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Mindful Mandala Art Therapy in Partial Hospitalization with Children:

Development of a Method

Capstone Thesis

Lesley University

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Art Therapy

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Abstract

This paper discusses an art therapy mindfulness mandala group method created for use within a partial hospitalization program (PHP) setting with children in Boston, MA. Literature regarding partial hospitalization population, therapeutic needs, and treatment was reviewed in order to develop a method to therapeutically benefit child clients aged nine-thirteen at the PHP. Due to the symptomology of clients within the program, much of which was due to frequent histories of trauma among clients, research into therapeutic treatment involved a review of mindfulness interventions for those who have experienced trauma. The writer then created a mindfulness mandala art therapy group, aiming to help clients improve their state of awareness of their thoughts and emotions, thereby decreasing suffering, anxiety, stress, improving well-being, and helping clients to make healthier choices going forward. This writer took process notes of clients' before and after feelings statements, observations during the group, and created response art after each group. Results of the intervention concluded that overall, the majority of children reported feeling neutral or negative emotions before the group and more relaxed and positive emotions after the group. Due to the lack of mindfulness research existing in the field of art therapy within acute treatment, this capstone provides an example of how a mindfulness art therapy mandala group might help children in a PHP to improve their emotional states and sense of well-being. Possible research and practice implications for more incorporation of mindfulness art therapy in acute treatment settings in the future are provided.

Mandala Art Therapy in Partial Hospitalization with Children: Development of a Method

Introduction

I have always considered myself to be a spiritual person, so reading books by transcendental teachers and maintaining my own ethereal connections have been passions of mine since I can remember. Therefore, the topic of mindfulness naturally became an interest for me since hearing about meditation as a teenager. I have had positive personal experiences in my life using mindfulness in different forms, such as yoga, meditation, music, dance, and art. I have personally experienced its benefits, including a calmer and more centered mind, body, and emotions, and an increased sense of self-awareness. Mindfulness has helped me to improve my sense of well-being as well my relationships, including my relationship to myself, to others, and to something beyond myself. In summary, my personal experiences in conjunction with all I have learned throughout my life in regard to the benefits of mindfulness have steered me in the path of writing this paper. Because my own mindfulness practices, including making my own mindful art mandalas, have provided me with so many benefits, I wanted to create an intervention to use with my clients at a partial hospital program so that they, too, could potentially reap similar benefits in well-being.

This paper is the product of the creation and implementation of a mindful mandala art therapy method with children in a partial hospitalization program (PHP), which I developed as an art therapy and clinical mental health counseling master's candidate at Lesley University in Cambridge, MA. First, I reviewed literature examining PHP treatment, including the population, needs, and therapy, especially specific with children. Next, I created an intervention method based on the literature findings on the topic and implemented this method at my PHP internship site. Lastly, I discussed results and further research implications at the conclusion of the project.

Brown (2004) defined PHP as structured treatment providing intensive care with a combination of services, often including group therapy, individual therapy, family therapy, and medication therapy, under the supervision of a psychiatrist and clinician. Individuals in PHP treatment can have different symptoms and diagnoses, including anxiety, depression, suicidal ideation, aggressive outbursts, and defiance (Schwartz & Thyer, 2000). Clients are discharged after symptoms reduce and the client is stabilized, or unfortunately, once insurance requires discharge at around two weeks of treatment (Dick, 2001).

One study showed the strong correlations between symptoms and behaviors of those in psychiatric treatment to be linked with trauma, suggesting that individuals within PHPs may benefit from trauma treatment approaches (Sarid & Huss, 2010). Moreover, Heckwolf, Bergland, and Mouratidis (2014) argue that treating trauma is most effective by utilizing the senses in a more indirect, subconscious way than traditional verbal therapy, especially when working with children who are less verbal and more play-oriented than adults. Because art therapy can access the senses and subconscious and unconscious minds in these indirect, non-verbal ways using colors, textures, lines, images, and archetypes of the art media, it can help those who have experienced trauma by enabling them to re-experience aspects of these memories and reframe them in a safe, therapeutic space (Sarid & Huss, 2010).

In the capstone that follows, I highlight the results from two groups which I conducted using the new method at the PHP with children aged nine-thirteen. The method consisted of giving each client a white paper with a pre-drawn circle on it to color in any way they choose as they listen to instrumental music. Results were recorded using process notes, (clients' before and after self-identified emotions and observations made throughout the group), and the researcher's own response art after each group session. Overall, clients' initial emotional states before the

group were reported as mostly neutral or negative, with only one client's pre-group report being positive. Responses after the mandala art therapy method were all self-identified as being positive, with many reports of feeling calmer after the art-making process. The results of the mindful art therapy mandala intervention suggest that child clients in PHP treatment may benefit from engaging in this method, improving their overall sense of well-being and calm. This capstone suggests more mindfulness art therapy in PHP treatment might be indicated in the future and expands upon the literature regarding acute treatment, art therapy, and mindfulness with children.

Literature Review

Partial Hospitalization Programs

Overview. Acute treatment centers can vary, and partial hospitalization programs are one type that can also vary depending on different factors, like population, location, and purpose. As Houvenagle (2015) describes, partial hospitalization treatment may involve a day, evening, or weekend program which utilizes many services, such as a less intensive alternative to inpatient hospitalization or a transitional program to help individuals re-entering the community. Partial hospitalization programs can vary from city to city and from country to country. There are three different types of PHPs which are generally recognized in the literature, and they are day treatment, crisis-support treatment, and intensive or rehabilitation treatment (Schwartz & Thyer, 2000). In 1982, the American Association for Partial Hospitalization (AAPH) created a definition for PHPs as, "an ambulatory treatment program that includes the major diagnostic, medical, psychiatric, psychosocial, and prevocational treatment modalities designed for patients with serious mental disorders who require coordinated intensive, comprehensive, and

multidisciplinary treatment not provided in an outpatient clinic setting” (as cited in Schwartz & Thyer, 2000, p. 1291).

Presenting problems. Clients of all ages may come to PHP treatment for a variety of reasons. Reasons for PHP treatment include disorders of anxiety, mood, eating, psychosis, dissociation, substance-use, and personality (Houvenagle, 2015). Furthermore, issues unrelated to client diagnoses may also be addressed and treated. Issues including, but not limited to, family dysfunction, interpersonal or intrapersonal psychological issues, and vocational issues may be treated at a PHP level of care (Schwartz & Thyer, 2000). Additionally, clients may come to treatment through different means. Some clients may be stepping down from an inpatient hospital, and others may be referred by outpatient therapists, crisis teams, emergency rooms, psychiatrists, or self-referral (Houvenagle, 2015).

Treatment and discharge. Each client’s treatment is unique to the individual. PHP treatment is similar to inpatient treatment due to the high degree of structure and intensive psychiatric treatment it provides by a combination of mental health services (Brown, 2004). Treatment of individuals in a PHP is vigorous in order to treat people who are experiencing serious mental health issues to stabilize them enough to be safe at home and in their communities (Brown, 2004).

Art therapy is often a component of PHP group treatment, and in acute settings, art therapy integrates each clients’ outlined treatment goals based on their treatment plans and then utilizes these goals to focus into the art therapy group (Dick, 2001). Among group art therapy goals are generally reducing psychiatric symptoms and improving life skills and social interaction (Dick, 2001).

Discharging a client from a PHP depends on different factors; generally, clients are discharged after their symptoms reduce and they become more stabilized (Dick, 2001). Client stabilization is one important reason for a discharge or a potential referral to a higher level of care. Each client's interdisciplinary team in the PHP schedules after-care treatment in order to continue with medical and psychiatric needs, which will often include outpatient therapy and/or a psychiatrist (Dick, 2001). The length of treatment can vary from client to client as well; how long clients stay in PHP treatment depends on how well their symptoms improve and on the client's insurance coverage, which is usually around eight-ten days of treatment at the PHP (Schwartz & Thyer, 2000).

Children in PHPs. Considering the many natural differences in adults and children, minor clients in PHP treatment can show different presentations, with some overlap, with adult clients. Often minors in PHP treatment present with depression, suicidality, and aggression (Houvenagle, 2015). Houvenagle (2015) further describes common presenting problems for children in PHPs as impulsivity, psychotic disorders, eating disorders, and school refusal. Further, children in PHPs benefit most from play therapy or art therapy, instead of traditional talk therapy, because children may gain minimal insight through verbalizing their difficulties (Schwartz & Thyer, 2000). In addition to play therapy and art therapy, family therapy is also important for helping with the child's issues at home and for greater communication around the client's progress during the length of the PHP treatment (Schwartz & Thyer, 2000). Furthermore, PHPs often use behavior modification in the form of rewards for positive progress in the program (Houvenagle, 2015). While trauma is the primary cause for many of the behaviors in PHP programs, how clinicians may best attend to experiences of trauma in PHPs is often not included in the PHP treatment literature; many of the behaviors children present with fit with the

research literature on trauma. Therefore, I discuss the need for trauma-informed treatment in PHPs in further detail below.

Trauma-Informed Treatment and PHPs

A traumatic event has been defined as “an event that involves actual or threatened death, serious injury, or a threat to physical integrity of self or other, to which the individual’s response involves intense fear, helplessness, or horror” (Sarid & Huss, 2010, p. 8). Thus, traumatic events can vary from person to person, including perceived threats of harm to the individual or an actual attack to the person’s safety. Additionally, The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) lists three other ways a person can experience trauma, including in-person witnessing of others directly experiencing trauma, learning of close family members or friends experiencing direct exposure to trauma, and continuous or severe exposure to details of traumatic events, like trauma workers consistently learning details of abuse, or viewing violent crime scenes (APA, 2013).

Specifically, the DSM-V lists criteria for acute stress disorder as well as post-traumatic stress disorder, which both involve similar mental and physical symptoms, including dissociative symptoms like depersonalization and derealization, anxiety, nightmares, intense memories, avoidance of internal and external trauma reminders, visceral flashbacks, negative cognition and mood, and hyperarousal, to name a few (APA, 2013). However, length of time is what differentiates acute stress disorder and PTSD; acute stress disorder occurs within the first month of an individual’s experience of trauma and lasts for three or more days, but PTSD symptoms must occur for over a month and may appear months or years after a traumatic event (APA, 2013). Furthermore, children who have experienced trauma may present with numerous other symptoms, behaviors, and formal mental health diagnoses.

Various literature discusses the links between children's externalizing and internalizing behaviors and their histories of trauma, including Fantuzzo et al. (1991), Schore (2002), Klingman, Koenigsfield, and Markman (1987), Klatt, Harpster, Browne, White, and Case-Smith (2013), Sarid and Huss (2010), Coholic and Eys (2016), and Hass-Cohen and Carr (2008).

One study by Fantuzzo et al. (1991) describes research in support of a link between children's externalizing behaviors, such as verbal or physical aggression, and children who have witnessed some forms of domestic violence. Children residing in homes who witnessed interparental violence (verbal and physical conflict between parents) showed these increased levels of externalizing behaviors in comparison to children who were not from violent homes and did not express externalizing behaviors (Fantuzzo et al., 1991). Therefore, while this study does not directly link trauma and PHP clients, there is a clear overlap between behaviors seen in children at PHPs, such as aggressive verbal and physical outbursts, and behaviors linked to trauma in the home. This indicates that a history of some types of trauma may be one cause of the maladaptive behaviors (Fantuzzo et al., 1991). Children who witnessed interparental violence may have observed yelling, name-calling, fighting, physical aggression, sexual aggression, and other forms of abuse between parents, and these children often go on to express aggression towards others, at times leading to inpatient hospitalization or another levels of care like a PHP (Fantuzzo et al., 1991).

Klingman et al. (1987) further discuss links between children who had experienced trauma and increased internalizing and externalizing behaviors, such as school avoidance, defiance, overwhelming sadness, and insomnia. Similarly, Klatt et al. (2013) note that children who have experienced poverty and/or other chronic life stressors, like low socioeconomic status, unemployed parents, hunger, lack of exercise, and sleep deprivation, often show increased

behavioral, social, and academic difficulties as compared to children who have not had persistent environmental stress. Moreover, Schore (2002) also argues for a link between trauma and maladaptive behavior; he explains research which supports that early infant relational trauma, taking place within the first two years of life, imprints in the brain, specifically the limbic and autonomic nervous systems. This can result in affective dysregulation, dissociation, and ineffective stress coping systems, which form the basis of PTSD.

Schore (2002) states that the effects of trauma are experienced psychophysically, even if the actual traumatic event caused no physical harm to the person. In other words, individuals who have experienced trauma can have physical and psychological effects from it which manifest within the body, regardless of whether or not the traumatic experience directly affected the person's body, indicating that trauma is processed and stored both in the brain and in the body itself (Schore, 2002). Furthermore, Hass-Cohen and Carr (2008) describe that traumatic memories are a unique kind of memory, because they can be stored in vivid, visceral ways, such as through images, smells, bodily sensations, and sounds. Unlike usual memories, traumatic memories can seem more intense, dramatic, and realistic, which can lead to trauma survivors feeling a lack of a sense of control or coherent narrative to their traumatic event(s) (Sarid and Huss, 2010). Therefore, understanding that trauma is processed in mental and physical ways means that trauma treatment in PHPs may benefit from therapy which helps to access both of these areas.

Art therapy and trauma treatment. A trauma-informed approach to therapeutic treatment at the PHP level of care may be valuable in helping children to work through their presenting issues in the most appropriate ways in accordance with their symptoms. Therapeutic interventions to help trauma survivors in PHP treatment would therefore benefit from involving a

reframing of the clients' traumatic memories, such as by use of a cognitive behavioral intervention and/or art therapy approach, so that they may eventually be experienced with less intensity both mentally and physically, thereby decreasing the symptoms of trauma and improving the client's quality of life (Klatt et al., 2013).

One study by Sarid and Huss (2010) compared trauma treatment methods in acute stress disorder. The study compared two different treatment methods which may be beneficial in treating acute stress disorder: cognitive behavioral therapy (CBT) and art therapy (Sarid & Huss, 2010). Firstly, they found that using CBT would help a trauma survivor to observe their thoughts around their trauma experience and notice cognitive distortions (errors in thinking) which they can then alter into a more positive or realistic perspective (Sarid & Huss, 2010). In other words, the cognitive approach to trauma treatment would, in part, involve analyzing and improving one's thinking to become more positive, thereby experiencing more positive emotions and leading to improvement in symptoms and behavior. Another CBT method to treat trauma involves engaging in visual imagery to recreate safe memories and replace or improve traumatic memories (Sarid & Huss, 2010).

Contrastingly, an art therapy approach would help the client to reframe their traumatic experiences by another route, through the more tactile, physical, and affective components of the art materials, in order to access similarly-sensed traumatic memories such as vivid imagery, emotions, and sensations (Klingman et al., 1987). Thus, the art therapy process helps individuals to access their stored sensory memories of traumatic events and then reframe them to help restore the person's feelings of control, calm, and coherent sequence of events (Klingman et al., 1987). In summary, reframing traumatic events using CBT or art therapy can help trauma

survivors to bring the events back into the rest of their life timeline in a way that is less disruptive to their overall functioning with fewer symptomatic behaviors (Sarid & Huss, 2010).

Hass-Cohen and Carr (2008) summarize that art therapy involves three levels in treating trauma with clients in order to help regulate and integrate their experiences and symptoms. The first step, according to Hass-Cohen and Carr (2008), is to engage clients using the senses as well as the body by feeling, seeing, and working with art materials. In other words, individuals engage in the art-making process to create something from their memories and experiences around the trauma (Heckwolf et al., 2014). Secondly, the art media elicits autobiographical memories of the individual's trauma through personal expression and meaning-making using colors, shapes, textures, and other components of the art (Hass-Cohen & Carr, 2008). This second stage of the art therapy process allows the client to form their own interpretations, perceptions, and relevance through the art they create (Sarid & Huss, 2010). Thirdly, the client and art therapist contemplate and reflect upon the client's art process together (Heckwolf et al., 2014). Perry, Pollard, Blakely, Baker, and Vigilante (1995) describe that "the client and therapist together, through elaboration, repetition and reframing of the art product, integrate a coherent and enabling narrative of the traumatic memories" (as cited in Sarid and Huss, 2010, p. 10.)

As Hass-Cohen and Carr (2008) further explain, the art therapist can use all three stages together or in a cyclical pattern where the third stage of processing will often lead back to the first stage of tactile and sensory art-making, helping the client to re-integrate new memories into their sensory, emotional, and cognitive levels. Additionally, while the client and art therapist shift through the three stages, the art therapy process can help the client to rearrange the over-excitation of past trauma sensory information, allowing the individual to construct an improved sense of control and, as follows, hopefulness (Hass-Cohen & Carr, 2008). Schore (2002) states

that art therapy's utilization of sensory triggers like smells, sights, sounds, and textures, helps people who have experienced trauma to re-integrate their excessive arousal experiences into regulatory processes. By modifying an individual's emotional-physiological reactions through the art materials, art therapy can aid in desensitizing the trauma response to stimuli (Sarid & Huss, 2010). Likewise, by manipulating the physicality of the art media, clients can experience a feeling of control over their sensory experience in therapy, such as motor control and muscle pressure (Sarid & Huss, 2010). Safran and Greenberg (1991) conceptualize this process as working from "bottom-up", as opposed to a "top-down", cognitive approach to treatment (as cited in Sarid and Huss, 2010, p.10). Utilizing an art therapy approach to trauma treatment allows for flexibility among pathways of the physical, cognitive, and emotional components to one's traumatic experiences, allowing for new, positive connections to be formed (Sarid & Huss, 2010).

One proposed explanation into how art therapy may help to heal individuals who have experienced trauma involves a neuro-scientific lens (Hass-Cohen & Carr, 2008). Researchers Hass-Cohen and Carr (2008) suggest that art therapy may aid in initializing a regulatory process in the brain which lowers the client's anxiety and negative emotional reactions by inhibiting a release of cortisol, the hormone responsible for stress, from the hypothalamus. The new pathways which form between the mind, body, and emotions through the art therapy process may help to moderate a person's stress levels, enabling the restructuring of traumatic memories into more positive memories (Sarid & Huss, 2010). Thus, Sarid and Huss (2010) state that this implies that the art therapist is less of a lead in the therapy work with trauma and more of a guide, helping to enable this positive reframing of memories by directing the client's attention to different aspects of their past traumatic memories through the client's artwork. For example, the

art therapist can bring a client's attention to their use of certain colors and prompt the client to ponder and discuss what these color choices may mean to them in their art process, leading to a discussion of the client's traumatic memories through the art, thereby reintegrating these memories back into a more positive trauma narrative during the therapy process (Sarid & Huss, 2010).

In addition to and in conjunction with art therapy, research has supported the use of a multi-modal therapeutic approach while treating complex symptoms and diagnoses like trauma (Heckwolf et al., 2014). The primary goal, according to Coholic and Eys (2016), of using simultaneous approaches in therapy is to increase the therapy's efficiency, efficacy, and applicability. Coholic and Eys (2016) go on to say that coordinating art therapy with Dialectical Behavioral Therapy (DBT) in therapy sessions and in case formulation can thus reinforce the skills gained within each singular approach as well as connect the different parts of the therapy for the client, synthesizing a greater coherence in treatment.

DBT, Mindfulness and Art Therapy

DBT itself has been shown to be one of the leading forms of treatment for individuals dealing with trauma; it incorporates mindfulness as a component to help clients center, focus, and calm, both in and out of the therapy session (Greenberg & Harris, 2012). Greenberg and Harris (2012) state that mindfulness has been shown to reduce anxiety, improve concentration and attention ability, increase one's awareness of thoughts and emotions, increase emotion regulation, empathy, and compassion.

Using art therapy and DBT together has also been shown to encourage bilateral integration, where the left and right hemispheres of the brain join to create more global and creative solutions in problem solving (Heckwolf et al., 2014). Combining a kinesthetic, sensory

approach like art therapy with the more verbal part of DBT seems to help with bi-lateral integration, and such linking has been recognized to help clients meet many of their treatment goals, like regulating emotions as well as decreasing stress (Klatt et al., 2013).

A study by Monti et al. (2006) provides an example of utilizing art therapy and DBT approaches together in mindfulness-based art therapy (MBAT) involving women with cancer and showed significant improvements in women's distress. In the study, the women participated in a group mindful art activity, which was paralleled by learning mindfulness skills in group (Monti et al., 2006). The mindfulness skills that the participants learned included engaging in body-scan meditations, mindful breathing, and learning about the attitudinal and philosophical foundations of mindfulness practice (Monti et al., 2006). Mindful breathing has been demonstrated as a component to mindfulness practice, as it encourages regulation of the body's autonomic nervous system, resulting in an increase in self-awareness and concentration and decrease in stress and problematic behavior (Klatt et al., 2013). The art therapy group they participated in included a mindful exploration of the art media in addition to practicing awareness of various sensory stimuli and response (Monti et al., 2006). According to Monti et al. (2006) the women who participated in the MBAT intervention showed significantly decreased levels of anxiety, depression, hostility, obsessive-compulsive behavior, somatization, and interpersonal sensitivity.

In addition, Heckwolf et al. (2014) describe another case study applying both art therapy and DBT approaches simultaneously. The use of DBT provided behavioral as well as interpersonal components to the clients' therapy process, which helped to support the client's introspective art therapy work (Heckwolf et al., 2014). Also, Heckwolf et al. (2014) explain that by overlapping the principles of both theoretical approaches, these perspectives helped to expand

and strengthen each aspect of the therapy. For example, connecting awareness, a common art therapy principle, with mindfulness, a common DBT principle, may help clients to become more present and less judgmental (mindfulness) as they increase their sense of personal knowledge of self (awareness). Heckwolf et al. (2014) further state that other overlapping principles of the two practices are: holding environment and egalitarian stance, containment and distress tolerance, sublimation and emotion regulation, intrapersonal effectiveness and interpersonal effectiveness, and transitional objects and homework.

Many researchers have studied mindfulness-based interventions (MBIs) specifically with children, which have shown to be promising in helping children to increase their awareness of self and become more accepting of their experiences in school as well as in clinical settings (Klatt et al., 2013). Greenberg and Harris (2012) also say that MBIs aim to help improve concentration and attention, develop emotion regulation, build self-knowledge, and increase compassion and empathy. Furthermore, Coholic and Eys (2016) summarize more benefits of MBIs, like reducing stress, decreasing internalizing and externalizing behaviors, and improving executive functioning. Coholic (2014) states that improving a child's self-understanding of feelings and thoughts can help them to make healthier decisions in regard to their emotional expression, and improve functioning at home, school, and with their peers. Along the same lines, Coholic and Eys (2016) state that children learning mindfulness can also help them to notice their negative thoughts and emotions as fleeting moments instead of interpreting them as reality.

The combination of using mindfulness and the arts synchronously can be traced back to spiritual and religious practices, where they served as encouraging transformation and healing (Rappaport, 2014). Rappaport (2014) goes on to explain that both mindfulness and the arts allow opportunities to tap into an inner knowing and to be fully present. One study by Klatt et al.

(2013) showed the benefits of an arts-based mindfulness program involving yoga, music, meditation, written, and visual arts which helped children to feel calmer and improve focus. Coholic and Eys (2016) also emphasize the importance of using arts-based mindfulness practices in groups of children (even though they could also be used individually). Due to many children's difficulties with poor socialization and coping skills, these groups provide an opportunity to improve upon these interpersonal skills.

Furthermore, while children may be able to learn mindfulness practices without using the arts, such as walking or sitting meditations, art can provide a more inviting, enjoyable form of mindfulness (Coholic & Eys, 2016). Coholic and Eys (2016) relayed that many children who participated in the arts-based mindfulness program described the program as being "fun", and the experience of having fun, they say, can be the factor which keeps children in a state of emotional receptivity, which helps them continue to learn positive messages. In this way, arts-based mindfulness methods can aid in learning skills which form foundations for future learning (Coholic & Eys, 2016).

The Use of Mandalas

Furthermore, mandalas are one form of mindfulness practice and art expression that have been used in art therapy and researched with many populations, showing success in treatment (Kostyunina & Drozdikova-Zaripoya, 2016). Originating from the Sanskrit word meaning "circle", mandalas began as tools for meditation in ancient Indian culture and tradition; the center of a mandala was thought to be a sacred type of space where universal energy can flow (Kostyunina & Drozdikova-Zaripoya, 2016). Hindus and Buddhists have also used mandalas for meditation in differing ways, helping people to reach levels of spiritual enlightenment (Buchalter, 2013). The circular shape of the mandala provides a safe, protected enclosure,

allowing its creator to self-express freely and with greater personal fulfillment; as a result, Carl Jung, known as the father of analytic psychology, thought that mandalas should be created during challenging times in one's life, so that the circle can help to stabilize the emotions and harmonize the mind (Kostyunina & Drozdikova-Zaripoya, 2016). Because the center of the mandala is thought to represent one single point of observation within the universe, mandalas do not need to conform to any one type of specific structure (Buchalter, 2013). Furthermore, Kostyunina and Drozdikova-Zaripoya (2016) describe that mandalas can be two-dimensional or three-dimensional and may be created using a variety of materials, such as sand, colored powders, wood, stone, fabric, or metal. Jung studied mandalas and found that they can be symbols of the unconscious mind, as people often turn toward the symbol of mandala-making throughout the world (Kostyunina & Drozdikova-Zaripoya, 2016). Jung describes the mandala as representative of the collective unconscious and believed that the unconscious mind can be reflected upon by the conscious mind through mandala art, leading the artist or client to increased self-awareness (Kostyunina & Drozdikova-Zaripoya, 2016).

As Buchalter (2013) discusses, the mandala circle can represent wholeness, the self, or the universe. Creating a mandala can metaphorically reflect an opening for an individual to create their perception of their own universe, which, for children, allows authentic expression without needing to use complex language or great insight into their conscious mind; this is important given children do not yet possess the cognitive skills and abstract thinking of adults (Buchalter, 2013). Therefore, using mandalas in therapy with children has been shown to benefit clients by allowing them, by way of the enclosed, circular "holding space", to express themselves non-verbally using art materials in an engaging and calming way, including the benefits of art therapy and mindfulness simultaneously (Buchalter, 2013). Despite the number of

potential benefits of mandala art therapy with children who have experienced trauma in PHP programs, no known literature has implemented any mandala art therapy interventions for children in an acute setting.

Methods

The method that I facilitated consisted of two mindfulness mandala groups for children at a PHP. The groups at the PHP are typically comprised of one-seven members of children aged nine-sixteen. The two groups conducted in this study included four members and two members respectively, (although one member from each group chose to remain in the room without participating in the activity), with children aged nine-thirteen. Each client participated in the group only once, so no two clients were in both groups. In my first group, consisting of four clients, two females and two males, all but one was twelve years old, and one was thirteen years old. In the second group, which included two members, one was a nine-year old boy and one was a twelve-year-old transgender female (who chose not to participate in the group activity). The groups ran during the PHP's already-existing forty-five minute DBT group on Friday afternoons.

As teaching clients at the PHP coping skills that they can use beyond their admission is vital to their treatment, psychoeducation is a part of the PHP's daily intensive structure (Coholic & Eys, 2016). Therefore, I began the group by introducing the group topic, which was DBT, defining DBT for the group, defining mindfulness as a part of DBT, and asking the group about their experience with mindfulness. By introducing this focus of the group and activity, clients can better make connections to learning the new skills, including how and why the method may help them, should they choose to use the mindful art therapy coping tool outside of the program setting. I explained what mandalas are and how they can be useful as a mindfulness coping tool to help alleviate stress, anxiety, negative feelings, and so forth, and as a way to center our

thoughts and feelings, so that we may become more aware of how we are doing (Greenberg & Harris, 2012). Helping to teach the children in my group how to tune in to their own thoughts and feelings may allow them to be able to use their newfound self-awareness to make good, healthy choices, instead of responding to situations in a more reactive way (Klatt et al., 2013). The beginning discussion part of the group lasted approximately five minutes, and then I asked that everyone take a deep breath. Deep breathing was encouraged in order to engage regulation of the body's autonomic nervous system, promoting self-awareness and concentration (Klatt et al., 2013). After taking a deep breath together, I asked the group members to tell us all one word they would use to describe how they are feeling in the moment before beginning the mandalas, so that I could keep track of the children's emotional states and compare them before and after the mandala activity.

Next, I provided art materials for the group: a white, eight-and-a-half by eleven inch drawing paper with a blank circle drawn in the center in permanent marker, colored pencils, and chalk pastels. I chose this size paper because it provided a medium, average sized drawing surface for the children so that they would have enough space to create without feeling intimidated by a too-large sheet of paper. I chose to limit the art supplies to only two options in order to stay consistent with the PHP's highly structured setting and to create limitations for the group members so that they may feel a sense of containment and not become overwhelmed by too many options. Structure is an essential component to PHP treatment, especially with child clients (Brown, 2004). I told the group members that they could use either of the two materials to create their mandalas, or both. The group worked on creating their mandalas for a maximum of twenty-five to thirty minutes while they were encouraged to work quietly as instrumental music

played. The intention of the instrumental music was to help the children to stay in a calm and relaxed yet focused state (Kostyunina & Drozdikova-Zaripova, 2016)

Afterwards, I prompted a discussion with the group members about how the experience was for them and asked three specific questions, going around in a circle to ask each group member individually. The questions I asked the group were to help facilitate processing of the art therapy activity, so that they could gain insight into their experiences, thereby promoting their own meaning-making and self-exploration as a result of their mandala art (Sarid & Huss, 2010). The questions were: 1) “Tell us about your mandala and what led you to create it?” 2) “How did it feel while you were creating your mandala?” 3) “How do you feel after creating your mandala?” To close the group, I asked each person, “What is one word you would use to describe how you are feeling after creating your mandala?” The last five minutes of the group were used for cleaning up and providing individual feedback to clients regarding their group behavior, which was conducted in a manner common to the rewards system of many PHPs (Brown, 2004).

I recorded my groups by taking notes of what the group members stated before and after the process, what I observed happening in the group, including dialogue, client interaction, color and media choices, affect, body language, and any extra activity, and by creating response art of my own mandalas after each of the two groups. Because many clients created such drastically different mandalas, I created my own response mandalas as reflections of my clients’ art in order to better empathize with how they were feeling in the moment and gain awareness of what impacts the different media choices may have had on each of them. I also created the mandalas spontaneously, without thinking about them too much before I created them, in order to stay consistent with traditional mandala art therapy; I wanted to allow my subconscious and

unconscious mind to come out through the art more than my conscious mind, so I created each mandala within a maximum of fifteen minutes.

Results

Session One

During the first group, the words that each member stated to describe how they felt before engaging in the mandala art process were a mixture of neutral or negative emotions, with only one positive emotion. There were many unanticipated components that took place during the first group process, including media choices, special requests, varying participant engagement levels, and an emotional outburst.

First, I had told the group that their only two options for creating their mandalas were chalk pastels and colored pencils; however, group members began to initially draw with pens which were also in the room and on the table. This was an oversight on my part, since I intended to begin the intervention with only the pre-planned supplies. However, once prompted again to only use one of the two media choices supplied or a combination of both, three of the group members continued their mandalas using only the two options originally provided, and only one group member continued his entire mandala using only pen. Two of the three group members who chose the color media provided chose to use chalk pastels, and one used the colored pencils. All four group members used only one medium throughout the mandala process.

Another unanticipated event was that all four group members requested, at least once, to start over on a new paper, opting to throw away their initial mandala design. One group member even asked for three extra mandala templates and completed all of them for a total of four mandala images. I decided to accommodate the group members' requests for additional blank mandala templates, even though it was not in my method plan, since it seemed important to all

group members that they be able to start a whole new page instead of working with what they considered to be their mistakes. Moreover, the same group member who drew four total mandalas chose to only use pen for all of his images, wanted to stand during the entire group session, and insisted that he needed a ruler to create his art in the way that he wanted using straight, even lines. I decided to accommodate the group member's request for a ruler, even though it was not in the original group structure, because he not only was very adamant about needing one, but there also happened to be one in the room already, and I wanted him to be able to create his art the way he spontaneously felt he needed to in that present, mindful moment.

In my first group, two clients were females, two were males, and all were twelve years old except for one thirteen-year-old. One client, a twelve-year-old male, opted out of the group after about ten minutes due to frustration intolerance regarding my prompting him to stay quiet and mindful while listening to instrumental music during the group activity. Although this client initially began a drawing, after I prompted him three times to remember to focus on his drawing and listen to the instrumental music, he stopped participating in the group entirely, and instead, continued to talk to other group members and write on his arms (after repeated prompts to not write on his skin).

There was discussion throughout the group, mostly led by the group member who chose not to participate in the group; however, all group members talked with each other off and on throughout the process, despite repeated prompting to focus on the art-making and listen to the instrumental music quietly while they worked. The discussion consisted of some self-critical comments some group members were making about their artwork and how it looked, compliments and questions directed at other group members' artwork, and commentary on how the process was going for them.

Each group member's mandala looked unique to the others in the group in terms of design, except for the majority use of cool colors (blue, green, and purple shades). After the mandala art process, each participant discussed their process in response to the three prompted questions; three of the four participants chose positive words to describe their state of being, and one declined to answer.

Session Two

The second mandala art therapy group consisted of two clients, a nine-year-old male and a twelve-year-old transgender female. The twelve-year-old transgender female client refused to participate, having entered the group in distress. Despite multiple attempts to include this group member, she opted not to participate and said that there was nothing she wanted to do. I will discuss this experience in more detail in the discussion section. The words which were provided by the clients regarding their states of being before beginning the mandala art group included one neutral word response and one highly negative response.

The client who did participate chose blue shades of chalk pastels and started with outlining the inside of the circle with a lighter color, then blending the lighter shade of blue with a darker shade of blue towards the center. He proceeded to blend the colors slowly, carefully, and intentionally until the colors looked like they were smoothly blended into one another, then he put his pastels down, looked up at me, and told me he had finished. He completed his first mandala in about five minutes. I encouraged him to work on it some more, but after another couple of minutes, he again stated that he was done. I offered him the option of starting a new mandala, which he did. He spent significantly more time on his second mandala, using a similar color scheme and design.

The twelve-year-old client remained in the group room during the entire art activity and quietly sat in her chair. She declined all offerings I made to her in terms of an alternative activity during the group time and continued to comment about how unhappy and mad she was feeling at the time.

After the participating group member finished his second mandala, I prompted him with my three post-activity questions, and we discussed what his experience of the group was like. The client responded by stating that he felt calmer and better after the activity. He also said that he would do the activity again outside of the PHP.

Self-Reflection Mandalas

Since some clients in the first group used blended chalk pastel colors and others used a ruler to create organized geometric pen lines, I made a hybrid mandala following the first group, where one half was inspired by the blended chalk colors, and the other, I used a pen and a ruler to re-create my own version of my client's geometric mandala (see Appendix, figure 1). I felt a big difference in how I handled the materials in the two different halves of my mandala, which gave me some insight into how differently the two group members may have been feeling at the time.

I created my second mandala art reflection to be another hybrid image, so I could attempt to tap into both of my contrasting group members' experiences again (see Appendix, figure 2). This time, one of the two group members declined to participate at all. I colored in the other group member's half of the mandala using colors inspired by his cool blue shades and colored his half in a similar careful rhythm, but I left the other half of the mandala blank in order to

reflect the other group member's desire to "do nothing" during the group. I felt sad leaving it blank, and it gave me a small glimpse into her potential perspective during the group session.

Discussion

I created this mindful mandala art therapy intervention for use at a PHP with children ages nine-thirteen years old in Boston, MA with the intention of helping the clients there in the most beneficial ways possible. Through my processing of reviewing existing research regarding symptoms and treatments of children in PHPs, I found that taking a trauma-informed approach using mindfulness, DBT, and art therapy approaches are among the most effective (Schore, 2002).

According to the participants' pre and post-group self-reported feelings, all but one client (five out of six total group members) reported neutral or negative pre-group emotions, and only one gave a positive pre-group self-report. However, everyone who engaged in the entirety of the group method (four out of six total group members) self-reported feeling better and more positive after the group intervention, and all but one felt calmer. Considering that the goal of my intervention was to utilize the researched benefits of mindfulness, DBT, and art therapy, including improved sense of awareness; decreased anxiety, stress, and overall sense of suffering; increased sense of well-being; and improved ability to self-reflect, think before acting, respond more productively, and problem solve, the results of my intervention support my literature findings (Greenberg & Harris, 2012).

Creating my response mandala art after each group helped me to process and realize more about the implementation of my method. Creating the art helped me to empathize a little better with each client's perspective during the group and made me aware of more than I was before I created the response art. One realization I had was in response to the client who insisted on

measuring every detail of his mandala out using only pen lines and a ruler. As a result, every line he drew was precise, exactly how he wanted it, and easily controllable. Creating response art from this group made me curious about his perceptions of control in his life. I am also curious if creating his mandalas in this way helped to mitigate any desire or need for control by using the art supplies, and by extension, over other aspects of his life. This client also stood up while drawing throughout the entire group, which further indicates his interest in wanting to feel like he was “on top” of his art and in charge of it completely. In reference to one study done by Fantuzzo et al. (1991), when children feel an overwhelming amount of stress in their environments, this can often lead to various behavioral issues. Maybe the intervention allowed this client a safe space to process his sense of control by using the “bottom-up” sensory art therapy approach, instead of the “top-down” more verbal, cognitive approach to treatment (Safran and Greenberg, 1991, as cited in Sarid and Huss, 2010, p. 10). This was a revelation I may not have recognized had I not engaged in my own response art after the groups.

The two groups I facilitated with the intervention surprised me in many ways, but according to the literature regarding symptoms of children who experienced trauma, the behaviors of my group members were typical of the population (Houvenagle, 2015). For example, although I had not anticipated clients refusing to engage in the group entirely, the results that two out of my six total group members chose not to participate aligns with literature regarding child clients’ behavior and symptoms in PHPs, such as school refusal, defiance, avoidance, and aggression (Schwartz & Thyer, 2000). It is also important to note that while many children in PHPs have an ADHD (attention deficit hyperactivity disorder) diagnosis, both of the group members who opted out of participating also had an ADHD diagnosis (Sarid &

Huss, 2010). This makes strong implications for future modifications of the group in order to accommodate more restless children.

A more movement-oriented mindful art therapy intervention may better benefit clients with attention and hyperactivity difficulties. For example, some of the literature I reviewed discussed mixing yoga with arts-based mindfulness practice, which significantly improved clients' mood and reduced anxiety (Monti et al., 2006). Thus, another potential improvement to the group may be to include mindful physical movement/exercise in addition to the art therapy component. This way, children can take part in different aspects of mindfulness without the need for focused attention, which might prove to not be responsive to the needs of children with ADHD. Further suggestions to make the group more movement-oriented may include creating a mandala while standing up and using an easel or wall, or creating a larger mandala collage using materials like stones or different objects, so that clients can have more mobility and express more energy.

Also, because all group members in the first group continued to talk throughout the activity, even with verbal prompting to stay focused and mindful, future groups may be more therapeutic without a speaking restriction. Repeated prompting to remain mindful and quiet during group only exacerbated the clients' difficulty focusing and increased their frustration. Given the differences between children and adults, allowing discussion during mindful exercises may better match developmental needs of this age group.

It is important to be aware of group dynamics as well, since some group relations may cause distraction to some of the group members. For those group members who decided or were unable to participate in the activity, redirecting them to another quiet activity was helpful in keeping the rest of the group focused on their mindful mandalas. Encouraging the clients who do

not participate to take space outside of the group room if desired is another option that may benefit the entire group during the intervention, so that as many group members as possible benefit from the group.

In both groups there were participants who finished their art early and proceeded to create multiple mandalas instead of only one. A potential modification for future mindfulness art therapy groups in PHP treatment may be to utilize more than one activity per group session, since most group members finished their mandalas well before the group time frame ended. In the future, facilitators might offer two or three different activities per group, including some which are more DBT/mindfulness oriented and others integrating the art therapy mandala component.

Another modification for future interventions might be to provide a pencil and eraser for clients to use in addition to art materials, since all clients initially began to draw with pens. The group members stated that they were using the pens to draw an outline first, so a pencil and eraser may be a better alternative which would allow them to erase their mistakes instead of asking for new templates with which to start over. All participating group members requested at least one extra blank mandala template, and many requested more than one. Instead of working with an image they had already started, they had all decided at least once that they preferred to start completely new and that their original art was not able to be saved. This may have implications regarding struggles with impulse control, frustration tolerance, a lack of creative problem-solving, and/or emotional lability, which are also common among the findings regarding the challenges of many children in PHP treatment and trauma survivors (Hass-Cohen & Carr, 2008).

Combining DBT, mindfulness practice, and art therapy is intended to make the approaches more entertaining and “child-friendly” so that children may be more naturally engaged in the activities while benefitting from the calming effects of awareness, presence, and expression (Heckwolf et al., 2014). However, many adjustments could be made for future use of the method in order to better serve all clients in the PHP group.

In addition, further research is needed regarding specifically treating children with ADHD. I would recommend reviewing literature on how children with ADHD learn best in order to help include these clients in the mindfulness art therapy method in the future. I would also read literature on both art therapy and mindfulness approaches with children with ADHD, in order to understand what may or may not work in helping these clients to benefit from these approaches. In addition, I would recommend looking into therapeutic approaches in general which may be effective with clients with ADHD, including specifically in acute treatment, so that if there are more beneficial approaches which may be used with these children, these additional therapies and methods can be added to the mindful art therapy intervention.

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Appendix

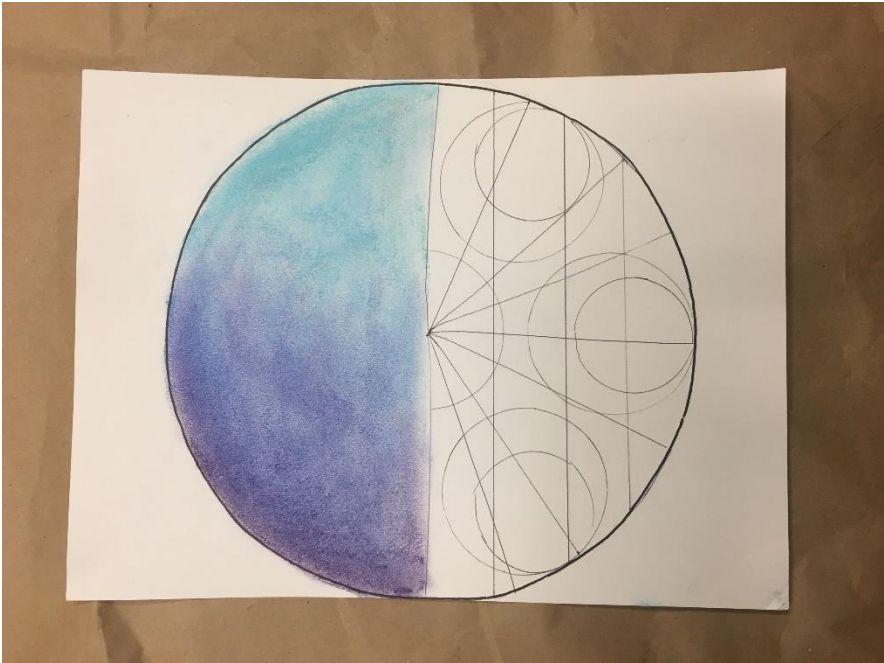


Figure 1. Group 1 mandala art response

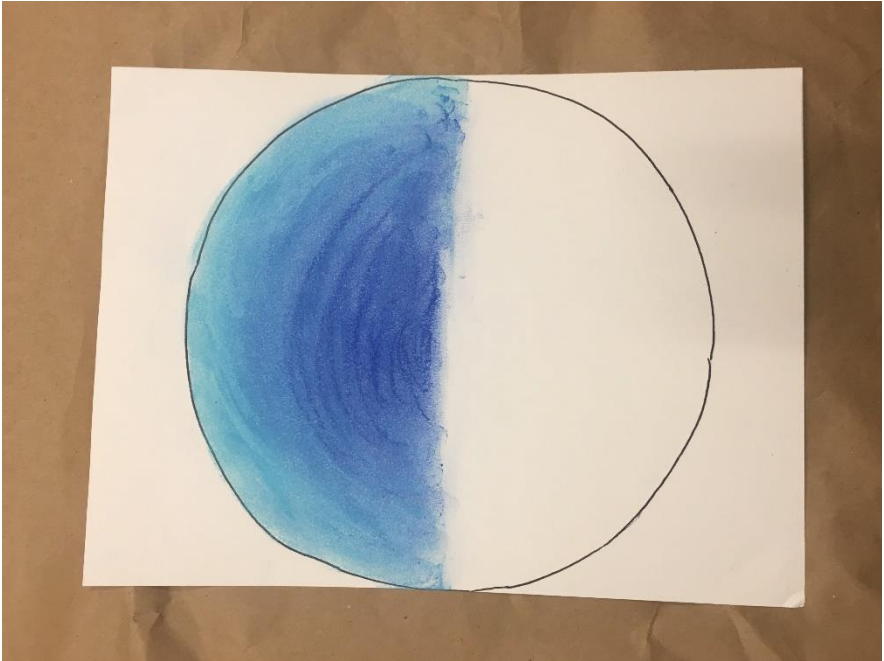


Figure 2. Group 2 mandala art response

THESIS APPROVAL FORM

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Student's Name: Kristen Sampson

Type of Project: Thesis

Title: Mindful Mandala Art Therapy in Partial Hospitalization with Children: Development of a Method

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In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: Christine Mayor