Art psychotherapy in an inpatient forensic psychiatric service: Excerpts from the patient-therapist dialogue

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ABSTRACT

Within the forensic psychiatric service, people can be diagnosed with a mental illness, while incarcerated in a secure setting for an offence that occurred while the person was mentally unwell. Although individuality, empowerment, hope and reconnection are synonymous with mental health recovery, they are contradictory to the custodial environment where one of the main concerns is to provide community safety. A person-centred art psychotherapy process places the individual central to its development. This approach provides an opportunity for an active participation in the recovery process. The person who is motivated to participate in therapy is more likely to resolve recidivist behaviour. This paper provides an introduction to the forensic psychiatric setting, discusses the implications for a person-centred art psychotherapy approach, and provides an overview of an art psychotherapy process in the context of a multi-disciplinary team approach.

INTRODUCTION

In forensic psychiatric health care, most of the problem areas identified for treatment are related to the *DSM-IV* (American Psychiatric Association, 2000) and to the individual patient's offences (Smeijsters & Cleven, 2006). The issues that most often present for therapy include psychosis, depression, impulsivity, aggression, fear and anxiety, a lack of expression, non-verbal behaviour and a lack of boundaries (Pittman, 2008; Smeijsters & Cleven, 2006; Teasdale, 1997). Patients are encouraged to learn about themselves and the circumstances of their offences so that they may resolve the offending behaviours (Pittman, 2008; Smeijsters & Cleven, 2006; Teasdale, 1997).

The application of therapeutic principles in a restricted forensic psychiatric setting where criminal justice occurs is perhaps an oxymoron (Cordess, 2002; Teasdale, 1997); incarceration and compulsory psychiatric treatment take place in a situation where one of the main concerns is to provide community safety. The approach to treatment must therefore meet obligations of safety for the community, while still providing a programme of treatment and rehabilitation (Cordess, 2002). In the case where an offence was of a violent nature, restrictions are endorsed until an expression of remorse has been developed. In this setting, conflict exists between the aims of the institution and the goals of therapeutic practice; between the conventions of the service and the needs of the individual (Cordess, 2002; Teasdale, 1997). The therapeutic space available for the patients' transformation to occur is diminished (Cordess, 2002; Teasdale, 1997).

It has been found that those people who share motivation to participate in therapies are more likely to resolve recidivist behaviours (McMurran, 2002; Smeijsters & Cleven, 2006; Teasdale, 1997), but such motivation is difficult to encourage in an environment where disclosure is perceived as threatening (Cordess, 2002; Gussack, 2007; McMurran, 2002).