitive issues or show emotion (Gussak, 2007).

One of the first things a counselor learns when working with inmates is that correctional facilities, unlike community agencies, are not designed to be supportive and promote

rehabilitation; they are designed primarily for the purpose of punishment (Kelly & Empson, 1999). First time therapists in a correctional facility may experience personal fears and feelings of inadequacy, loneliness and intimidation. Each therapist needs to confront fears related to the place, the patients, and the staff. Karban (1994) described her experience as “jumping in at the deep end” as she entered the jail as an art therapist. She continues, “This level of fear was quite different from anything I had encountered before. I felt it as soon as I entered the building every morning. It felt like going on to a boat that was leaving the outside world, as I left my normal reality and entered a far more intense environment” (Karbon & West, 1994 p.136).

Correctional personnel often resist treatment programs because they appear contrary to correction goals, since correctional facilities are perceived primarily as a place for punishment (Byrne, 2005). Thus, those exercises that are designed to encourage creativity while producing and encouraging unity, self-esteem, and empowerment, are viewed by some as contrary to the primary purpose of correction facilities (Stanford, 2004). Staff and others with this attitude see therapy of any kind as an option that should not be offered to inmate populations. Staff with an antagonistic view of the presence of therapy programming can impede treatment in subtle ways. Opposition to therapy programs result in increased inmate resistance, difficulty in establishing a trusting therapeutic environment and impaired ability to address issues related to individual dysfunction and recidivism (Liebmann, 1994). Just as the focus and direction of counselors appears contrary to that of correctional staff, inmate behaviors and attitudes appear on opposite ends of the scale.

Incarcerated people can be creative, intelligent, and capable. On the other hand, they may also be manipulative and dishonest, having learned to recognize and take advantage of the

sympathies of others (Mageehon, 2003). In light of these limitations, group art therapy in a correctional facility is still possible and potentially beneficial to the incarcerated client and the institution. Professionals who provide counseling services to female arrestees face many inherent challenges. In local jails, one challenge is the short-term nature of incarcerations. The length of stay for inmates in a county jail ranges from overnight to a sentence of up to one year. The population is moving and changing with little predictability making consistency in treatment difficult to maintain (Henriquez, 2002). Because the focus of corrections staff is to provide custody, care, and control, counseling programs are often met with resistance. Concerns about compromising security and the nature of punishment engender limited support from a large portion of corrections staff (Kelly & Empson, 1999).

Research has demonstrated that creative activities can be beneficial to both the individual and the correctional institution. When using art therapy in prison, Gussak (2005) saw evidence of better compliance with directives and an improvement in behavior among those treated. Gibbons (1997) found that inmates who were able to engage in creative endeavors showed improvement in their mental health, attitudes, and behaviors. Creativity has often been used throughout history to process life experiences.

Expressive Arts

Expressive arts therapies are “art forms ranging from those that are primarily auditory or written to those that are predominantly visual” (Gladding, 2005, p. 2) that are used in counseling. They offer verbal and nonverbal ways of identifying, expressing and exploring feelings that may be difficult to express verbally. Expressive arts “foster different ways of experiencing the world. They are enriching, stimulating and therapeutic in their own right. When employed in clinical

situations, they help counselors and clients gain unique and universal perspectives on problems and possibilities” (Gladding, 2005, p. vii). Creative arts therapies include music, dance and movement, imagery, visual arts, literature and writing, drama and psychodrama, and play and humor and are used individually or in combinations (Gladding). Expressive arts use can prevent and resolve problems, enrich the lives of participants, enhance the process of change, and help improve self-concepts and personal insight (Gladding; Pressman, 2005; Ulman, 1992). Carlson (1997) observed theoretical similarities between the ideas of art and narrative therapies and suggested a rationale for the integration of these two approaches in therapy. Stanford (2005) while conducting poetry workshops in a women’s prison found that the creative work assisted inmates in coping with prison while developing images of the women they want to be. Music therapy was used by Daveson & Edwards (2001) in a women’s facility to reduce tension, stress and anxiety while increasing self-expression.

The goal of expressive arts exercises is to stimulate emotional arousal and enhance expression leading to catharsis and a better understanding of self. Many media sources such as music, films, books, psychodrama and creative arts can be used effectively to help individuals express feelings, understand their experiences, and recognize and release emotions through a variety of artistic media (Gladding, 1992; Young & Bemak, 1996). To express the feelings is not enough, though. It is also necessary to experience personal insight and change as a result of the experience (Young & Bemak). In jail, Liebmann (1994) observed that crisis situations were often eased through catharsis. Expression of pent-up emotions, reduction of feelings of isolation and increased coping skills with difficult issues were also observed (Liebmann, 1994). Research has

shown that expressive arts therapies provide effective ways to help clients improve self-concepts and increase personal insight in a variety of settings (Gladding, 2005; Ulman, 1992).

Advantages of Expressive Art Therapies

Expressive art therapies can provide a non-threatening approach to ease into a verbal dialogue. With its use, individuals are able to verbalize feelings and experiences that were previously kept secret. As they express themselves, they are able to see their problems more clearly and begin to work towards solutions (Riley, 2001). The finished art product alone does not complete the expression, rather it comes when the feelings evoked through the exercise are expressed to others (Liebmann, 1994). Pennebaker (1990) found that although expression in itself was helpful, the greater benefits were recognized in the form of insight into personal experiences over time (Ferszt, Hayes, DeFedele, & Horn, 2004).

Art and other expressive mediums have been used throughout history as a means of helping individuals cope with the aftermath of upsetting experiences and trauma. In recent years, it has become common practice to address these types of issues using expressive arts in a group setting. For example, group art therapy was utilized with adolescents who had witnessed the terrorist attacks of September 11, 2001 in New York City. Teenagers participated in a project to process this experience by creating documentary films about the events (Tosone, Gelman, & McVeigh, 2005). Riley (2001) suggested that art therapy helped adolescents to view problems from a new perspective and externalize their experiences. Art therapy fosters support for youth who have experienced abuse, depression, low self-esteem, and feelings of failure (Riley).

Creative mediums such as art, music, dance, and drama enables the expression of deeper emotions and pain than is possible with verbal therapy. Wilson posited that the therapist's

primary responsibility is to serve as a witness or guide while clients make personal interpretations of their own work. Art therapy techniques help clients access deep feelings and memories and may expose hidden issues never expressed previously (Wilson, 1998). For inmates, creative expression provides socially acceptable coping skills by providing an emotional escape from the challenges experienced while incarcerated (Gussak, 2007; Liebmann, 1994). The work of Richards, et al. (2006) established that traumatic and upsetting experiences lead to physical, mental, psychological problems. Art therapy provides a socially acceptable way of expressing difficult experiences often considered inappropriate to express in other ways (Malchiodi, 2005). Through written and visual expression the health and behavior of the inmates was improved (Gussak, 2006; Richards, et al., 2006).

Another benefit of creative therapies is its unique ability to by-pass client defenses such as dishonesty and denial (Wilson, 1998). In many treatment situations, art therapy or another creative medium may be utilized to encourage clients to discover and express feelings that are difficult to express verbally (Ferszt et al. 2004; Gladding, 2005; Malchiodi 1998, 2003). According to Gussak (2006), art therapy encourages simplified expression of difficult concepts. It allows inmates and others to disclose emotions visually when they may not be comfortable or able to disclose verbally. In her work with a death-row inmate, Eisdell (2005) used visual expression to communicate where the client refused to do so verbally. Working with traumatized women, Wilson observed that most clients are willing to participate in creative activities after an initial hesitation.

Effectiveness in Correctional Facilities

Liebmann (1994) explained the factors leading to a successful implementation of art therapy in prison. Foremost, creative therapeutic intervention requires emotional risk. If successful, clients leave with a renewed curiosity about themselves and others. Images bypass well-practiced defenses. Visual expression can assess deeply held feelings and memories and open up issues that have been hidden or obstructed by denial and repression. Over treatment, it leads to a more direct expression of emotions through the use of images rather than words. Art therapy has the potential to engage even those individuals that are withdrawn and depressed, while alleviating feelings of isolation and desperation (Liebmann).

Incarcerated clients are ideal candidates for art and other creative therapy interventions. Their ability to express emotion is often severely limited by their setting and by their verbal skills (Eisdell, 2003; Ferszt et al., 2004; Young & Bemak, 1996). In a correctional facility, inmates withdraw in order to avoid criticism and disciplinary action (Gussak 2006). This treatment medium engages them through active participation, by encouraging creativity, and addressing difficult issues with a sense of play (Liebman, 1994). Individuals who have difficulty expressing feelings because of rigid defenses will benefit more from expressive therapies than those who are already adequately expressive or over-expressive. Young and Bemak concluded that those individuals who are under expressive may benefit most from expressive therapies.

Due to the difficulty in administering individual treatment in a jail setting, group therapy is often used (Merriam, 1998). This treatment medium requires active participation engaging clients in the process, encouraging creativity, and addressing difficult issues often with a sense of play (Liebmann, 1994). Malchiodi (2003) found that art therapy groups utilized the curative

factors identified by Yalom (Yalom & Leszcz, 2005) including: instilling hope, enhancing interaction, promoting universality, providing catharsis, and allowing altruism. Because of the isolation of incarcerated individuals, group work can be an important therapeutic tool for those who are in detention facilities. When the benefits of creativity for incarcerated individuals is considered, it is easy to recognize the necessity of investigating group art therapy in corrections facilities (Gussak, 2006).

Even without encouragement, creativity emerges in the form of drawings, tattoos, carvings, and crafts. According to Harrington (1997) art is one of the few legitimate profit-making enterprises in incarcerated settings. Inmates create a variety of items including portraits, crafts, and greeting cards that are traded for commodities and personal items (Harrington, 1997). Creative activities allow inmates to experience autonomy, self-expression and self-exploration, and provide them with opportunities to express emotions in an institutional setting that is rigid and controlling. Emotional expression while incarcerated sometimes leads to negative consequences from other inmates or staff. Expression through art and writing facilitates intense expression in acceptable and appropriate ways. Art has been prevalent in incarcerated settings (Gussak 2005).

Expressive Writing

Researchers concluded that expressive writing had been shown to improve physical health of persons who tend to be more inhibited, high in hostility, and are members of stigmatized groups (Richards, Beal, Seagal, & Pennebaker, 2000). Pennebaker (1990) theorized that unexpressed emotions led to physical, mental, psychological problems and monitored physical responses as evidence. He and his colleagues found expressive writing effective in

reducing infirmary visits among psychiatric prison inmates who were dealing with traumatic events (Richards et al). Further examination of his results led him to the conclusion that benefits from expressive writing treatments had long-reaching effects and were tied to the individual gaining greater self-understanding and insight into their experiences (Pennebaker). Bradley & Follingstad (2003) combined expressive writing and Dialectical Behavioral Therapy with incarcerated women who had experienced interpersonal violence. They found it to be effective in reducing PTSD, mood, and interpersonal symptoms and suggested that future research may be beneficial which incorporates other active interventions.

Pennebaker's (1990) theory of inhibition is based on the idea that individuals who fail to express upsetting emotions become physically and psychologically ill. In his studies he encouraged participants to disregard rules for writing and record whatever they felt best described upsetting and traumatic experiences. He monitored physical symptoms and visits to health facilities. Based on his results, writing therapy efficacy increased with the frequency of emotional words in the writing samples (Frattaroli, 2006). An overwhelming majority of participants benefited from improved personal insight and a better understanding of themselves and their experiences.

Art Therapy

One of the expressive therapies that has been used most successfully in corrections facilities is art therapy. Art therapy, often considered an adjunct to psychotherapy, can be an effective treatment modality in a variety of settings (Rubin, 2001). The American Art Therapy Association has defined art therapy as “the therapeutic use of art making, within a professional relationship, by people who experience illness, trauma, or challenges in living” (American Art

Therapy Association, 2005, p. 1). Treatment using art therapy involves “the use of art in the service of change on the part of the person who created the artwork” (Merriam, 1998, p. 9).

Each experience with art therapy provides an opportunity for growth and insight. Phillip (1994) elaborated on the value of a single art therapy session. She found that one experience of art therapy could potentially reawaken a sense of play, creativity and spontaneity. A single experience could help to establish a positive attitude about therapy and promote an increase in personal awareness. Riley (2001) posited that art is can serve as a non-threatening invitation to begin verbal dialogue. Illustrating the problem allows the individual to see problems from a new perspective.

The artwork becomes the focus and clients are able to distance themselves from their problem and begin to work toward solutions (Riley, 2001). Given the opportunity, clients are able to address the meaning of their own work while the therapist can help them to explore its meaning. Interpretation is ultimately up to the artist (Wilson, 1998). Wilson (2000) suggests that art therapy helps to develop a personal language of expression through images. Artistic expression fulfills both emotional and psychological needs, gives form to chaos, helps to master anxiety. She also found it helpful in dealing with addiction, feelings of powerlessness, and the feeling that life is unmanageable.

The art therapy treatment medium requires active participation, engaging clients in the process, encouraging creativity, and addressing difficult issues often with a sense of play (Liebmann, 1994). Ulman (1992), a pioneer in art therapy, describes art therapy as more than a springboard for the patient’s verbal association. She believes that the arts can make contribution to therapy that are not available in other mediums. She emphasizes the importance of both art

and therapy in treatment, that art is not therapy on its own. “Therapy is not enough, art is not enough either” (Rubin, 1999, p. 63).

Art Therapy for Trauma Treatment

Art therapy combines the inherent healing capacities of the creative process with the informed use of psychological principles integrating the essentials of creativity and healing. In a sense, art therapy provides an alternative language for examining and expressing human experience (Rubin, 1984). Researchers have discovered that traumatic memories are often stored in the mind in visual form. Thus visually expressing difficult memories may be more intuitive than verbal expression (Malchiodi, 1998). “Art therapy is a modality with special qualities for reparation, transformation, and self-exploration” (Malchiodi, 1998, p. 9). Merriam (1998) agreed that incarcerated women present with a wide range of treatment challenges due to the repeated traumas they have experienced including sexual and physical abuse such as incest, rape and physical assault. In addition, they suffer from extreme emotional effects such as fear, depression, anger, terror, grief, anxiety, rage and present with eating disorders, substance abuse, dissociation and self-injurious behaviors and suicide attempts (Merriam). Women detainees have experienced multiple loss and exhibit extreme symptomology which requires increased sensitivity in treatment. Merriam observed that art images enabled women to reconnect with upsetting thoughts and feelings safely (Merriam).

Merriam (1998) described some of the unique benefits of the use of art therapy with incarcerated women who had experienced severe trauma. Art therapy helped women with Dissociative Identity Disorder (DID) to facilitate connections among alters (Liebmann, 1994).

In her work with women who had experienced trauma, Gerity (1997) indicated that the clients most often drawn to art therapy were those who had been diagnosed with borderline personality disorder, dissociative identity disorder and PTSD, and/or who shared a history of various kinds of trauma or abuse. These clients seemed better suited for art therapy than for verbal groups due to the visual storage of traumatic experiences. Her explanation was that much of the trauma occurred before clients had developed language. Consequently, they were more accessible through art therapy (Gerity).

Art therapy benefits women who have been traumatized by providing a protected environment for lowering defenses, releasing tension, and providing opportunities for insight. It has also proven helpful in gaining access to information that clients have repressed, denied or dissociated. Art therapy can also help to foster improved self-soothing in women who have been abused (Liebmann, 1994; Merriam, 1998). Wilson (2000) utilized art therapy techniques focused on shame related to trauma and addiction. This shame results in feelings of unmanageability and powerlessness, and a continuation of dysfunctional behaviors. Shame is difficult to verbalize and more easily expressed through imagery and symbolism. Through art therapy, they are empowered to begin the process of recovery (Wilson, 2000).

Art Therapy within Correctional Facilities

Several facets of prison life and culture render art therapy an effective treatment for inmates. Emotional expression while incarcerated sometimes leads to negative consequences. Verbal expression of some emotions may be viewed by correctional staff and other inmates as a weakness, or as a threat (Ferszt et al., 2005). However, art and writing exercises facilitate intense expression in acceptable and appropriate ways. Art has been a prevalent pastime in incarcerated

settings (Gussak, 2005). Inmates, already comfortable with art and creativity, transition effectively to a therapeutic use of art. (Ferszt et al., 2005).

The ability of art therapy to overcome obstacles to verbal communication has been demonstrated in a correctional setting. It also equalizes individuals on the basis of education and literacy (Gussak, 2005). Cronin (1994) argued that art therapy is especially effective with women in prison because it is a place of great uncertainty. While incarcerated, women face a separation from family, friends, and familiar surroundings, long periods of waiting, stress of appearing in court, and lack of communication with family, which all contribute to anxiety and feelings of insecurity. In addition, prison is associated with punishment, loss of freedom and choice. Offering therapy with its implication for change, and empowerment, sometimes seems to clash with the prison environment. Some view prison as a pause, or a break from their stressful existence outside jail, which enables inmates to step back and reevaluate life patterns. Visual images in the form of art enables prisoners to associate with several experiences simultaneously and make links between the content of therapy sessions, prison and offending behavior (Cronin).

Creative expression provides socially acceptable coping skills by providing diversion and emotional escape from the challenges of prison life (Gussak, 2007; Liebmann, 1994). Gussak found that the art therapy participants' attitudes improved, their acceptance of one another and the environment increased, and there was better interaction between staff and peers. (Gussak, 2005). Inmates utilize art as a means to cope with the drab sterile environment and dragging time of prison life. Art therapy encourages simplified expression of difficult concepts, and allows the inmate to disclose visually when he may not choose to or feels unable to disclose verbally (Harrington, 1997).

Through the use of art therapy a permanent tangible record of the therapeutic process is available for observation and continued discussion with the client and could serve as a record and a reminder of insights and growth (Ferszt, et al., 2004; Pennebaker, 1990). In the event that the images are difficult to talk about at the time they are created they can be revisited when the issues can be addressed (Wilson, 1998). At any point the therapist or the client can refer back to stimulate or reinforce therapeutic work with an accuracy that is not possible with verbal therapy. Client art work can also be viewed chronologically to identify emerging patterns and cite therapeutic progress (Hanes, 2001).

In an attempt to establish more quantitative evidence of the effectiveness of art therapy against depressive symptoms, Gussak (2007) conducted consecutive studies with male inmates. His studies took place in a state correctional facility. Inmates participated in art therapy sessions over a period of eight weeks. Testing instruments were administered at the beginning of treatment and again at the conclusion of the treatment. Results from the Beck Depression Inventory-Short form (BDI-II) indicated significant improvement in depressive symptoms, however, the results were inconclusive using the Formal Elements Art Therapy Scale (FEATS). Although the initial study did not have a control group, subsequent studies were compared to a similar group of inmates who did not receive art therapy treatment. This important research resulted in long term research placement for art therapy in the state prison system. Other positive effects observed in this study included decreased depression, improved mood and attitude, better inmate behavior, improved socialization skills, and increased compliance with staff and facility rules. (Gussak, 2004a, 2006b, 2007c).

Arts Therapy in Groups

Creating art in a group setting adds unique benefits to working alone (Malchiodi, 1998). Waller (2003) stated that producing images in a group setting added a dimension to communication and expression that could not be achieved while working alone. Using art therapy in group settings allows each individual to work at the same time to illustrate their feelings and then find support from others as they share these feelings verbally (Gladding, 2005). Because all of the members of the group have shared the experience of creating the art, they are more likely to be empathetic and receptive to giving and receiving feedback to one another (Waller). In treatment groups people can share traumatic material within the safety, cohesion, and empathy provided by other survivors (Collie, et al. 2006; Pressman, 2005). Although individuals learn from their own work, there is an added effectiveness to the group as they view the artwork of others and listen to their stories (Samuels, 1994).

Creative arts therapy can be adaptable to large groups where counselors have limited time for treatment. In a group of this kind, each participant is able to be personally involved in their own treatment work and each gain personal insight required to address difficult issues (Kahn & Villanova, 1999). Women inmates share common issues and gain increased insight as they view others work while hearing about their experiences in group discussions. This allows a connection on a more personal level and broadens the opportunity for insight and growth (Kahn & Villanova; Samuels, 1994).

Anticipating an increase in military personnel suffering from trauma, Collie, Backos, Malchiodi, and Spiegel (2006) recommended art therapy in group settings. They proposed that it would provided efficient and effective treatment for combat related PTSD. Art therapy provides

for them an effective means to address avoidance, emotional numbing, and other symptomology. When used in a group format, clients are able to share traumatic experiences and express empathy with others in a safe, cohesive, trusting environment. Art therapy and group therapy have been used effectively in the past to help individuals who were traumatized by war (Rubin, 1968). This treatment enables non-verbal expression, relaxation, externalization, containment, symbolic expression, and the pleasure of creation (Collie, et al., 2006).

Because of the isolation of incarcerated individuals, group work can be an important therapeutic tool for those who are in detention facilities (Liebmann, 1994). When coupled with the known benefits of creativity for this population, a strong case can be made for continuing to investigate group art therapy in detention facilities. Art therapy is adaptable to large groups where counselors have limited time for treatment while availing each participant with the personal involvement and insight required to address difficult issues (Kahn, & Villanova, 1999). Women inmates share common issues and may benefit from viewing the work of others while hearing their stories and can often relate to the experience on a personal level (Kahn & Villanova; Samuels, 1994).

This review of the literature indicates that art therapy has been used with incarcerated individuals. Literary sources are primarily anecdotal in nature exploring the use of art therapy in a variety of settings with generally positive results. However, empirical research is limited. This study is designed to provide additional empirical data addressing the usage of group art therapy with incarcerated women.

CHAPTER THREE: METHODOLOGY

This research study was designed to empirically test the effect of art therapy techniques used with incarcerated women measured by psychological outcome scores. The treatment consisted of a variety of art therapy treatment exercises used with a group of incarcerated women over a three week period of time. The treatment group and the control group were pre and post-tested with instruments to assess trauma and psychological distress. This chapter describes the methodologies, considerations, and procedures used to conduct this study.

Research Question

Are expressive arts treatments effective in decreasing symptoms of trauma and psychological distress in incarcerated women?

Research Design and Limitations

This study is a quasi experimental design comparing two groups of incarcerated women. Women from two county correction facilities in the Southeastern United States participated in the study. Control and treatment subjects were obtained from both institutions. The treatment group received art therapy treatment while the control group received the mental health services available to all inmates in the correctional facility. Art therapy participants met twice weekly for three weeks for a total of six sessions. Pre and post treatment measures were administered to all subjects at the beginning of the first session and following the last session. Demographic information was collected using a separate survey to help better characterize the participants of the study. A post study evaluation questionnaire was completed to obtain participant reactions to their experience with the study.

Groups for this study were conducted by the primary investigator. Working in a correctional facility can be intimidating for someone entering this environment for the first time. Prior experience working with inmates in a corrections setting allows the therapist to be prepared for the atmosphere and procedures inherent in jails. Though the counselor needn't be an artist or art therapist, experience and understanding of the art therapy medium is essential. Inmates are sometimes difficult clients, experience and confidence in the counseling profession is important to the effectiveness of the study.

Participants

Participants were incarcerated women over the age of 18. Correctional facility rules eliminated anyone whose incarceration was related to extreme violence or those individuals being held temporarily for federal matters. The initial sample number (N=50) began the study by completing a demographic questionnaire and outcome measures. Of those 50, 26 were completers, with 12 in the control group and 14 in the treatment group.

Women inmates are housed in dorms called *pods* and spend all of their time in relative proximity to one another. This made confidentiality difficult to maintain even though participants were asked to refrain from discussing their treatment outside of the session. For this reason and practical requirements of the correctional facility, treatment groups were assigned by dorm. This also helped to simplify the process of assembling the participants and escorting them to and from the treatment location by correctional staff.

Approval Procedures

Approval procedures included an application to the Director of Corrections and programs staff at the John E. Polk Correctional Facility, Seminole County, Florida, and the Lake County,

Florida Correctional Facility. Each facility was supplied with a description of the study and all treatment materials. Procedures for obtaining authorization for conducting research inside corrections facilities differ according to each organization. The primary investigator complied with a background check and attended a volunteer security training session before receiving approval to enter the facilities. The study was conducted in compliance with all regulations set forth by the American Corrections Association and the National Commission on Correctional Health Care. Institutional Review Board (IRB) applications were submitted and approved through the University of Central Florida (see Appendix A).

Recruitment and Enrollment Procedures

A flyer was displayed in *pods* where female inmates were housed which described the study and asked for volunteers for participation (Appendix B). They were invited to attend an introductory session where they would learn about the study, trauma, and related symptomology. They were informed that participation was voluntary and that they had the option to drop out at any time without negative consequences. They were informed that their participation would have no effect upon their standing in the jail and that they would receive no tangible rewards such as money or goods for participation according to corrections regulations. They were assured that personal information, drawings, and test results would be kept confidential and that all drawings would be returned to participants. The women were further informed that the results of the study would be shared with the correctional administrators and potentially published, but would not include any individual identifying information. Informed consent agreement forms were discussed and completed at the beginning of the study (Appendix C).

Each participant was assigned a confidential identification number which was used to identify treatment work and research instruments. These numbers coincided with a master list of participants kept by the primary investigator in a password protected file on a laptop computer and were used only to ensure that instrument scores were matched appropriately when recorded. Participants were asked to refrain from adding identifying information to their drawings and any inadvertent use of names were blacked out before the work was viewed or photographed.

Treatment Procedures

Art therapy groups were held in a classroom inside each facility. All sessions consisted of a brief introductory discussion that clarified concepts, stimulated introspection, and described treatment exercises. Materials were issued and participants were given time to complete each sessions treatment work (45 minutes to one hour). Each session concluded with a group discussion where each individual talked about their drawing as well as feelings and insights about the experience. All sessions lasted between 60 and 90 minutes.

All materials required for the interventions were provided by the primary investigator. All regulations concerning appropriate materials for inmate use were strictly observed. Materials included drawing paper, water-based markers, crayons, and pencils. These materials were chosen because they were inexpensive, non-toxic, required little clean-up and most clients were comfortable using them. During the sessions, participants were able to use their choice of the materials offered which included unlimited paper. In a jail setting, it is necessary to inventory all drawing materials before ending the session as a precaution that materials may be stolen and misused by inmates according to jail regulations.

An emphasis was made in every session to discourage self-consciousness about drawing expertise. Participants were informed that art therapy was not concerned about the final product quality, but rather concerned about the thinking involved. They were informed that their drawing ability would compare to the drawings they had done as a child, and that these results were acceptable for study purposes. The simplicity of the drawing materials also contributed to the basic quality of drawings, as they were the materials commonly used by children.

Six art therapy exercises were chosen to address issues commonly experienced by women related to incarceration, trauma and addiction (Appendix D). The first sessions were designed to help establish comfort with the art therapy medium, establish group norms, and begin to develop trust between the therapist and group members. Each subsequent exercise by design increased in intensity and depth evoking deeper feelings while encouraging increased client insight and disclosure. Exercises contained opportunities for creative thinking and humor to ease self-consciousness about each individual's ability to draw and to enable expression.

Each drawing exercise was designed to help participants begin to address issues related to trauma and incarceration. For some, this was their first exposure to therapy of any kind. The first exercise, *My Happily Ever After*, directed participants to think about what the phrase would mean to them individually (Boothroyd, 1995). They were asked to identify the elements they would like to have in their lives that they believed would lead to happiness then illustrate these ideas. This exercise was mild in intensity so that participants would have a better idea of what would be expected of them in the program. It also contributed to the beginning of the development of group cohesion and a therapeutic relationship.

Exercise two, *Masks*, required additional introspection and self-disclosure (Malchiodi, 1998). The session began with a discussion about masks, how and why people use them, examples of masks observed in others and the positive and negative effects of wearing masks. For those who were especially uncomfortable with drawing, the option of beginning their drawing with an outline of a mask was introduced. Participants were asked to identify the masks they wear to protect themselves or to hide the truth.

Exercise three, *The Child Within*, was based on Bradshaw's (1998) concept that three voices or roles can be identified in our thoughts. These include the child voice, the parent voice and the adult voice, each influencing our ability and methods for making decisions. This concept was difficult for participants to grasp and it became necessary to alter the concept of the drawing exercise. Through guided imagery, volunteers visualized themselves as children and identified a particularly traumatic experience they had during childhood. These were illustrated and discussed. The concept was considerably easier to grasp. The original concept was too complicated for a beginning group and might be more appropriate with a group who had had more therapeutic involvement.

Exercise four, *Monsters*, was based partially on concepts introduced by Malchiodi (1998). During the introductory discussion, participants explored the concept of monsters. What are their characteristics, what feelings do monsters evoke, are they the same for everyone? Participants were asked to identify one or more personal monsters in their lives that fit the qualities discussed. This exercise provided an opportunity to address serious issues with humor and contributed to group cohesion and comfortable and appropriate self-disclosure.

Exercise five, *My Most Upsetting Experience*, originated from Pennebaker's (1990) work with expressive writing. He asked study participants to write about the most upsetting experience they could share that they had never shared before. Participants were asked to illustrate their most upsetting experience. Early in the discussion, it was obvious that the concept was overwhelming to group participants. They were required to review a lifetime of difficult experiences in order to identify the most upsetting. Group members were hesitant to begin drawing, silent and unresponsive. The exercise was modified by reducing the size of the task. The assignment was limited by narrowing the time of life to either childhood or adolescence. Group members were then able to identify a specific experience and complete the exercise. This exercise was effective after the changes were made.

Exercise six, *Lost and Found*, was designed as a termination exercise for the group. The opening discussion encouraged participants to think back over traumatic experiences and identify the losses and the gains that may have resulted from difficult experiences. Participants were encouraged to identify strengths or knowledge gained that may be viewed in a positive way as well as the real losses they had experienced. When drawings were shared, group members discussed how traumas had changed their lives and how they could be dealt with in the future.

Women in the treatment group and the control group had access to other psychiatric services routinely made available within the correctional facilities. Mental health professionals provided mental health status assessments, psychiatric referrals, medication management, and mental health observations. Psychoeducational groups were offered related to addiction, anger management, domestic violence, and related topics. Inmates at their own discretion or by referral attended life management sessions and Alcoholics Anonymous or Narcotics Anonymous

meetings. Upon release, inmates were provided with referrals to services in the community for additional services. Records of inmate participation data in these groups were not accessible.

Instruments

Four instruments were used to gather data for this study. A demographic questionnaire developed for this study was used to gather information about the participants which included age, marital status, education level, number of children and their custody status, reason for incarceration, substance use history, incarceration history, and mental and medical health history (Appendix E). The Trauma Symptom Inventory (TSI) and the Outcome Questionnaire (OQ-45-2) were used as pre-test and post-test measures. At the conclusion of the study participants completed a short questionnaire with open-ended questions to describe their experience in the study.

Trauma Symptoms Inventory (TSI)

The Trauma Symptoms Inventory (TSI) (Briere, 1998) was designed to evaluate acute and chronic traumatic symptomatology in adults. The measure was a self-report instrument that consisted of 100 items describing trauma-related symptoms rated on a 4-point Likert scale (0 = never, 3 = often) and their frequency of occurrence over the preceding six months. The test was written on a fifth to seventh grade reading level and required approximately 20 minutes for completion. Scores reflected ten symptom domains: Anxious Arousal (AA), Depression (D), Anger/Irritability (AI), Intrusive Experiences (IE), Defensive Avoidance (DA), Dissociation (DIS), Sexual Concerns (SC), Dysfunctional Sexual Behavior (DSB), Impaired Self-reference (ISR), and Tension Reduction Behavior (TRB). It also provided three validity scales that indicated atypical responses (ATR), response level (RL), and inconsistent responses (INC)

Outcome Questionnaire (OQ45.2)

The OQ-45.2 (Outcome Questionnaire) developed by Lambert and Burlingame (1998) is a 45-item self-report questionnaire designed as a brief screening and outcome assessment scale that measures subjective distress as well as the effects of this stress on how individuals function in the world. (Lambert, et al., 1998). The instrument can be completed in approximately 10-15 minutes and was written at a sixth grade reading level (Hanson, 2007; Merker, 2007). The questions were rated on a five-point Likert scale ranging from never to almost always. In addition to the total score, the OQ-45.2 measured how a person was feeling, getting along with others, and how they were functioning in important life tasks, with three sub-scores: symptom distress (SD), interpersonal relationships (IR), and social role and occupational functioning (SR). This instrument has been shown to be sensitive to change and was designed for repeat administrations. The OQ45.2 has been found to be broadly applicable across ages, diagnoses, treatment modalities and clinician orientations (Hanson, 2007; Merker, 2007)

Demographic and Post-test Questionnaires

A demographic questionnaire was used to identify information including age, ethnicity, education level, marital status, number of children and their custody standing, substance use history, incarceration history, and mental and medical health history (Appendix E). This instrument addressed inmate issues such as the cause for incarceration, number of times the inmate had been incarcerated, substances used, along with past and present mental and medical diagnoses. The follow up questionnaire contained a series of short answer questions that encouraged participant feedback about the study. Attendees were asked to identify how the experience was positive or negative, if the treatment had been enjoyable, whether or not they

considered the experience to be beneficial or worthwhile, and if they would recommend the group to others (Appendix F).

Data Collection Procedures

Four self report instruments were administered in a group setting according to the administration procedures provided with each test instrument. At the beginning of the study, participants completed the demographic questionnaire, the OQ-45.2, and the TSI. The instruments were issued to participants in a large envelope marked with a confidential identification number on the outside which coincided with a master list. Each inmate entered the number on the questionnaires, completed the instruments, and placed them back in the envelope for collection. At the conclusion of the study, a similar procedure was followed with care taken to match individuals using the same confidential identification number as was initially used for the completion of the OQ-45.2, TSI, and post-test evaluation questionnaire.

Data Analysis

Data was entered into and analyzed using Statistical Package for Social Sciences (SPSS) 13.0 for Windows Student Version. An Independent *t* test was used to compare pretest scores to establish equality of variance. Pre and post-test TSI and OQ-45.2 scores were compared using paired sample *t*-tests. Effect size was calculated using a Pearson's correlation (Field, 2005). A multivariate analysis of variance (MANOVA) was used to identify interactions between the subscores and identify potential type I error introduced by using multiple *t* tests. Frequencies were calculated using the information contained in the demographic questionnaire.

Summary

This chapter describes the methodology applied to test the effectiveness of art therapy treatment with incarcerated women. Two groups participated in this quasi-experimental study, one group participated in art therapy sessions over three weeks, the other received standard treatment provided through the correctional facility. The procedure for conducting the groups and exercises used are discussed and outlined. Each participant completed psychological outcome questionnaires before and after the treatment to test the effectiveness of the treatment in decreasing symptoms of trauma and psychological disturbances. All treatment groups and testing were administered between November, 2007 and April, 2008. The results of this study provided information regarding the use of group art therapy with female prisoners.

CHAPTER FOUR: FINDINGS

This chapter contains a summary of information obtained from demographic questionnaires, two outcome measures, and post-study qualitative evaluations completed by the participants. The demographic questionnaire provided background information on the participants including ethnicity, family background, legal infractions and trauma experienced. The two outcome instruments used at pretest and posttest were the Outcome Questionnaire (OQ-45.2) (Lambert & Burlingame, 1998) and the Trauma Symptom Inventory (TSI) (Briere, 1998). Data from the OQ45.2 and TSI were entered into SPSS. Tests performed are described and the results are reported. Qualitative results of the treatments are reported, including participant post-study qualitative evaluation responses with feedback on the perceived value and efficacy of the study.

Study Participation and Data Collection

Fifty incarcerated women in two county correctional facilities were initially enrolled in the study and completed preliminary measures including the demographic questionnaire and psychological outcome measures (TSI and OQ-45.2). Participants were assigned to treatment groups according to living arrangements. Thus, those in the control group were not in the same dormitories as those in the treatment group. Of the original 50 volunteers, twenty-six women (N = 26) completed the study including retaking the psychological outcome measures and the qualitative post-study evaluation. Figure 1 illustrates the reduction of group numbers. Due to the transient nature of individuals in the county jail environment twelve participants were eliminated from the study due to various administrative legal actions. Four subjects chose to withdraw and

three additional subjects were removed for disciplinary reasons. Five subjects discontinued for undisclosed reasons leaving 26 subjects completing the study.

According to test creator recommendations, some scores were considered invalid and were not included in the statistical analysis. OQ-45.2 guidelines indicate that total scores of 20 or below are invalid, resulting in two subjects not being included in the analysis. Remaining OQ-45.2 scores included 13 individuals in the art therapy treatment group and 11 in the control group. The TSI contains three validity scales that evaluate lack of response or inconsistent and atypical responses that may invalidate the instrument. Scores for one subject were outside these limits and were therefore eliminated before statistical analysis was conducted. The final TSI data included 14 in the art therapy treatment group and 11 in the control group.

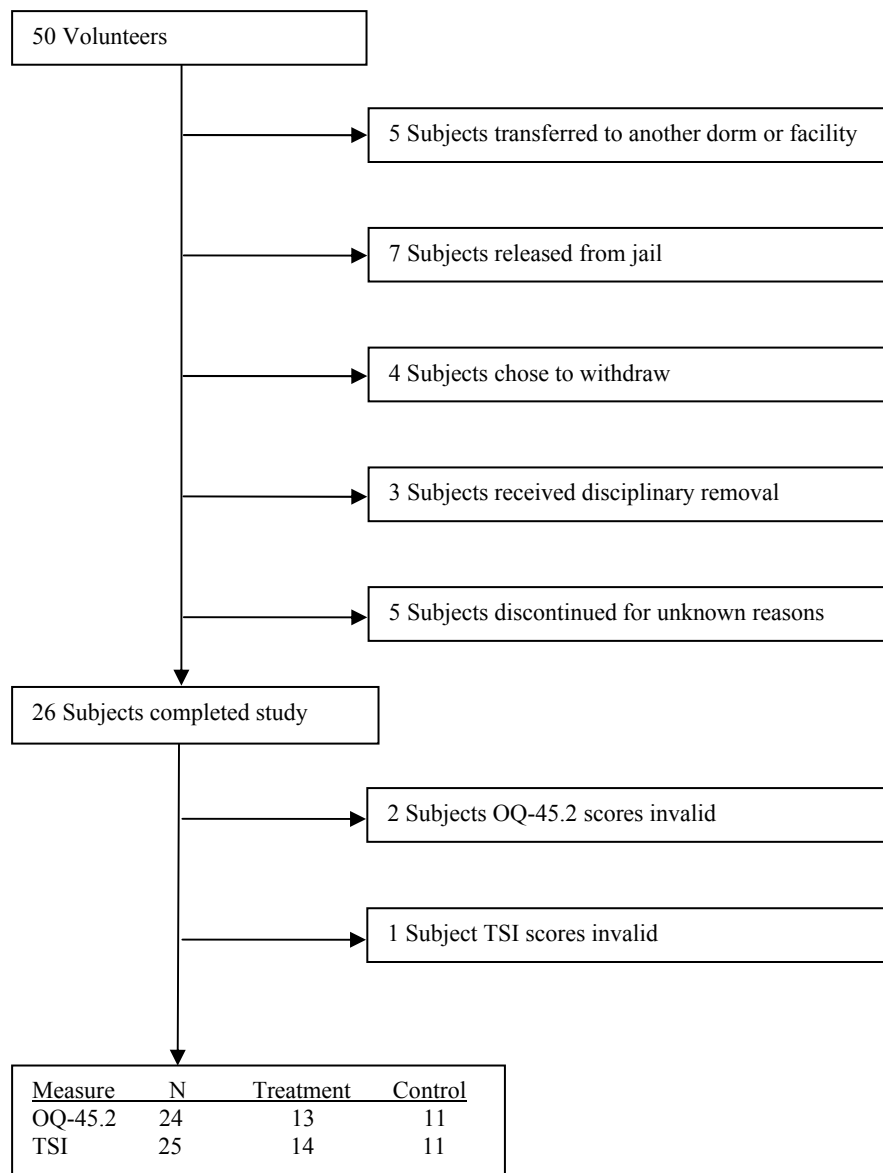


Figure 1 Attrition Flow Chart

Demographic Summary

In the initial session, participants were asked to complete a demographic questionnaire. When asked about ethnicity, participants responded 52% white, not Hispanic Origin, and 48%

Black or African American. Ages ranged between 20-50 years old with the mean age of 31.24. The majority of study participants were mothers (80%). Of those participating, 24% were incarcerated for the first time, while 76% reported previous jail terms. Times incarcerated ranged from 1-25 with 6.25 representing the average number of times in jail. Over half of study participants (52%) reported that members of their immediate family had been incarcerated or were incarcerated at the time of the study.

Nearly half of participants (48%) reported a history of physical abuse and/or sexual abuse, (36% before the age of 20) and 32% reported physical abuse and domestic violence. Medical diagnosis was reported at 28% and mental health diagnosis at the same rate. In addition, nearly a fourth (24%) reported having been hospitalized in a mental health facility. Nearly half (48%) of participants chose not to answer questions related to drug use while 36% reported that they regularly used drugs and alcohol with 28% admitting to being under the influence at the time of arrest.

Participants were asked to describe the charges leading to their incarcerations. Responses included charges related to drugs, which included possession of drugs and drug paraphernalia, purchasing drugs, trafficking drugs, fraud and forgery charges, robbery, burglary, grand theft, and grand theft auto. Some were arrested for violation of probation and driving violations such as driving without a valid license, hit and run, and driving under the influence. Only two were charged with violent crimes such as assault with a deadly weapon, and battery, and one was arrested for failure to comply as a sex offender. Two individuals did not respond to this item. In most cases, individuals were arrested for more than one charge.

Statistical Analyses

It was assumed that population variances between the treatment and control groups were the same at the beginning of the experiment. Following the data analysis pattern found in similar tests reported in the literature (Gusssak, 2006; Pifalo, 2006), an independent samples t test was performed to test this assumption using the initial scores on the OQ-45.2 (Table 1) and the TSI (Table 2). As previously indicated in Figure 1 the OQ-45.2 scores included 13 individuals in the art therapy treatment group and the control group included 11 individuals. The analysis for the TSI included 14 individuals in the art therapy treatment group and 11 in the control group.

The independent t test for the OQ-45.2 supported the assumption of homogeneity of variances for scores on the Total and all subscales, including Symptom Distress (SD), Interpersonal Relations (IR), and Social Role Performance (SR) (Table 1). The data in the table shows means (M), standard deviations (SD) and the degrees of freedom (df) for both the art therapy and control groups. The data in the t test (t) column show $t = .813, .629, -.516,$ and $.586$ for SD, IR, SR and Total respectively. Statistical significance is $.425, .535, .611$ and $.586$ for SD, IR, SR and Total respectively, none of which approach significance at the $p = .05$ level. Pearson's r data as seen in Table 1 range from $.167$ to $.121$ across the scores, all of which indicate a small effect size.

Table 1. OQ-45.2 Scores for Art Therapy and Control Groups at Pretest

OQ Score	Group	<i>M SD</i>	<i>df</i>	<i>t</i>	significance	<i>r</i>
Symptom distress	Art therapy	37.31 (10.77)	23	.813	.425	.167
	Control	32.83 (16.39)				
Interpersonal relations	Art therapy	19.46 (6.24)	23	.629	.535	.130
	Control	17.67 (7.98)				
Social role performance	Art therapy	10.38 (4.21)	23	-.516	.611	.121
	Control	11.25 (4.16)				
Total score	Art therapy	67.15 (18.21)	23	.586	.563	.121
	Control	61.75 (27.31)				
<i>p</i> < .05						

Table 2 follows the same pattern as found in Table 1, but provides statistical analysis on TSI pre-scores utilizing the independent *t* test. The test assumption again was that there was no variance between the pre-treatment test scores of the treatment and control groups. With one exception the assumption of homogeneity of variances between the two groups was established. Data for Anxious Arousal (AA), Depression (D), Anger/Irritability (AI), Defensive Avoidance (DA), Dissociation (DIS), Sexual Concerns (SC), Dysfunctional Sexual Behavior (DSB),

Impaired Self Reference (ISR) and Tension Reduction Behavior (TRB) produced non-significant t tests and all Pearson's r results indicated small effect sizes. The exception was the Intrusive Experiences (IE) scale where the group did not meet the assumption of homogeneity and equal variances could not be assumed according to Levene's test for equality of variance ($p = .03$). Therefore, Table 2 reports M, SD, df, t , significance and r for the alternate hypothesis on this scale, supporting unequal variances between the art therapy and control group at the beginning of the study for this scale.

Table 2. TSI Scores for Art Therapy and Control Groups at Pretest

TSI Scale	Group	<i>M SD</i>	df	<i>t</i>	significance	<i>r</i>
Anxious arousal	Art therapy	52.57 (9.53)	23	.084	.934	.018
	Control	52.18 (13.75)				
Depression	Art therapy	55.00 (9.17)	23	.373	.712	.078
	Control	53.64 (8.93)				
Anger/irritability	Art therapy	57.29 (11.38)	23	.724	.476	.149
	Control	54.09 (10.36)				
Intrusive experiences ¹	Art therapy	61.57 (7.52)	15	.600	.558	.153
	Control	58.91 (13.13)				
Defensive avoidance	Art therapy	62.07 (8.98)	23	.631	.534	.130
	Control	59.36 (12.48)				
Dissociation	Art therapy	57.57 (8.72)	23	1.087	.289	.221
	Control	53.45 (10.23)				
Sexual concerns	Art therapy	54.71 (10.44)	23	-.229	.821	.048
	Control	55.82 (13.69)				
Dysfunctional sexual behavior	Art therapy	65.07 (16.76)	23	.278	.784	.058
	Control	63.09 (18.86)				

TSI Scale	Group	<i>M</i> <i>SD</i>	df	<i>t</i>	significance	<i>r</i>
Impaired self-reference	Art therapy	57.14 (8.71)	23	-.449	.658	.093
	Control	59.00 (12.01)				
Tension reduction behavior	Art therapy	61.50 (14.83)	23	.024	.981	.005
	Control	61.36 (13.31)				

p < .05
¹ Levene's test for equal variances not assumed *p* < .05

Paired-samples *t* tests were conducted comparing pretest and posttest scores for the art therapy group and then the control group. These statistical analyses indicated the degree of change within each group over the duration of the experiment. With the OQ-45.2 data with the treatment group the SD sub-score improved significantly as did the Total score. The IR sub-score approached significance (Table 3). Specifically, results for SD indicated that pretest scores (*M* = 37.31, *SD* = 10.77) were significantly better than posttest scores (*M* = 31.00, *SD* = 12.85), *t*(12) = 2.25, *p* < .05, (*r* = .544) a large effect size. Results for IR pretest scores (*M* = 19.46, *SD* = 6.24) approached significance when compared with the posttest scores (*M* = 16.69, *SD* = 5.62), *t*(12) = 2.17, *p* > .05, (*r* = .53) a large effect size and the results for total score pretest (*M* = 67.15, *SD* = 18.21), and posttest (*M* = 57.69, *SD* = 22.07, *t*(12) = 2.34, *p* < .05, were also significantly different with a large effect size (*r* = .56).

The only OQ-45.2 scores not showing improvement in the art therapy group were associated with SR (pretest $M = 10.38$, $SD = 4.21$), and posttest ($M = 10.46$, $SD = 4.31$, $t(12) = -.09$, $p > .05$, $r = .025$).

Table 3. Art Therapy Treatment Comparison for Pretest and Posttest OQ-45.2 Scores

OQ Score	Pretest <i>M SD</i>	Posttest <i>M SD</i>	df	<i>t</i>	significance	<i>r</i>
Symptom distress	37.31 (10.77)	31.00 (12.85)	12	2.25	.044	.544
Interpersonal relations	19.46 (6.24)	16.69 (5.62)	12	2.17	.051	.530
Social role performance	10.38 (4.21)	10.46 (4.31)	12	-.09	.933	.025
Total score	67.15 (18.21)	57.69 (22.07)	12	234	.038	.559

$p < .05$

Table 3: Art Therapy Treatment Comparison of Pretest and Posttest OQ-45.2 Scores.

The paired-samples t test comparing OQ-45.2 pretest and posttest scores for participants in the control group indicated no statistically significant changes within this group during the study (Table 4). However, the numerical values did improve unexpectedly even with no treatment and will be discussed in more detail Chapter Five.

Table 4. Control Group Comparison of Pretest and Posttest OQ-45.2 Scores

OQ Score	Pretest <i>M SD</i>	Posttest <i>M SD</i>	df	<i>t</i>	significance	<i>r</i>
Symptom distress	32.83 (16.39)	29.50 (19.29)	11	1.67	.123	.450
Interpersonal relations	17.67 (7.98)	13.83 (8.16)	11	1.84	.093	.485
Social role performance	11.25 (4.16)	11.08 (6.22)	11	.14	.895	.041
Total score	61.75 (27.31)	54.33 (31.45)	11	1.80	.099	.477

$p < .05$

Statistical comparison of TSI scores pretest and posttest for the art therapy group unlike those previously reported with the OQ-45.2 resulted in only one of the ten scales indicating significant change and two of the scales somewhat approaching significance. The remaining seven scales indicated no significant change resulting from the art therapy treatment. Scores for ISR were significant at the 95% confidence level with pretest ($M = 57.14$, $SD = 8.71$) and posttest ($M = 53.14$, $SD = 8.71$), $t(13) = 1.83$, $p < .05$, $r = .525$, while scores for IE and DSB approached significance. Scores for the IE scale were significantly improved at the 90% confidence interval, pretest ($M = 61.57$, $SD = 7.52$) and posttest ($M = 58.29$, $SD = 7.69$), $t(13) = 1.88$, $p < .10$, $r = .461$, and DSB results were significant at the 90% confidence level, pretest ($M = 65.07$, $SD = 16.76$) and posttest ($M = 58.64$, $SD = 9.66$), $t(13) = 1.17$, $p < .10$, $r = .453$.

Table 5. Art Therapy Treatment Group Comparison of Pretest and Posttest TSI Scores

TSI Scale	Pretest <i>M SD</i>	Posttest <i>M SD</i>	df	<i>t</i>	significance	<i>r</i>
Anxious arousal	52.57 (9.53)	50.07 (8.91)	13	1.40	.186	.361
Depression	55.00 (9.17)	52.07 (7.48)	13	1.45	.170	.373
Anger/irritability	57.29 (11.38)	53.36 (11.12)	13	1.38	.191	.357
Intrusive experiences	61.57 (7.52)	58.29 (7.69)	13	1.88	.083	.461
Defensive avoidance	62.07 (8.97)	60.29 (10.08)	13	.93	.371	.248
Dissociation	57.57 (8.72)	54.71 (10.92)	13	1.69	.114	.425
Sexual concerns	54.71 (10.44)	52.00 (7.57)	13	1.17	.262	.309
Dysfunctional Sexual Behavior	65.07 (16.76)	58.64 (9.66)	13	1.17	.090	.453
Impaired self-reference	57.14 (8.71)	53.14 (8.71)	13	1.83	.044 *	.525
Tension reduction behavior	61.50 (14.83)	56.57 (9.98)	13	1.43	.175	.369

* $p < .05$

Similar to the results on the OQ-45.2 the analysis of pretest and posttest data on the control group TSI scores generally indicated numeric improvements even though no treatment was received, but resulted in no statistically significant improvements. Unlike the remainder of the data the DIS scale on the TSI instrument resulted in a non-significant negative response. Scores for the DIS scale pretest ($M = 53.45$, $SD = 10.23$) were not significantly different than posttest scores ($M = 56.73$, $SD = 11.70$), $t(10) = -1.121$, $p > .05$, $r = .334$, but resulted in a -1.121 non-statistical negative response.

Table 6. Control Group Comparison of Pretest and Posttest TSI Scores

TSI Scale	Pretest M SD	Posttest M SD	df	t	significance	r
Anxious arousal	52.18 (13.75)	51.73 (12.95)	10	.252	.806	.079
Depression	53.64 (8.93)	52.09 (9.86)	10	.765	.462	.235
Anger/irritability	54.09 (10.36)	51.73 (10.52)	10	.992	.345	.299
Intrusive experiences	58.91 (13.13)	57.09 (15.62)	10	.995	.343	.300
Defensive avoidance	59.36 (12.48)	58.82 (12.03)	10	.367	.721	.115
Dissociation	53.45 (10.23)	56.73 (11.70)	10	-1.121	.289	.334
Sexual concerns	55.82 (13.69)	53.36 (12.27)	10	1.155	.275	.343
Dysfunctional sexual Behavior	63.09 (18.86)	59.64 (18.02)	10	1.026	.329	.309
Impaired self-reference	59.00 (12.01)	56.82 (10.74)	10	.976	.352	.295
Tension reduction behavior	61.36 (13.31)	58.36 (14.09)	10	.974	.353	.294

$p < .05$

Independent t tests were lastly conducted to compare posttest OQ-45.2 and TSI scores for both the art therapy and control groups to determine if group changes were significantly different (Tables 7 and 8). Since significant reductions in scores were observed with the OQ-45.2 data comparing pretest and posttest results in the art therapy group evaluations with no significant reductions with control group data, it was suspected that posttest OQ-45.2 scores comparing art therapy and control groups might indicate significant changes in this test comparison. However, neither the individual scale scores nor the total score of the OQ-45.2 indicated significant differences between art therapy and control group variances (Table 7), establishing the

assumption of homogeneity of variances between the posttest results of the art therapy and control groups.

Table 7. OQ-45.2 Scores for Art Therapy and Control Groups at Posttest.

OQ Score	Group	<i>M SD</i>	df	<i>t</i>	significance	<i>r</i>
Symptom distress	Art therapy	31.00 (12.85)	22	-.143	.888	.030
	Control	31.91 (18.23)				
Interpersonal relations	Art therapy	16.69 (5.62)	22	.660	.513	.139
	Control	14.91 (7.61)				
Social role performance	Art therapy	10.46 (4.31)	22	-.823	.419	.173
	Control	12.09 (5.39)				
Total score	Art therapy	57.69 (22.06)	22	-.109	.914	.023
	Control	58.82 (28.68)				
p < .05						

Similarly, the independent *t* test conducted on data from the TSI posttest comparisons of the art therapy and control groups resulted in no statistically significant findings on any of the ten TSI scales (Table 8). Effect size in these analyses was generally small. However, Levene's test for equality of variances indicated that scores for the IE and the DSB scales of the TSI were significant ($p = .001$ and $p = .047$ respectively) therefore equal variances could not be assumed

for these two scales. Therefore, Table 8 reports *M*, *SD*, *df*, *t*, significance and *r* for the alternate hypothesis for the IE and DSB scales. The assumption of homogeneity of variances was tenable for the remaining eight scales of the TSI.

Table 8. TSI Scores for Art Therapy and Control Groups at Posttest

TSI Scale	Group	<i>M</i> <i>SD</i>	<i>df</i>	<i>t</i>	significance	<i>r</i>
Anxious arousal	Art therapy	50.17 (8.91)	23	-.379	.709	.078
	Control	51.73 (12.95)				
Depression	Art therapy	52.07 (7.48)	23	-.006	.996	.001
	Control	52.09 (9.86)				
Anger/irritability	Art therapy	53.36 (11.12)	23	.372	.713	.077
	Control	51.73 (10.52)				
Intrusive experiences ¹	Art therapy	58.29 (7.69)	14	.232	.820	.048
	Control	57.09 (15.62)				
Defensive avoidance	Art therapy	60.29 (10.08)	23	.332	.743	.069
	Control	58.82 (12.03)				
Dissociation	Art therapy	54.71 (10.92)	23	-.443	.662	.092
	Control	56.73 (11.70)				
Sexual concerns	Art therapy	52.00 (7.57)	23	-.342	.735	.071
	Control	53.36 (12.27)				

TSI Scale	Group	<i>M</i> <i>SD</i>	df	<i>t</i>	significance	<i>r</i>
Dysfunctional sexual behavior ¹	Art therapy	58.64 (9.66)	15	-.165	.871	.043
	Control	59.64 (18.01)				
Impaired self-reference	Art therapy	53.14 (8.71)	23	-.946	.354	.194
	Control	56.82 (10.74)				
Tension reduction behavior	Art therapy	56.57 (9.98)	23	-.372	.713	.077
	Control	58.36 (14.09)				

p < .05
¹ Levene's test for equal variances not assumed p < .05

Statistical Analysis: MANOVA

The use of multiple *t* tests on individual data sets is known to allow for increases in Type 1 errors, or errors which indicate significance even when no significance exists (Fields, 2005). Consequently, the data from both the OQ-45.2 and the TSI were analyzed using multiple analysis of variance (MANOVA) testing to correct for type 1 errors and to evaluate any interactions between the scales within each data collection instrument. For the MANOVA analyses posttest mean scores were subtracted from pretest mean scores of each scale in both the OQ-45.2 and the TSI to provide a single number representing either positive or negative change in symptomology over duration of the experiment. With the OQ-45.2 the total scale is the sum of the 3 subscales, SD, IR and SR, and therefore was not included in the analysis.

The results of the MANOVA on the OQ-45.2 data indicated no significant differences ($F = .255, p = .857, df = 3, 19$) in the improvement of the OQ-45.2 scores between the art therapy and control groups. No significant changes were observed in the SD scale ($F = .606, p = .445, df = 1$), the IR scale ($F = .001, p = .978, df = 1$) and the SR scale ($F = .055, p = .817, df = 1$). No interactions were observed in the OQ-45.2 data set. Similarly, results of the MANOVA of the TSI posttest changes were not significant ($F = .432, p = .905, df = 10, 13$). Further, no significance was observed in the AA scale ($F = .214, p = .648, df = 1$), D scale ($F = .060, p = .809, df = 1$), AI scale ($F = .034, p = .856, df = 1$), IE scale ($F = .037, p = .849, df = 1$), DA scale ($F = .196, p = .662, df = 1$), DIS scale ($F = 2.585, p = .122, df = 1$), SC scale ($F = .003, p = .956, df = 1$), DSB scale ($F = .316, p = .580, df = 1$), ISR scale ($F = .501, p = .486, df = 1$) and the TRB scale ($F = .026, p = .872, df = 1$), nor were significant interactions observed.

Figure 2 illustrates the differences in OQ-45.2 scores between pretest and posttest mean scores for the control and art therapy treatment group participants. As previously described for both groups the mean posttest group scores were subtracted from the mean pretest scores. Therefore a positive number indicates improvement in the symptomology over the course of the experiment. The blue bars represent the control group scores, while the purple bars represent art therapy group scores. The total bar for both control and treatment is the sum of respective group subscale pretest scores for SD, IR and SR minus the respective group subscale posttest scores.

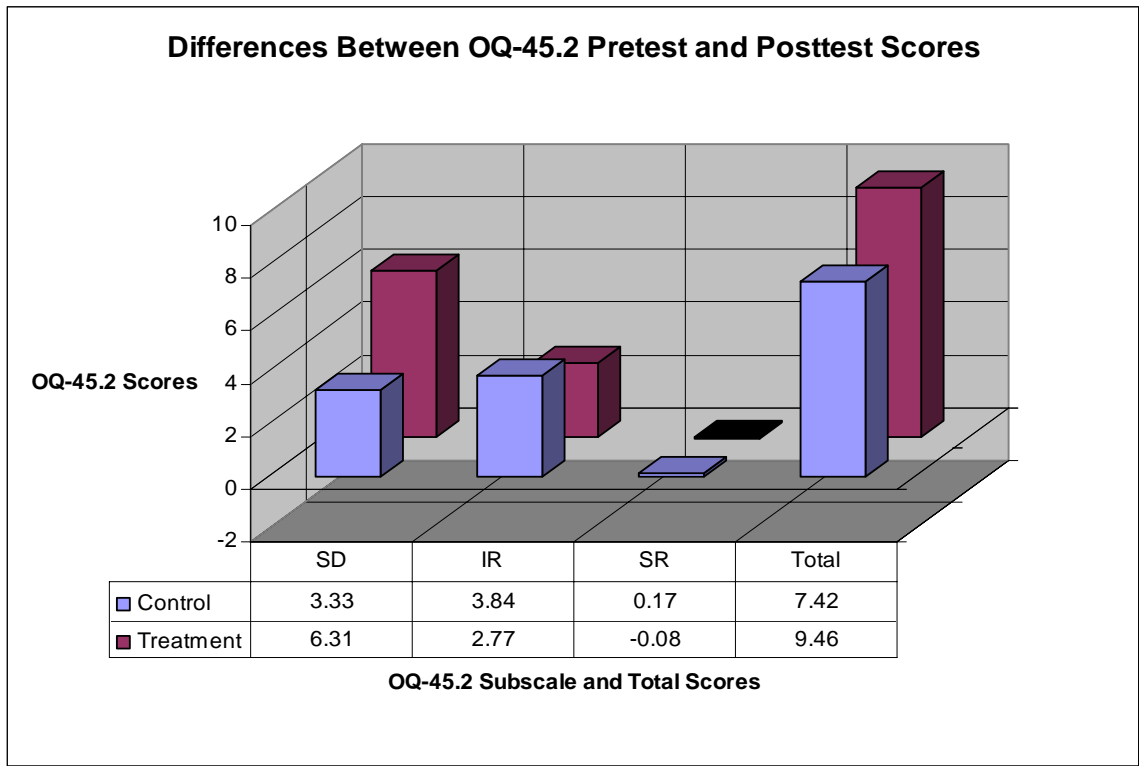


Figure 2 Differences Between OQ-45.2 Pretest and Posttest Scores

The SD subscale shows a greater reduction in treatment group score (6.31) than the control group score (3.33), while the IR subscale indicated a greater reduction in the control group (3.84) compared to the treatment group (2.77). The SR subscale scores changed minimally in either group. The total scores show a greater overall reduction in the treatment group (9.46) compared to the control group (7.42). However, none of these changes were statistically significant.

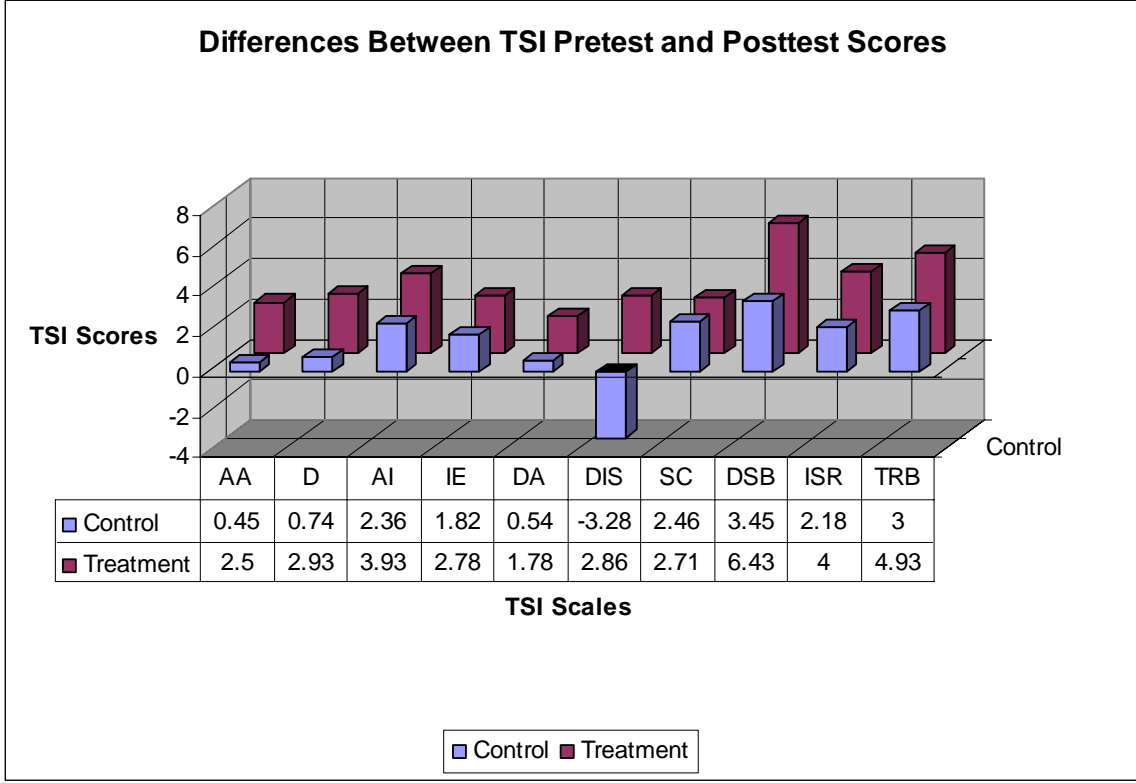


Figure 3 Differences Between TSI Pretest and Posttest Scores

The differences in the TSI data for control and treatment group pretest and posttest mean scores are indicated in Figure 3. As with the OQ-45.2 data figure, the blue bars represent the change in the control group mean scores and the purple bars represent the change in the treatment group mean scores. With the exception of the DIS scale, which showed a negative increase reported in this behavioral characteristic, all control scores were reduced. All TSI scale scores were reduced in the art therapy treatment group over the treatment time period. Positive changes in art therapy scores were greater than those in the control group. None of the differences between pretest and posttest scores represent a statistically significant change.

Qualitative Results

The results of this study can be better understood qualitatively by examining client artwork and verbal feedback during the treatment sessions. Though test results did not indicate a statistically significant effect, observation of the treatment sessions and client responses indicated a positive effect. Samples of client artwork along with a summary of verbal responses can be found in Appendix G. Qualitative responses to the treatment are also contained in the post study evaluation (Appendix F).

The questionnaire consisted of five open-ended questions that gave participants an opportunity to give feedback about the group and their participation. Responses were extremely positive indicating that all participants had enjoyed the experience and would recommend it to others. When asked if the experience had been positive and how it was positive, respondents comments included that it had reduced stress, helped them address problems, helped them to open up and express pent up feelings. In addition, they stated that they had enjoyed the opportunity to use art materials and talk to each other. When asked what they did not like about the program, the majority answered “Nothing”. Some responded that it had been difficult to talk about their drawings at first, but realized that it was helpful. When asked if they would recommend the group to others, and why, all responses were affirmative. When asked if the experience had helped them to address unpleasant past experiences 76% responded “yes”. The most frequent suggestions for improvement of the program was to make the treatment sessions longer and continue them for a longer period of time. Group participants felt that they would benefit from continued participation in art therapy treatment.

Summary of Findings

A sample of 50 incarcerated women participated in art therapy groups to study the effect of treatment on psychological outcome scores. Of the original 50 women, 26 completed the study. The Outcome Questionnaire (OQ-45.2) and the Trauma Symptom Inventory (TSI) were completed before starting treatment and at the conclusion of the treatment period. Initial scores from both groups were used to determine equality of variance. Initial scores from each group with each instrument were compared to post scores using a paired sample *t* test procedure. A MANOVA was conducted to analyze interactions between subscores. Control group scores did not change significantly during the test period for either instrument. Art therapy group scores improved significantly on the SD scale and the total score of the OQ-45.2 and approached significance on the IR subscale. TSI results were significantly different on the ISR scale and approached significance on the IE and DSB scales. An independent *t* test was used to compare posttest scores. Changes in posttest scores were not significantly different among groups. MANOVA analysis was not significant for either instrument. Qualitative information was helpful in understanding the clinical effects of the treatment, and added perspective to the scope of the study.

CHAPTER FIVE: CONCLUSIONS

This study was designed to evaluate the effectiveness of group art therapy treatment in decreasing symptoms of trauma and psychological distress in incarcerated women. Based on literature in art therapy and expressive writing, it was hypothesized that participants who engaged in art exercises and then described the process in a group setting would demonstrate reduced symptoms as evidenced by scores on the OQ-45.2 and the TSI. This chapter discusses the empirical findings of this study and qualitative results evident in inmate responses to post study evaluation questions and client treatment work samples. The research question posed by this study was, “Are expressive arts treatments effective in decreasing symptoms of trauma and psychological distress in incarcerated women?”

Results of this study did not provide empirical evidence that the treatment was effective in achieving the desired effect, therefore, the null hypothesis was confirmed. Though the results of data analysis did not indicate statistically significant changes in overall scores some significance was found on individual treatment scales. Treatment group scores changed significantly between pretest and post test on the SD (Symptom Distress) scale and the total score (OQ-45.2), and the ISR (Impaired Self Reference) subscale (TSI). Scores measuring psychological distress and trauma symptoms generally decreased over time for all study participants, however, treatment participants scores improved at a greater rate. In addition, the qualitative results were extremely positive and provided anecdotal evidence that art therapy may still be a promising treatment option for incarcerated women warranting further study.

Limitations of the Study

Research conducted in a correctional facility comes with inherent limitations. Personnel involved in administering the study are required to obtain security clearance and training prior to entering the facility. Some correctional staff members view unofficial staff as outsiders and the services they offer as counter to the purpose of incarceration. While some correctional staff were cooperative and supportive, others perceived art therapy treatment as unnecessary and disruptive to jail procedures and sometimes hindered the participation and success of the treatment. Their actions, though subtle, often discouraged inmate participation. In some instances corrections officers forced inmates to choose between attending an art therapy group or spending time outside, an opportunity that is usually offered only once a day. Another officer searched each individual as they left the classroom causing some individuals to withdraw from the group to avoid the searches.

Group treatment was administered by the primary investigator who had prior experience working with incarcerated clients and the use of art therapy. Entering a corrections facility for the first time can be intimidating and uncomfortable (Karban & West, 1994). Because this population is especially distrustful, it is imperative that counselors working in the corrections environment be able to establish a strong relationship with inmates. Counselor needs to be able to be non-judgmental and unaffected by stereotypes of arrestees. As with all counselors, it is important for them to be empathetic and able to instill confidence while quickly develop trusting relationships (Young , 2005). An in-depth understanding of addiction and trauma issues is also important. The counselor also needs a basic understanding of art therapy theory and techniques.

Constancy in the facilitator encouraged early development in the therapeutic relationship which facilitated participant self disclosure.

As a result of the living arrangements in the jail, sample selection was restricted. In the jail, inmates are divided into dorms or *pods* of approximately 25 – 40 women. Correctional policies prohibit contact between the residents of separate dorms. Consequently, groups were formed with volunteers from a single limited pool. This resulted in small group size, and did not allow for the random selection of group participants. These two factors necessitated the use of a quasi-experimental design. In addition, the small group size precluded more sophisticated tests such as MANOVA. which was conducted but yielded no significant statistical information. Thus, one of the weaknesses of the study was the inability to utilize more sophisticated statistics.

Attrition was also a major hindrance in this study. The sample number was reduced by nearly half as the study proceeded. Since groups were closed to new attendees due to the closed experimental design, attrition could not be offset by the addition of new members. Some group participants may have been eliminated from the group due to lack of communication with corrections program staff about jail procedure prior to conducting art therapy sessions. Some attendees were lost due to jail staff failing to place individuals names on subsequent attendance rosters after one absence. Efforts to inform corrections staff of expectations and being thoroughly informed in jail attendance policies ahead of time could have improved study outcomes. County jail inmates are also more likely to move without warning. Many of them are awaiting trial and their future is uncertain so changes happen unexpectedly leading to attrition. State and federal prisons may provide opportunities for more individuals to complete treatment and a prison may yield a larger population and larger participant groups.

According to the study design, groups were closed to new participants after the first session. Only those who attended the first session were allowed to complete the study. Some individuals were removed from the group roster by corrections staff members because they chose to attend another activity held at the same time. This resulted in the group losing members even though they had not made a decision to withdraw from the group.

Control group participants received art therapy treatment after the final data was collected. At that time, attendance was open to any inmates who desired to attend. The group grew from six members to fifteen, the maximum number of group attendees allowed in any group in the facility, with additional inmates who desired to attend. This surge in attendance indicated that inmates had shared positive attitudes about the program with others in their dorm. This positive feedback about the art therapy groups in the dorms encouraged others to be interested in participation. Future studies may avoid some attrition by utilizing an open group enrollment allowing new attendees to join the group and then be monitored for a specific number of sessions. Completion of testing instruments could be done individually at the beginning and end of treatment or at regular intervals during the study.

Instruments

While the instruments were designed to measure psychological improvements in distress and the severity of symptoms related to trauma, instrumentation was thought to be somewhat limited in effectiveness with incarcerated individuals. Even though inmates were informed that responses to the test materials would be kept confidential and would not effect inmate status in corrections, responses appeared to be unreliable in some instances either because inmates have a limited awareness of personal issues or are reluctant to disclose it. This may be explained by the

distrust inherent in the jail environment and fears that information disclosed on the measures may be shared outside the study to influence either inmate legal standing or ongoing parental custody proceedings. Some responses were extremely low which may indicate efforts to minimize distress levels. Inmates may also have become bored or tired of the process before completing the 100 questions on the TSI and may have given random answers without considering the response. Instruments were repeated at a three week interval suggesting that questions may have been familiar and responses repeated.

The OQ-45.2 is designed to be brief and sensitive to change, to measure client progress, and to assess common symptoms indicating emotional distress (Lambert, et al. 2004). Test makers recommend that test-takers respond to items on the OQ-45.2 regarding work or school according to current life activities. Scores on the SR and IR subscales were inconsistent which may indicate that study participants were unable to relate the questions to their life in jail.

According to test creators the Social Role sub-score “focuses on patient level of dissatisfaction, conflict, distress, and inadequacy in tasks related to their employment, family roles and leisure life. Assessment of social roles suggests that a person’s intrapsychic problems and symptoms can affect a person’s ability to work, love, and play” (Lambert, et al. 2004, p. 2). It is arguable that while they are incarcerated individuals are not able to function in any of these roles causing SR evaluation responses to be erratic.

The Interpersonal Relations (IR) subscale relates to satisfaction and problems in interpersonal relationships (Lambert, et al. 2004). In an incarcerated setting individuals must rely on mail and brief visits to continue primary interpersonal relationships with family, spouses, and long-term friends, while the friends and associates in a jail system are limited in depth and

intimacy and complicated by the restrictions in a correctional facility. The utilization of the OQ-45.2 in this study has brought to light some limitations that need to be resolved to make it adaptable to use with incarcerated individuals.

The Trauma Symptom Inventory (TSI) is “intended for use in the evaluation of acute and chronic traumatic symptomatology, including, but not limited to the effects of rape, spouse abuse, physical assault, combat, major accidents, and natural disasters, as well as the lasting sequelae of childhood abuse and other early traumatic events” (Briere, 1995, p. 1).

The TSI was tested with general populations, clinical, university, and male and female Navy recruits. This instrument is also designed to address specific symptoms experienced by those who have been victims of childhood and adult interpersonal violence such as anger, depression, dissociation, sexual problems, interpersonal difficulties, disturbance in self-functions, and acting out behaviors such as self-mutilation and compulsive or dysfunctional sexual activity (Becker, Skinner, Abel & Treacy, 1982; Pifalo, 2006). In addition, the TSI includes validity scales which detect responses of those who tend to minimize or exaggerate symptomology. Though not specifically tested with inmates, the issues addressed and the validity scales indicated positive expectations in its use with this study. Some complications in utilizing the TSI with this population may have resulted from the length of the instrument.

Completing the OQ-45.2 and the TSI required approximately 45 minutes. Some participants may have hurried through their responses to test items in order to finish quickly. Others may have found the task emotionally taxing and rushed through to avoid emotional difficulty. Control group participants may have resented the expectation to complete the instruments twice without receiving treatment and may not have given the test instruments full

attention. Some responses may also have been influenced due to the familiarity of the instrument since the interval between testing was only three weeks.

Review of Findings

The results of data analysis did not indicate statistically significant changes in overall scores. However, significance on some treatment scales and anecdotal evidence indicate that art therapy may still be a promising treatment option for incarcerated women. Psychological distress and trauma symptoms generally decreased over time for treatment participants. While scores reduced in control group members as well, greater changes took place in treatment group scores. Several factors may have contributed to the lack of statistical significance in the final comparison of scores. Three weeks, though longer than some treatments used in earlier studies, may not have been long enough to allow for the phenomenon that scores drop early in treatment and then increase as the therapy proceeds (Gussak, 2006). A longer duration of treatment may have achieved more change because the therapeutic movement seemed to be going in the desired direction. Though his population was markedly different, Gussak (2007) found significant changes in BDI II (Beck Depression Inventory) scores in a similar study with male inmates in a psychiatric treatment program after eight sessions of art therapy. The sample size was comparable with this study (N=27) and results were mixed with the BDI II yielding significant change in scores.

Though study participants were informed that results from the measures would not be shared with correction personnel, inmates who are often reluctant to trust may have given inaccurate answers for several reasons. Study participants, many who had not yet been to trial, may have purposely elevated responses out of fear that confidentiality may be broken and that

information might be used to complicate judicial or child custody outcomes. Bradley & Devino (2007) found a high level of resilience among incarcerated women, which may also result in minimized reports of distress. Coping mechanisms such as denial, lies, and dissociation, common among incarcerated women, would also contribute to the tendency for inaccurate responses to test items.

Scores for both the treatment group and control group improved, though not at significant levels, over the treatment period, with the treatment group producing the largest changes on most of the scales tested (Figures 2 & 3). Improvement in control group scores may be explained by the phenomenon that though a jail environment is not pleasant, it may offer a curative atmosphere compared with real life challenges. It is secure and all basic needs are provided through the system. While outside, women see themselves as caretakers and providers struggling with responsibilities and stressors. While in custody, at least short term solutions have been implemented to solve concerns even though they may not be to the satisfaction of the inmate. Female detainees have little responsibility other than complying with correction staff directives, and many take advantage of forced opportunities to rest, read, exercise, and participate in jail programming, which includes attendance of psychoeducational groups, twelve-step support groups and church meetings. Some inmates see jail as a refuge, and after repeated arrests, they become familiar with the expectations and view it as an opportunity to escape the everyday cares of stressful lives.

While the overall hypothesis was not supported in this study, results of the statistical analysis on scores from the OQ-45.2 identified several statistically significant changes between pre and post scores. The OQ-45.2 scores for art therapy treatment group subjects for symptom

distress ($p = .044$) and the overall total score ($p = .038$) were lowered significantly. The Interpersonal Relations sub score approached significance ($p = .051$), while Social Role Performance did not change significantly. Scores for the control group were not significantly changed on any scale. Treatment and control scores reduced over the three week treatment period in total scores and Symptom distress scores, with the largest changes occurring in the treatment group. Treatment and control scores for Interpersonal Relations (IR) were reduced with the larger change occurring in the control group. Scores for Social Role Performance control group scores were reduced slightly, while the treatment group had a slight increase (Figure 2). Scores on the Interpersonal Relationship (IR), and Social Role Performance (SR) scales were not consistent. The IR subscale “assesses such complaints as loneliness, conflict with others and marriage and family difficulties” (Lambert, et al. 2004, p.29). Inmates are likely to view loneliness and conflict with others as the norm for incarceration while relationships with family and significant others are put on hold or limited to brief contacts, making it difficult to make an accurate assessment on these items. The SR subscale “measures the extent to which difficulties fulfilling workplace, student or home duties are present. Conflicts at work, overwork, distress and inefficiency in these roles are assessed” (Lambert, et al. 2004, p. 29) Written instructions on the instrument direct test takers to “Look back over the last week...mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth” (Lambert, et al. 2004, p. 63). Study participants may not have been able to make the connection between these questionnaire items and incarceration.

The Trauma Symptom Inventory (TSI) was designed to measure the extent to which respondents experience specific symptoms of trauma. Data analysis found significant changes in the ISR (Impaired Self Reference) scale ($p = .044$) and approached significance with the IE (Intrusive Experiences) scale ($p = .083$) and the DSB (Dysfunctional Sexual Behavior) scale ($p = .090$) for art therapy treatment group participants. Changes were not significant in TSI scores for control group participants.

Mean scores for the TSI for both the control group and the treatment group were lower at posttest, however greater changes appear in the treatment group with one exception. The scores in the DIS (Dissociation) scale increased for control group participants at a higher rate than scores for the treatment group decreased (Figure 2). Statistical analysis did not indicate that the changes in scores were significant between pre and posttest applications.

Treatment Procedures

In the initial discussion, clients were told that their artwork would not be evaluated according to artistic merit and that they should not worry about drawing skill. The emphasis was placed on thinking and feeling. Apologies for drawing ability no longer occurred after the first session and with a few exceptions, drawings were openly shared with the group. As participants talked about their work, disclosure was usually kept at appropriate levels. Because of the intensity of feelings evoked through expressive arts, it is important for the facilitator to conduct the verbal portion of the session with some attention to limiting client responses to a comfortable level. There is a tendency to over disclose, resulting in the participant withdrawing in future discussions or in withdrawal from the group. This may be especially applicable in a jail setting.

Six art therapy exercises were designed for use in the study (Appendix D). In this section, each will be evaluated based on their perceived effectiveness in the treatment groups. Samples of treatment work and client responses will be provided. Descriptions, administration format, and treatment work samples of the exercises can be found in Appendix D. The first two exercises focused on the development of the therapeutic relationship and group cohesion and required a limited amount of self-disclosure. Exercises increased in intensity and depth as the study progressed. The final exercise was intended to leave group members with a positive outlook and insight into their future, confidence in their ability to change, and a new life perspective. Results were not always consistent with the plan and required some alteration in the exercise protocols. However, each exercise stimulated group members to self disclose and participate in the therapeutic process.

Exercise one, *My happily ever after*, was easy and comfortable for study participants to complete. It helped to allay client discomfort with drawing ability, allowed for a playful atmosphere and reduced resistance to disclosure. Two themes emerged in this exercise. The first was a happy home with family and basic comforts such as a car and adequate money (Figure 4). This theme was evident in the majority of the drawings. The second theme was less prevalent, but did appear in a few drawings. Participants viewed the theme from a spiritual perspective, indicating a relationship with a higher power or a peaceful afterlife existence. At the conclusion of the exercise, participants recognized that they shared many of the same dreams and goals because their drawings and verbal descriptions shared the same themes. As a result, participants recognized that their feelings were shared by everyone. Group members became aware of

common experiences and feelings and contributed to the development of group cohesion and aided participants to overcome part of the distrust and resistance in the group.



Figure 4 Happily Ever After.

This drawing was done by a woman who had recently lost her significant other to a drug overdose. She saw happiness as including a place of her own with a child, animals, nature, and a significant other.

Exercise two titled *Masks* required introspection, deeper thought, and increased self-disclosure. This exercise was effective in helping participants discuss personal coping styles and evaluating their effectiveness in dealing with problems. Visual and verbal responses identified commonalities among group members and strengthened group cohesion. One theme that emerged was a mask of unconcern and over happiness, or flat affect. Most group members stated that they hid real emotion behind a mask of apathy or confidence. Others identified masks of anger and aggression that they used to deal with or hide problems. |



Figure 5. Masks A.

The mask on the left was described as “free as a bird”. The artist explained that this is the face she uses to give others the impression that everything is fine and that she doesn’t have any cares. She described the mask on the right as being one of glamour, but explained that it isn’t really pretty and doesn’t really work.



Figure 6. Masks B.

The mask on the left is described as being beautiful and glamorous. The figure is dressed as an exotic dancer. The face on the right illustrates the mask she wears when things are not going her way and she wants to get things done.

Exercise three, *The child within*, was based on Bradshaw's (1988) concept of shame-based upbringing. This exercise concept was difficult to explain and participants found it difficult to conceptualize. Drawings included thoughts and ideas related to their own parents rather than the parent voice in their thinking. The adult voice was ignored in the drawings. It was necessary to alter this exercise to fit group needs. Instead, inmates participated in a guided imagery where they pictured themselves as a child and were directed to identify some specific upsetting experience they had during that time. Then they were asked to illustrate it. Some illustrated abandonment or abuse. Though quite different from the original concept, this change facilitated deep disclosure about personal feelings of inadequacy and unresolved issues with

parents and difficult times encountered while growing up and helped them to identify areas where they still experienced negative feelings from childhood. The original exercise proved to be too complex for this group but might be effective after the group had met together for a longer period of time and had established a broader understanding of personal issues.



Figure 7. The Child Within

This inmate spent her childhood in facilities for orphans and was placed there by her parents. She described the feelings of waiting there with the hope that she would someday be adopted, and the experience of watching others, including her own siblings, go to homes and families who wanted them.

Exercise four, *Monsters*, proved to be enjoyable and effective. Inmate responses were insightful with appropriate disclosure. Their work illustrated a variety of causes for fear and powerlessness and included addictions, personal weaknesses, specific individuals and living situations. This exercise was powerful and required deep introspection and disclosure. The

discussion included humor and group cohesion was strengthened as participants recognized common experiences. Themes that emerged included drugs and other addictive substances, powerful people, and jail. This exercise was very effective for all group participants.



Figure 8. Monsters A.

This inmate included her home and her children in the picture. She said that there was a lot of clouds and storms in her life, and that she was her own monster.

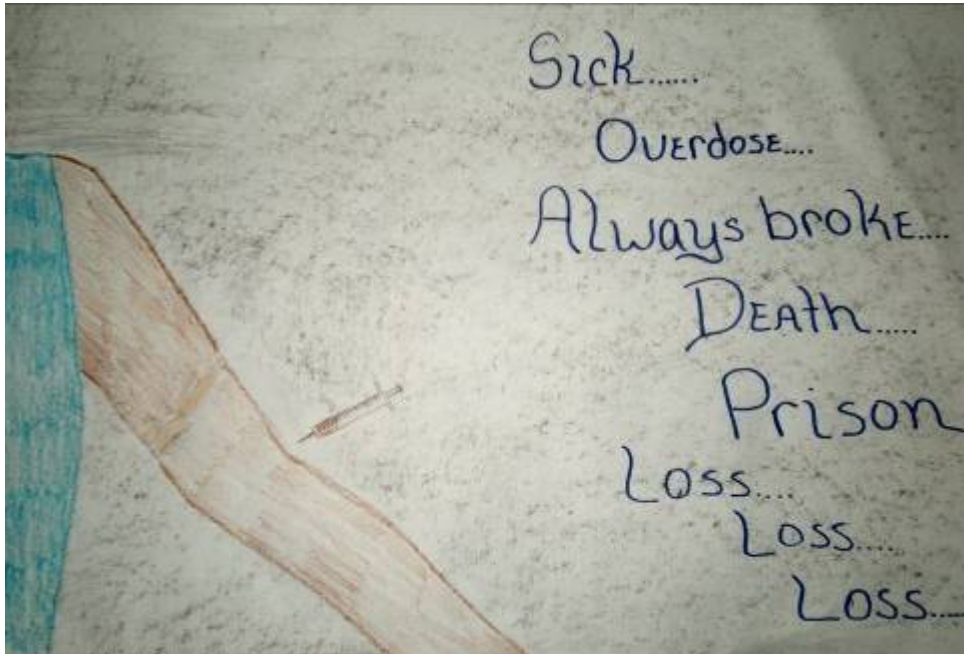


Figure 9. Monsters B.

The inmate who drew this first illustrated a green hairy creature. She took more paper and began to draw this indicating that her addiction was her monster.

Exercise five, *My most upsetting experience*, was adapted from James Pennebaker's therapeutic writing study (Pennebaker, 1990). However, when the topic was introduced in the first session it was overwhelming to study participants. To choose the most upsetting experience was, in itself, traumatic due to the severity and frequency of difficult events in the lives of female inmates. Instructions were modified to identify traumatic experiences during childhood which reduced the time in this exercise involved and made the task manageable. This resulted in illustrations of abandonment, abuse, loneliness, helplessness and trauma. The exercise in its original form required a mental review of a lifetime of upsetting experiences, requiring more emotional strength than group members could expend. Because these women had experienced

many and severe upsetting experiences it was necessary to reduce the exercise in size by limiting time period.



Figure 10. My Most Upsetting Experience A.

The artist described being in her backyard hanging out clothes when a friend came into the yard and was shot by a policeman. She described how the day had been beautiful and she was enjoying the weather when the incident happened.



Figure 11. My Most Upsetting Experience B.

This inmate chose an incident from her childhood. She said that this was the day her Dad left. She was 8 year old when it happened.

Exercise six, *Lost and Found*, was designed to help participants identify what they had lost due to trauma and to recognize positives and strengths they may have gained from experience. This exercise encouraged prisoners to recognize losses and consequences of experiences and personal choices. Each also identified strengths and positive outcomes they had gained. This exercise was effective in helping to bring closure to the art therapy group and instill confidence and courage to change in the thoughts of participants. Inmates knew that this would be the last session, disclosure was limited, and the exercise did not evoke the same depth of thought as earlier ones.

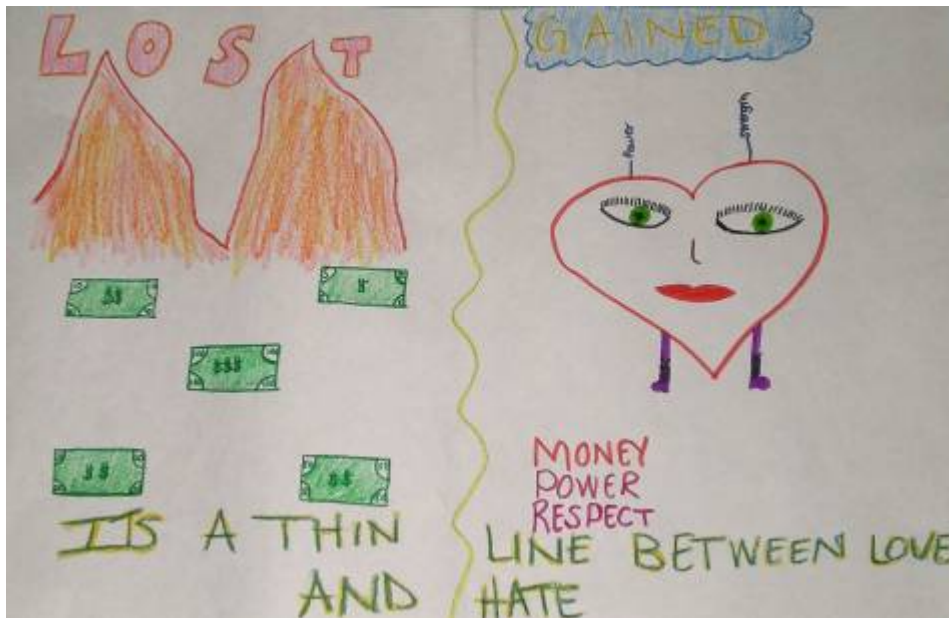


Figure 12. Lost and Found.

On the left, the participant said that everything she had ever had went up in flames. She said that she had gained money power and respect but that they had all been lost. She felt that she had gained and retained power and strength. In each of this individuals drawing she wrote the words “It’s a thin line between love and hate”.

The most successful art exercises were directive. They were designed with a specific outcome in mind such as the masks or monsters.. These exercises allowed for a use of humor and they evoked common responses to shared experiences. For example, the closing discussion in session four, *Monsters*, included a discussion about fear of the dark, and a discussion about addiction and jail and how the individuals felt they were caught and couldn’t explain how they got there. Non directive exercises were less effective. These exercises gave a lot of freedom in the drawing subject and may have placed too much responsibility and discomfort on the participant for beginning clients. A good example of this was the response to exercise 5, *the child*

within, participants responded with confusion, there was little interaction during the drawing portion of the group and participants had difficulty determining what they wanted to draw. When the drawing exercise was altered, participants were able to identify something they wanted to share.

Materials used in the group were appropriate from a corrections facility standpoint and also contributed to the success of the study. Study participants were not confident in their ability to draw and were comfortable with the drawing materials used. Inmates were issued both markers and crayons. Many were more comfortable with crayons and were given the option of folding the paper to reduce size when desired.

These drawings illustrate the effectiveness of the art therapy medium in helping clients identify and address difficult experiences. Some were able to take advantage of the opportunity to identify and address life-changing issues and begin to make those changes. Some of the drawings were not very illustrative or remarkable to look at, however, the verbal descriptions and responses indicated that experience had sparked some deeper thinking and emotional awareness.

Qualitative Results

Questions on the post study evaluation indicated the feelings of participants about their experiences in the study. Participant responses were overwhelmingly positive. The most frequent suggestion for improving the program was to lengthen group sessions and extend the study. The majority of participants responded warmly and positively to the art exercises and produced effective therapeutic work and open verbal responses. The inmates indicated that they enjoyed the experience and would recommend the program to others. They also felt that the experience had been positive and had helped them to address issues from their pasts.

The post study evaluation questionnaire (Appendix F) consisted of five open-ended questions. In response to question one: How was this experience enjoyable for you? One individual responded, "It has helped me cope with my problems here and in the past. It also has made me feel loved and wanted when I thought I wasn't. I have truly been inspired by this program. Drawing makes me relieve a lot of stress". Another stated, "I like putting my thoughts and feelings on paper and actually seeing them". A third added, "...it made me feel like I can talk about my problems in life instead of keeping them inside of me."

Question two "What was there about this experience that you did not like?" received a similar response. The majority of participants stated that there was not anything they disliked about the program. Some expressed some misgivings about disclosure, for example, "At first I didn't like talking about our pictures in front of everyone, but now I am okay." Another said, "I didn't like having to talk about some experiences but it was helpful to do so."

Question three asked "Would you recommend this group to others? Why or why not?" Every inmate responded "yes". Their reasons included, "...art lets us get into our inner minds and brings out more of what is inside of us." Another said, "Yes, because this group can help you take a lot of things off your mind and ease a lot of pain". A third stated, "Yes, it helps to get things out. It helps you have an understanding about your life and you won't have to be ashamed."

Question four asked "Did this experience help you to address unpleasant experiences from your past?" Over two thirds of the participants answered "yes". Their explanations included, "The projects were just right, every drawing released some of my anger and sadness." Another responded, "Yes, it let me express or release what has happened, what bothers me, and

recent tragedies in my life on paper so I could know what they were, then I felt much better and could deal with them in my mind.” A third said, “Yes, because I never knew I could tell anyone how I felt because I never. Nobody could ever listen.” Those who answered “No” shared these reasons: “We weren’t expected to say much”. Another said, “Not really, they’re still there but knowing I could still bring them to the surface”.

Question five invited additional comments and suggestions. The most frequent comment was a suggestion that groups would be better if they were longer, more frequent, and continuous. Some comments of interest included, “ It will help a lot of women who have no way of letting go of things. This way is better, through art.” Another commented, “I loved the class. I think you should maybe focus more on specifics (the assignments sometimes left too much up to us) or maybe have some writing assignments.” Many express appreciation for the opportunity to participate and a hope that the treatment can be continued.

Recommendations for Future Research and Implications

Further research utilizing art therapy and other expressive arts therapies with incarcerated individuals are needed. Current literature is filled with positive applications of art therapy with a wide range of populations and diagnoses but is generally anecdotal (e.g. Eisdell, 2005; Samuels, 1994; Ulman, 1992;). Because it is so versatile, little specific, empirical research has been conducted. Gladding (2005) identified a dearth of research involving creative arts therapies while, at the same time, acknowledging the difficulty in conducting research in this arena. “If the creative arts in counseling are to be uniformly respected, they must merit appreciation based on more than anecdotal testimony” (Gladding, 2005, p. 192). There are many opportunities to

compare the effectiveness of expressive arts techniques with each other and used in combinations, as well as making comparisons with established therapeutic practices

Outcome measures specifically developed for incarcerated women and the problems they face would improve the ability to assess treatment effectiveness with improved accuracy and contribute to accurate diagnosis and treatment of serious mental health problems (Henriquez, 2002). Studies specific to pathologies such as DID, personality disorders, substance abuse, and trauma would make may provide valuable information to mental health professions who work with this group.

Future research in utilizing group art therapy offers several advantages to the corrections community. Group art therapy could relieve some of overwhelming treatment loads faced by mental health professionals currently working in jail facilities. A better understanding of inmate issues would benefit corrections programs in identifying and treating inmates more efficiently and effectively. Improvement in the delivery of treatment could facilitate a drop in disciplinary problems during incarceration and may lead to successful prisoner transitions back into society. Ultimately, the cycle of arrests and recidivism may be reduced benefiting individuals, families, and society.

Work in correctional facilities may be improved with the development of training programs for security, mental health and substance abuse professionals, correctional and treatment staff. Training programs need to be developed to educate staff to understand specific issues of female detainees and treatment interventions designed to affect women diagnosed mental illness in jails (Henriquez, 2002). From a corrections perspective, implementing expressive arts therapies with female inmates could result in improved inmate behavior and

reduced recidivism while providing much needed treatment to inmates at a reduced time demand for mental health professionals and at a lower cost.

Creativity is an important element of counseling. Developing or practicing counseling professionals would benefit from increased education and personal confidence in utilizing expressive arts techniques. (Carson & Becker, 2004). Students would gain valuable practical experience through participation in experiential workshops and classes, where they would have opportunities to experience the potential power of expressive techniques and learn to integrate them into their work with clients. Students could improve counseling capabilities through exposure to treatment of incarcerated individuals through internships, group facilitation and research involvement with this population.

Future research should examine the effects of art therapy in a group setting. Interaction in the group is an important factor in the favorable implications of this study. Though this study provided limited statistical significance, feedback from participants suggest that it was clinically significant. Art therapy conducted with groups offers an economical, efficient treatment medium that may capacitate treatment for women who currently receive little treatment in jail, helping them to cope with prison life and difficulties in their lives after release. Incarceration for women has a far reaching influence with individuals, children, families and communities. Finding effective treatment for incarcerated women would be a boon to them and to society in general

As stated earlier, this study has several limitations. The sample size was greatly reduced through attrition. The instruments used were limited in their application to incarcerated women. The desired empirical evidence was not produced in this study. However, the qualitative information indicated that the treatment was effective, and that those who participated in the

study felt a positive result. The challenge for future research may be to find ways to establish empirical evidence to match the overwhelming anecdotal evidence.

APPENDIX A: IRB APPROVAL



University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901, 407-882-2012 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Notice of Expedited Review and Approval of Requested Addendum/Modification Changes

From: **UCF Institutional Review Board**
FWA00000351, Exp. 5/07/10, IRB00001138

To: **Bonnie Erickson**

Date: **November 28, 2007**

IRB Number: **SBE-07-05243**

Study Title: **Art Therapy Treatment with Incarcerated Women**

Dear Researcher:

Your requested addendum/modification changes to your study noted above which were submitted to the IRB on 11/27/2007 were approved by **expedited** review on 11/28/2007.

Per federal regulations, 45 CFR 46.110, the expeditable modifications were determined to be minor changes in previously approved research during the period for which approval was authorized.

Use of the approved, stamped consent document(s) is required. The new form supersedes all previous versions, which are now invalid for further use. Only approved investigators (or other approved key study personnel) may solicit consent for research participation. Subjects or their representatives must receive a copy of the consent form(s).

This addendum approval does NOT extend the IRB approval period or replace the Continuing Review form for renewal of the study.

On behalf of Tracy Dietz, Ph.D., IRB Chair, this letter is signed by:

Signature applied by Joanne Muratori on 11/28/2007 02:54:36 PM EST

A handwritten signature in cursive script that reads "Joanne Muratori".

IRB Coordinator

Internal IRB Submission Reference Number: 001614

APPENDIX B: RECRUITMENT FLYER



Art Therapy Treatments with Incarcerated Women.

This is an invitation to participate in a research study:

You are being invited to take part in a research study which will include about 45 people. To participate in this study you must be 18 years of age or older and be a female inmate in the John E. Polk Correctional Facility in Seminole County Florida.

This study will be conducted by Bonnie J. Erickson, a doctoral student in the College of Education and the Department of Child, Family & Community Sciences at the University of Central Florida. This research is being supervised by Mark E. Young, PhD, a UCF faculty supervisor in Counselor Education. For more information, contact Mr. Joseph J. Acton, Program Coordinator, or call 407-823-3063 (UCF, department of counselor education) or write P.O. Box 161250, University of Central Florida, Orlando, Florida 32816.

Purpose of the study: The purpose of this study is to study the effectiveness of art therapy in helping female inmates express and cope with upsetting memories and traumas from their pasts.

What you will be asked to do in the study: Volunteers will be asked to complete three questionnaires before and after the group sessions. Participants will participate in six treatment sessions over a period of three weeks using art therapy to explore and process personal experiences involving upsetting feelings and trauma.

Time required: The study will require two one hour sessions, held weekly for three weeks for a total of six sessions. Volunteers will also be invited to attend a one hour introductory presentation about the study.

Compensation or payment:

In accordance with Seminole County Corrections policy, inmates will not receive compensation of any sort for their involvement in this research. At the conclusion of the study, all treatment work produced in the sessions, whether art or writing will be returned to study participants. Inmates will not receive negative consequences for deciding not to be involved with this study.

APPENDIX C: INFORMED CONSENT



Informed Consent

Researchers at the University of Central Florida (UCF) study many topics. To do this we need the help of people who agree to take part in a research study. You are being invited to take part in a research study which will include about 45 people. You can ask questions about the research. You can read this form and agree to take part right now, or take the form with you to study before you decide. You will be told if any new information is learned which may affect your willingness to continue taking part in this study. You have been asked to take part in this research study because you are woman and an inmate. You must be 18 years of age or older to be included in the research study and sign this form.

Study title: Art Therapy Treatment with Incarcerated Women.

This study will be conducted by Bonnie J. Erickson, a doctoral student in the College of Education and the Department of Child, Family & Community Sciences at the University of Central Florida. This research is being supervised by Mark E. Young, PhD, a UCF faculty supervisor in Counselor Education

Purpose of the research study: The purpose of this study is to explore the effectiveness of art therapy in helping female inmates express and cope with upsetting memories and traumas from their pasts.

What you will be asked to do in the study: Volunteers will be asked to complete pre-test and post-test evaluations and a demographic questionnaire. Participants will participate in six treatment sessions over a period of three weeks which involve drawing activities about personal experiences involving upsetting feelings and trauma.

Voluntary participation: You should take part in this study only because you want to. There is no penalty for not taking part, and you will not lose any benefits. You have the right to stop at any time. Just tell the researcher that you want to stop. You will be told if any new information is learned which may affect your willingness to continue taking part in this study.

Location: The study will be conducted in the Lake County Corrections Facility in Lake County Florida.

Time required: The study will require two one hour sessions, held weekly for three weeks for a total of six sessions. Volunteers will also be invited to attend a one hour introductory presentation about the study.

Audio or video taping: You will not be audio or video taped by the researcher.

Risks: It is possible that participation in this study may bring up unpleasant memories of past experiences. Mental Health Services are available on site through the mental health staff at the Lake County Correctional Facility. In addition, the primary researcher is a Licensed Mental Health Counselor and will conduct all research sessions.

There are no expected risks for taking part in this study. You do not have to answer every question or complete every task. You will not lose any benefits if you skip questions or tasks. You do not have to answer any questions that make you feel uncomfortable.

Confidentiality: Every effort will be made to protect confidentiality, however, in a group treatment setting, confidentiality cannot be guaranteed. The researcher will make every effort to prevent anyone not on the research team from examining treatment work and will not discuss information shared in the group with others. Your identity will be kept confidential; you will be given a confidential identification number to label your work. A list of names and numbers will be kept in a different place in a password protected computer file. When the data is done and the data have been analyzed, this list will be destroyed. Your information will be combined with information from other people who took part in this study. When the researcher writes about this study to share what was learned with other researchers, she will write about this combined information. Your name will not be used in any report, so people will not know how you answered or what you did.

Exceptions to Confidentiality: There are times when the researcher may have to show your information to other people. For example, the law may require the researcher to show your information to a court or to tell authorities if the researcher believes you have abused a child, are in danger to yourself or to someone else, or disclose information about an undisclosed crime. The researcher may have to show your identity to people who check to be sure the research was done right. These may be people from the University of Central Florida or state, federal or local agencies or others who pay to have the research done.

Benefits: Participation may provide a better understanding of the effects of traumatic experiences, and provide therapeutic benefit through the use of expressive art treatments. Participants may gain personal insight into personal experiences and reduce the negative results of past upsetting experiences. In addition, participants may learn more about how research is conducted.

Additional Benefits: This study may provide good treatment options for women who are incarcerated.

Compensation or payment:

In accordance with Lake County Corrections policy, inmates will not receive compensation of any sort for their involvement in this research. At the conclusion of the study, all treatment work produced in the sessions will be returned to study participants if possible. Inmates will not receive negative consequences for deciding not to be involved with this study.

Study contact for questions about the study or to report a problem: If you have questions, please address them to Bonnie J. Erickson, Doctoral Candidate, Counselor Education Program, Department of Child, Family and Community Sciences in the College of Education. Additional questions can be directed to Bonnie Erickson or Dr. Mark E. Young, Faculty Supervisor, Department of Counselor Education at the University of Central Florida.

IRB contact about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901.

How to return this consent form to the researcher: Please sign and return this consent form to Bonnie J. Erickson. By signing this letter, you give me permission to report your responses anonymously in the final manuscript to be submitted to my faculty supervisor as part of my course work

- I have read the procedure described above
- I voluntarily agree to take part in the procedure
- I am at least 18 years of age or older

_____	_____	_____
Signature of participant	Printed name of participant	Date
_____	_____	
Principal Investigator	Date	

APPENDIX D: ART THERAPY TREATMENT EXERCISES

Group Format

Six exercises were chosen for use in the study. The exercises are outlined in the following pages. Each exercise provides areas of focus for the session, experiential exercises, and suggested follow up questions to be discussed as a group. Each session begins with a 10-15 minute discussion to introduce the exercise topic. During the next 30 minutes, participants compose drawings illustrating their thoughts and feelings. The last 15 minutes participants form a circle away from the tables and share their drawings and feelings with the group.

Materials

Materials for treatment work will be provided by the primary investigator and will be stored in a cabinet provided inside the correctional facility. Art materials will consist of pencils with erasers, water-based markers, crayons, and 11"x18" drawing paper.

Intervention: My Happily Ever After

Objectives

Clients will identify elements in their lives that they want to eliminate, and the absence of elements they want to include. Clients will visualize possible changes in their lives when the effects of trauma are dealt with. Clients will experience hope for the future.

Procedure:

Step 1: Group Discussion

Direct clients to visualize a life without the present difficulties they are experiencing. Encourage a realistic view of possibilities for the future. Discuss the areas of life that may change as progress and

growth are achieved. Some of these might include: social, physical, financial, relationship issues, education, behavioral changes, and emotional changes.

Step 2: Experiential Exercise

Clients will illustrate what they hope their lives might look like after they have dealt with some of the present difficulties in their lives. Ask them to identify how far in the future this will be.

Step 3: Processing

Invite clients to share thoughts, feelings, and insights relative to this exercise. The process questions below can be used to help clients express more about their work.

1. How far in the future is this place?
2. What barriers will you need to remove to get to this place?
3. Are you making progress to get there now?
4. What will it be like for you to be there?

Intervention: Masks

Objectives

Clients will gain an understanding of the images they project and how this relates to interactions with others. In a discussion, clients evaluate these images to determine if they have a positive or negative effect on their progress towards therapeutic goals. Finally, clients will translate their inner thoughts and feelings to words as they discuss their work.

Procedure

Step 1: Group Discussion.

The facilitator conducts a discussion about defense mechanisms and involves the clients in a discussion about the masks that people hide behind. Examples and ideas about why we do this are recorded on a board or flip chart. Clients are then asked to describe their own defense mechanisms and those they have observed in others. Related terms are defined including, “attitudes,” “facades,” “stereotypes” and “poses.” In the discussion, clients identify a variety of masks, such as confidence, strength, invincibility, sexuality, being dangerous and unapproachable, vulnerability and dependence, among many others. Discussion includes the positive and negative effects of the use of these masks.

Step 2: Experiential Activity. Clients are asked to identify and draw the masks they have identified for themselves. They are not limited to one mask but are encouraged to identify as many of their personal masks as possible, including a combination of one or more.

Step 3: Processing.

Clients assemble away from tables in a group to process the exercise. Clients are encouraged to share the feelings and thoughts they experienced during this exercise. To alleviate feelings of inadequacy, it is important to stress the fact that this exercise is not about creating great art, but about the process of thinking and gaining personal insight. Ideas about strategies to eliminate, replace, or alter dysfunctional behaviors are discussed.

The process questions below can be used to help clients express more about their work:

1. How does your mask help you and how does it hinder you?
2. Do you remember when you first started to use this mask?
3. What does the mask conceal?
4. Did you experience any surprises in doing this activity?

Intervention: The Child Within

Objectives:

Clients will identify the child, adult, and parent roles in their thoughts and feelings. Clients will evaluate the origin and strength of each. Clients will gain insight into their origins and their ability to make choices.

Procedure:

Step 1: Group Discussion

Discuss the concept of the child, adult, and parent roles in our thinking. The parent voice is often identified through thinking scripts that use “should”. It may also be negative self-statements. This is an internal parent, not necessarily the actual parent. The child voice is motivated by emotion rather than thought and often indicates decisions made as a reaction to others influences, whether real or imagined. The adult is the thinking that leads to individual conscious choices. Discuss the origins of ideas, values, and scripts. Discuss the differences in perspective of childhood and adulthood.

Step 2: Experiential Exercise

Clients will draw the three roles of parent, child, and adult in their lives. Encourage clients to determine the proportion of each role, and what choices they may have made in the past relative to each role.

Step 3: Processing

Invite clients to share thoughts, feelings, and insights relative to this exercise. The process questions below can be used to help clients express more about their work.

1. After learning about these roles in your thinking, how would you like to change them?
2. What would you need to do to make the changes?

3. Can you identify positive self-statements that may counteract negative self-talk.

Intervention: Monsters

Objectives

Clients will identify their worst fear and thoughts and feelings related to it. Fears will be normalized and externalized. Coping strategies for dealing with fear will be identified.

Procedure

Step 1: Group Discussion.

Conduct a group discussion to develop a definition of what a monster is. The discussion may include: something that is unidentifiable, scary, may harm you, usually large in size, invokes fear, and are sometimes irrational. A personal monster may include problems that are perceived to be monumental, and are too large or too difficult to deal with or control.

Step 2: Experiential Exercise:

Clients are to identify, and illustrate their own personal monster, or monsters. Examples may be a self-defeating behavior, anger, addiction, dissociation, domestic violence, eating disorders, or a past or present abuser or anything that client identifies.

Step 3: Processing

Invite clients to share thoughts, feelings, and insights relative to this exercise. The process questions below can be used to help clients express more about their work.

1. Does identifying the monster make it a little less intimidating?
2. Does it help to know that the same monster belongs to others?
3. Is your perspective realistic?

4. How do you work to shrink the monster down?

Intervention: My Most Upsetting Experience

Objectives:

Clients will identify specific experiences that were the most upsetting. Clients will express feelings and thoughts related to the trauma.

Procedure:

Step 1: Group Discussion

Discuss trauma and the physical and psychological effects it creates. Discuss the importance of identifying and expressing emotions related to trauma. Traumatic memories include emotions, visual and sensory impressions such as smells and tactile sensations that make expression difficult.

Step 2: Experiential Exercise

Clients are directed to identify one traumatic experience that was particularly upsetting to them. As they illustrate this experience, they are asked to be aware of all of their senses at the time of the trauma, and their present thoughts and emotions as they express this experience.

Step 3: Processing

Invite clients to share thoughts, feelings, and insights relative to this exercise. The process questions below can be used to help clients express more about their work.

1. What about this exercise surprised you?
2. How has the traumatic experience affected you?
3. What do you wish you had done differently?
4. Are you a victim or a survivor? If you are a victim, what would it take to be a survivor?

Intervention: Lost and Found

Objectives:

Clients will identify losses related to trauma they have experienced. Clients will identify positive areas of growth or strength they may have developed due to the trauma. Clients will recognize personal progress in coping.

Procedure:

Step 1: Group Discussion

Discuss the losses that clients have experienced due to trauma. They may include a sense of safety and security, meaning and purpose in life, physical health or body integrity, the ability to relate effectively with others, self-esteem or identity, or someone or something they love. Discuss emotions related to trauma such as shock denial, anger, vulnerability and grief. Discuss the positive things that may have occurred such as individual growth and coping, compassion for others that may have developed because of the trauma experienced.

Step 2: Experiential Exercise

Clients will illustrate the losses they have experienced due to trauma and identify any positive changes related to it.

Step 3: Processing

Invite clients to share thoughts, feelings, and insights relative to this exercise. The process questions below can be used to help clients express more about their work.

1. Are the losses permanent or are there ways that they can be recovered?
2. How are the losses effecting current decisions and behaviors?
3. If you have found positives, how can they be used to deal with the losses?

4. How can this experience help you to gain a sense of personal control in your life?

APPENDIX E: DEMOGRAPHIC QUESTIONNAIRE

1. **Confidential I.D.** _____

2. **Age**_____

3. Race or Ethnicity

- White (not of Hispanic Origin)
- Black or African American (not of Hispanic Origin)
- American Indian & Alaska Native
- Asian
- Native Hawaiian & Pacific Islander
- Hispanic or Latino of any race
- Some other race

4. Education completed: (check one)

- Less than High School Graduation
- High School Graduation or GED
- One Year Post-High School Education
- Vocational degree
- Two years of college or Associates Degree
- Four years of College or Bachelor's degree
- Post-Bachelor's work
- Graduate degree

5. Did you experience learning and behavioral problems while in school?

- no
- yes

6. Please select any exceptional learning or academic educational services you were qualified for in school:

- Gifted & Talented
- SLD (Specific learning disabilities)
- Mentally Handicapped
- Emotionally Handicapped (SED, EH or EBH)
- Other Health Impaired (OHI, OH, TBI, DHH)

7. Relationship Status

- Never married
- Married
- Divorced/Separated
- Living together

8. If you are or have been married, how many times have you been married? _____

9. How many natural or adopted children do you have? (whether in your custody or not) _____

10. Of your children, how many are: (check all that apply)

- Under 18 years old ► How many? _____

- In your custody ► How many? _____
- In the custody of a family member ► How many? _____
- In State custody ► How many? _____

11. Did you grow up in a home with:

- Both natural parents present
- Single Mother
- Single Father
- Remarried parents (one parent and a step-parent)
- Other (explain) _____

12. Do you have any medical problems?

- no.
- yes ► If yes, please describe them. _____

13. Have you ever been told by a doctor that you have a mental health diagnosis?

- no
- yes ► If yes, please describe your diagnosis. _____

14. Have you ever been hospitalized for mental health reasons?

- no
- yes

15. What are the charges for your current arrest?

16. How many times have you been incarcerated? _____

17. Are other members of your immediate family currently incarcerated or have been incarcerated in the past?

- no
- yes

18. Do you have a history of (check all that apply)

- sexual abuse
- physical abuse
- domestic violence
- none of the above

19. How old were you when you experienced the abuse?

- Under ten years old
- Between 10 and 20 years old
- Between 21 and 30 years old
- Older than 31

20. Before your arrest, were you:

- employed
- seeking employment
- unemployed, not seeking employment

21. Were you under the influence of drugs and/or alcohol at the time of your arrest?

- no
- yes

22. Describe your drug and alcohol use prior to your arrest: (please check all that apply)

If you ever used the substance mark “yes” and if you used it regularly check the box provided.

- | | | |
|----------------------|------------------------------|------------------------------------|
| Alcohol | <input type="checkbox"/> yes | <input type="checkbox"/> regularly |
| Marijuana or hashish | <input type="checkbox"/> yes | <input type="checkbox"/> regularly |
| Cocaine or crack | <input type="checkbox"/> yes | <input type="checkbox"/> regularly |
| Heroin/opiates | <input type="checkbox"/> yes | <input type="checkbox"/> regularly |
| Depressants | <input type="checkbox"/> yes | <input type="checkbox"/> regularly |
| Stimulants | <input type="checkbox"/> yes | <input type="checkbox"/> regularly |
| Hallucinogens | <input type="checkbox"/> yes | <input type="checkbox"/> regularly |
| Inhalants | <input type="checkbox"/> yes | <input type="checkbox"/> regularly |

APPENDIX F: POST STUDY EVALUATION

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