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Emotional Layering:
An Art Therapy Intervention with Children and Adolescents in an Inpatient Setting
Capstone Thesis
Lesley University

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Art Therapy

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Abstract

Emotion regulation is the ability of a person to identify and control their emotions during life experiences. This form of regulation can be a struggle for some people, especially during their adolescent years. If a teenager is then in crisis, experienced trauma(s), and/or made a suicide attempt, it is even harder to work through and be able to identify their emotions. Existing research shows the difficulty some adolescents have with identifying emotions, especially after going through crisis and being placed on a locked psychiatric unit (Ciarrochi, Heaven, & Supavadeeprasit, 2008; Perez, Venta, & Garnaat, 2012; Hatkevich, Penner, & Sharp, 2019). Working on such a unit, there was an additional challenge operating around the limitations the unit had in place with specific materials to keep clients safe. Utilizing the intervention *Emotional Layering*, using only different colored tissue paper and glue, allowed clients to safely explore identifying emotions. By matching a color to a specific emotion, the same colored tissue paper then layered with any number of other emotions/colors a client was experiencing, they created a tangible image that represented their feelings. By using “I am the one who...” language in the group, clients were able to find commonalities between art pieces within the community, allowing for exposure to the emotion, which exposed them to the vulnerability of expressing emotions, and a better understanding of naming emotions, nonverbally. Deepening a client’s connection to emotions and learning how to regulate them are key steps to a healthier life.

Key words: emotion regulation, emotional competence, emotional intelligence, art therapy, emotional layering

Emotional Layering:

An Art Therapy Intervention with Children and Adolescents in an Inpatient Setting

Introduction

A locked psychiatric unit can look very different in different settings. The locked, short-term, psychiatric unit at my internship, called Unit 1, was a completely locked-door unit. Upon admission, clients had no way off of the unit except with staff or family members, if insurance permitted. Unit 1 was one of the highest levels of psychiatric care, a crisis unit, for children and adolescents immediately following an emergency room visit after a suicide attempt/ self-harming, a rapid decline in cognitive/psychical function, and/or their first psychotic episode. When a child or adolescent arrived on the unit, they were assigned a social worker and psychiatrist as their core treatment team. The goal was to supply them with enough psychoeducation about what brought them in and coping skills for them to either go home or to another, less restricted unit.

Emotion identification, the practice of verbalizing and naming specific emotions (Bukley & Saarni, 2006; Ciarrochi, Heaven, & Supavadeeprasit, 2008) was a common area children struggled with on Unit 1. I made this my primary focus of group directives during my time at my internship because of how many children I noticed who were not able to put words to how they were feeling that day when asked. Because of this being my primary focus and having the additional experience and knowledge around art therapy, social workers and psychiatrists asked me to be a part of a child's treatment team as an extra level of support. I then began meeting with a child individually during their stay on the unit. My goals for a child then became identifying emotion(s) nonverbally

with the use of art, and I slowly transitioned the child to verbalizing the emotions more comfortably.

I was fortunate enough this year to be supervised by a Board Certified Dance Movement Therapist and Art Therapist, who assisted me in creating the *Emotional Layering* directive. Because of her background working on locked units, she was a huge asset in helping to develop directives with all of the limitations of materials put in place by the site. Since a good majority of the clients on the unit had some history of self-harming and/or suicidal thoughts, and just for safety purposes, tape, scissors, any materials held with staples or hard plastic, and sometimes even colored pencils were not permitted on the unit. My supervisor was also a huge asset in developing the language for my directives. As a therapist-in-training, language development was something that was a core focus of my learning. Working on a locked unit with children and adolescents, it was important to remember how vulnerable and complex their current situation was. Language development and understanding the importance of therapeutic language was something I tried to build during my time on Unit 1.

After creating the directive, I was still very unsure of how *Emotional Layering* would be useful with practicing identifying emotions in a nonverbal way because of the limitations with materials. Choosing to further study this intervention through a thesis allowed me to expand my knowledge and language for future work with children and adolescents in a similar setting. I also used the *Emotional Layering* intervention with many different groups within the inpatient setting, so I witnessed varying results and experiences from clients. In this thesis, I attempted to further explore how two basic materials, tissue paper and glue, were used to increase nonverbal emotion identification

skills through art making and transitioned into clients safely verbalizing emotions without dysregulating.

Literature Review

This literature review will explore and attempt to answer how *Emotional Layering* as a directive in an inpatient setting would be useful in emotion identification practice for children and adolescents. It is important to get a better understanding of how emotions develop over a lifespan, specifically in the early years, and what could lead to the use of unhealthy coping skills due to the limited ability to regulate certain emotions. The areas of research have been divided into different sections in this literature review:

development of emotional intelligence and competence, emotion identification skill to emotion regulation, alexithymia, colors and emotions, and why art therapy. The research collected in this thesis supports the directive, aiding children in practicing and building on their emotional intelligence. It is also important to acknowledge the multitude of factors that influence an individual's development, such as, but not limited to, attachment, exposure to trauma in early childhood, cultural difference, and cognitive development. All of the factors that go into emotional intelligence are beyond the scope of my research therefore I will be primarily focusing on what is relevant to the directive.

Development of Emotional Intelligence and Competence

Emotional intelligence, defined by Buckley and Saarni (2006) is, "... the ability to perceive accurately, appraise, and express emotion... the ability to understand emotion and emotional knowledge; and the ability to regulate emotions to promote emotional and intellectual growth (p. 52)." The development of emotional intelligence and knowledge occurs from experiences, or "emotion-related phenomena (p. 53)." This involves how a

person responds emotionally to an event and the ways in which they attempt to manage their emotions. This all stems from being able to identify the emotions a person is experiencing. Emotional intelligence can be so-called “measured” based on how a person handles their emotions, but other measurable factors, such as cognitive, spatial and social intelligence, also integrate with emotional intelligence. Gaining a healthy emotional intelligence means having an average or typical cognitive and social development. According to Saarni (2000), having emotional intelligence then leads to, or is linked with, emotional competence; the skills a person needs to positively manage their social environment. Factors that influence the development of emotional knowledge are a person’s family, peers, social environment, media and societal norms (Buckley & Saarni, 2006).

The relationship between a child and their caregiver is one of the primary factors that influence the development of emotional competencies. Emotional competence refers to social skills to recognize and react beneficially to emotions in self or others (Saarni, 1999). The quality of attachment between a caregiver and child, or lack of one, can be a key factor in the child’s ability to develop positive relationships later in life. For example, if a child does not have a secure attachment with a caregiver due to the caregiver being inconsistent or not present when the child is in need, the child could develop maladaptive behaviors (seclusion, aggressiveness towards others, or self-harming), to self-soothe. In the future, this could cause a person to develop anxiety and/or fear related responses to emotionally challenging situations (Ciarrochi, Heaven, & Supavadeeprasit, 2008).

According to Buckley and Saarni (2006), primary contributors to emotional competence are an individual's ego, moral disposition, and developmental history. Other areas that influence emotional competence include cognitive development, temperament, past social experiences, and the beliefs and values of an individual. Buckley and Saarni named eight skills of emotional competence, listed below, categorized by expression, understanding, and regulation of emotions:

1. Awareness of one's emotional state, including the possibility that one is experiencing multiple emotions, and at even more mature levels, awareness that one might also not be consciously aware of one's feelings due to unconscious dynamics or selective inattention.
2. Skills in discerning and understanding others' emotions, based on situational and expressive cues that have some degree of consensus as to their emotional meaning.
3. Skills in using the vocabulary of emotion and expression in terms commonly available... and at more mature levels to acquire cultural scripts that link emotion with social roles.
4. Capacity for empathic and sympathetic involvement in others' emotional experiences.
5. Skill in realizing that inner emotional state need not correspond to outer expression, both in oneself and in others, and at more mature levels, the ability to understand that one's emotional-expressive behavior may impact on another and take this into account...

6. Capacity for adaptive coping with aversive or distressing emotions using self-regulatory strategies that ameliorate the intensity or temporal duration of such emotional states.
7. Awareness that the structure or nature of relationships is in part defined by both the degree of emotional immediacy or genuineness of expressive display and by the degree of reciprocity or symmetry within the relationship; e.g., mature intimacy is in part defined by mutual... sharing of emotions, whereas a parent-child relationship may have asymmetric sharing of genuine emotions.
8. Capacity for emotional self-efficacy... as feeling, overall, the way he or she wants to feel. That is, emotional self-efficacy means that one accepts one's emotional experience, whether unique and eccentric or culturally conventional... acceptance is in alignment with the individual's beliefs about what constitutes desirable emotional 'balance' ... emotional self-efficacy is integrated with one's moral sense, (p.53).

It is important to mention that the skills are listed separately for clarity, but they are actually dependent on one another. These skills are acquired by one's social interactions, whether they experience the emotions themselves or they witness them being experienced by another, throughout their development. If any of these skills are not matched in a healthy way, it could lead to someone developing maladaptive coping skills, such as isolation, aggression, and self-harming behaviors (Rolston & Lloyd-Richardson, 2019) which could bring a child or adolescent to seek help on the unit.

Emotion Identification Skill to Emotion Regulation

Emotion regulation focuses on how a person manages their emotions when engaging with others and coping with challenging circumstances (Buckley & Saarni, 2006). This knowledge not only comes from emotional intelligence and experience, but emotional identification skills, or EIS. EIS is a term used by Ciarrochi, Heaven, and Supavadeeprasit (2008) in their study. EIS essentially stands for the strategies a person uses, or could use, to regulate emotion. In their study, they hypothesized that low EIS in adolescents could lead to larger issues in adulthood if they are not addressed (i.e. poor/lack of close relationships, depression). A person, who is low in EIS, could have issues with regulating their negative emotions, which can impact building healthy relationships and living a healthy life. Building these EIS skills is what can help lead to better emotion regulation.

Healthy emotion regulation is the goal for all of the clients I see and who attend my groups. Emotion regulation is described as a person's ability to successfully manage and respond to an emotional experience, internally or externally (Rolston & Lloyd-Richardson, 2019). As stated earlier, emotion regulation is meant to be something that is done unconsciously to navigate challenging emotions someone could experience throughout the day. More likely than not, people have a typical development with no cognitive or developmental issues. When there are attachment issues in childhood and/or any sort of delays, this is when emotion identification and regulation can become a challenge if someone is not given the correct tools to help practice those skills (Buckley & Saarni, 2006; Ciarrochi, Heaven, & Supavadeeprasit, 2008). Without practicing regulating emotions in a healthy way, maladaptive and unsafe behaviors could be used to help someone deal with their emotions.

Self-harming or self-injurious behavior is something that many children and adolescents use as a form of coping with their emotions. There are many other explanations for why children and adolescents use self-harming as a coping tool, but I will only be focused on emotional responses. Self-harming behaviors can include, but are not limited to, injuring oneself by mutilation (cutting, burning, scratching, pinching), alcohol or substance abuse, physical and verbal aggression towards others, and withdrawal from situations (isolation, not attending mandatory events because the event itself causes anxiety/ stress, lack of involvement towards life) (Perez, Venta, & Garnaat, 2012; Rolston & Lloyd-Richardson, 2019). It is important to recognize as clinicians that clients who utilize self-injurious behaviors are not always suicidal. Perez, Venta, and Garnaat (2012) called this nonsuicidal self-injury, or NSSI. NSSI as they defined it, is, “the deliberate destruction of body tissue without conscious suicidal intent but resulting in injury severe enough for tissue damage to occur (p. 393).” In their findings, they estimated 21% of adolescents in the community self-injure and 61-68% of adolescents in an inpatient setting use self-injuring behaviors as coping mechanisms. This NSSI behavior is a way for children and adolescents to escape and/ or cope with overwhelming emotions they experience. However, for some children and adolescents if they do not receive the help they need to practice handling the emotions they experience daily, over time NSSI behavior and the overwhelming emotions, could lead to more dangerous behavior and/ or suicide.

Suicide is the second leading cause of death amongst people between the ages of 15 and 24. Over the course of a year, 41% of psychiatric inpatient adolescents disclosed experiencing suicidal ideations and 31% have attempted to take their own life in their

lifetime (Hatkevich, Penner, & Sharp, 2019). This is unacceptable. These statistics are one of the reasons I found emotion regulation to be a core area to practice within my work as an art therapist in an inpatient setting.

Alexithymia

It is important to note the difference between Alexithymia and poor emotion identification and regulation. Alexithymia came up numerous times in my research, but is something separate from poor emotion skills that happens throughout the development of someone's life.

Alexithymia was coined in 1973 by Peter Sifneos, but has now been modernized "...as a cluster of cognitive traits, which include difficulty identifying feelings, difficulty describing feelings of others, externally oriented thinking, and limited imaginative capacity... people with alexithymia may demonstrate deficiencies in emotional awareness and communication... Alexithymia is described as a deficit, an inability, or a deficiency in emotional processing... (Ricciardi, Demartini, Fotopoulou, & Edwards, 2015). It is something that is commonly seen amongst psychiatric, psychosomatic disorders, and neurological issues (i.e. traumatic brain injury, stroke, Alzheimer's, dementia, stroke), but has not yet been included into the DSM (Taylor & Bagby, 1997; Taylor & Bagby, 2004). There are assessments to see if someone could have Alexithymia, such as the Toronto Alexithymia Scale, or TAS-20, and there are methods to help assist someone with alexithymia to practice emotion skills. However, for people with severe neurological trauma, this could be rather difficult to achieve (Ricciardi, Demartini, Fotopoulou, & Edwards, 2015).

Colors and Emotions

In 2015, PIXAR Animation Studios released a movie titled *Inside Out*, which follows a young girl, Riley, and her inner emotional struggles when her family moves from the Midwest to San Francisco. Riley is guided by the emotions that live in “Headquarters,” the control center of Riley’s brain. The emotions that control how Riley responds to different stimuli in her environment are Joy, Anger, Fear, Disgust, and Sadness. Joy is the leader of the group, who attempts to keep Riley, and all of her memories, happy. During a number of experiences, Joy and the other emotions try to guide Riley as she navigates her new life (Rivera & Docter, 2015).

Most of my clients had previously seen *Inside Out* or watched it during movie nights on the unit. To my surprise, the movie became a helpful reference when working with children and adolescents and matching emotions to colors. In the movie, the characters each had their own color scheme and affect, recognizable within their different complexions, expressions, and clothing. Joy was always cheerful and her main goal was to make Riley happy. She had a glowing aura around her that none of the other emotions had, she was always smiling, and her complexion was yellow. Sadness tried to be positive, but sometimes felt the need to just lie down and cry. She wore a white, comfy sweater, a slight frown most of the time, and was all blue. Anger had such a fiery spirit, that when he became too angry, the top of his head would explode with fire and he would be taken over by rage. Anger wore a white button-up, tie, and slacks, with his always furrowed brows, and red complexion. Disgust had very high standards and was very opinionated. Whether it was about clothes, other people, or vegetables, she had something to say. Disgust was well kept with her hair neatly in place, always seemed to have her nose in the air, and was all green. Finally, Fear kept a lookout for every

possible disaster that could come their way. He was slightly neurotic, wore a bowtie, houndstooth-patterned sweater vest, a worried expression, and his complexion was purple. Even if the creators of *Inside Out* did not consciously intend to connect these characters (emotions), with specific colors, it was something that my clients remembered.

In the English language, there are many sayings that use a group of words but the words being used, do not match their true definition, also called idioms. “Raining cats and dogs” is an example of an idiom, which means there is a lot of rain. There are many idioms that connect colors to meanings as well. “Black and white thinking” means straightforward or direct thinking, “seeing red” means very angry, “feeling blue” means someone is sad or upset, and “green with envy” means someone is jealous (Pasechnik, & Savelieva, 2019). Using these colors does not mean those colors are being seen, but it establishes an emotion matching with a color (p. 719).

The “color glossary” is a term I coined for the directive, which is the collection of emotions the group named, paired with eleven basic colors, to create our nonverbal understanding of the emotions within the art that was individually created. Refer to the method section in this thesis for examples from clients who participated in the *Emotional Layering* directive, and matched colors with certain emotions or feelings. The “color glossary” will be further explained in the methods section. It is important to note that my method was based off of the English language and culture. Many other cultures do not connect the same colors to emotions, as I have done in the “color glossary.” For example, when I would create the “color glossary” with the clients on the unit, they labeled envy as green. In one article comparing multiple studies that asked people of different cultures what colors they related to certain emotions (Fugate & Franco, 2019),

envy was placed with black, yellow, and purple by Russian participants, yellow by German participants, and black and purple by Mexican participants (p. 4). These results were in one of the studies that were being compared in the article. Other studies showed consistency with some colors and different cultures. The overall results showed some consistency with two colors and a specific emotion; green consistently matched with envy, and red was consistently matched with anger (p. 14). In conclusion, to this idea of matching colors with emotions in the directive, it is to be understood that not all the clients will match with the colors or emotions listed. This will be further discussed within the methods as well in the discussion section.

Why Art Therapy

Many art therapists have reported working with children and adolescents to be one of the most challenging, yet rewarding, populations (Riley, 2001; Miller, 2012; Moon, 2016). During this part of development, children and adolescents experience many feelings of uncertainty, wanting to belong, and emotional, physical, and social changes (Miller, 2012). With all of these challenging factors that are part of normal development, experiencing some form of trauma, mental health issues, and/ or family/ support system changes, can have a significant impact on a child's later development. Art therapy can be used as a nonverbal communication tool, that is nonthreatening, where the child or adolescent is the one who controls what or how much they are ready to communicate through creating (Riley, 2001). With an inpatient setting, that was exactly what clients needed to feel.

As a whole, art therapy offers a number of benefits. Art therapy not only avoids the pressure of goal-oriented therapies (Liebmann, 2008), like Cognitive Behavioral

therapy, but is flexible and allows for clients to reflect back on their process during a challenging time, and see how they moved through it using art. In Marian Liebmann's book, *Art Therapy and Anger* (2008), she listed what art therapy offers to clients. Liebmann also reviewed findings of research other books and articles had mentioned such as art therapy is a non-threatening way to communicate, exposes clients to past experiences and/ or emotions, and, in the group setting, allows a client to see commonalities between peers, which helps reduce isolation (Riley, 2001; Liebmann, 2008; Moon, 2016). She primarily focused on anger management, but her information is relevant amongst other emotions and feelings. One unique point Liebmann made mentioned the use of art therapy as a way for a client to "slow down" and reflect on the process. She also mentioned neurological research showed that art therapy links different parts of the brain, such as communication, creative process and language, with long term-memory, which aids in cognitive learning. Another important point mentioned by Liebmann is how art therapy provides a vessel (the art created) to hold many thoughts and feelings, sometimes contradictory, in one single image. It can assist in the process of understanding complex emotions (p. 14).

According to Shirley Riley (2001), art and images connect with a person's earliest understanding of the world and how to react to it. Collaging using magazines with adolescents was a way to avoid the perfectionistic qualities that can come from clients when thinking about "creating an image." Riley called this "nonartistic art," because the client would be creating an image about their internal struggle, using someone else's words. Collage is a way for art therapists to get a better understanding of a client's thinking and/ or presenting issues while building a client's confidence within art making

by completing and image. Miller (2012) believed collage was a nonthreatening way of communicating using symbols and avoided the critical thinking that usually would come from drawing (p.251). Miller even brought up a similar directive to *Emotional Layering*, that she had done with her adolescent clients. Using tissue paper and Mod Podge, clients arranged and overlapped colors to represent an emotion they chose. It was a way for a client to experience and verbalize a concern or emotion they were feeling in the moment, in a nonthreatening way (p. 252).

It was so important to understand the inner workings of emotions, especially when clinically supporting children and adolescents in crisis on an inpatient unit. Many of the clients I saw on the unit were brought in because of maladaptive behaviors that had become so severe the behaviors were life threatening and/or affecting their typical function in society. Self-harming behaviors of cutting and scratching, substance abuse, physical and/ or verbal aggression towards others, and isolation, are all common behaviors that are associated with poor emotion regulation and/ or emotion identification skills (Saarni, 1999; Buckley & Saarni, 2006; Rolston & Lloyd-Richardson, 2019). The astonishing numbers of 61-68% of inpatient adolescents who use self-injuring behaviors (Perez, Venta, & Garnaat, 2012), the 41% of inpatient adolescents who thought about suicide within a year, and the 31% who had attempted to take their own life at some point in their short lives (Hatkevich, Penner, & Sharp, 2019), formed the foundation for why I attempted to bring emotional awareness and skills to the children and adolescents on my inpatient unit with the use of art therapy. Art therapy is a nonthreatening form of therapy, using nonverbal communication, and gives the clients the control of what they are ready to share (Riley, 2001; Liebmann, 2008; Moon, 2016). The *Emotional Layering* directive

attempted to educate the children and adolescents on the unit how they could safely navigate and share the emotions they were experiencing. A group setting, which was where the directive was typically held, allowed the clients to further practice recognizing emotions of others as well (Liebmann, 2008) which was an important aspect of learning emotions, supported by Buckley and Saarni (2006) and their eight areas of emotional competence (p. 53). This literature review as a whole supports the important goals of an *Emotional Layering* directive in an inpatient setting.

Method

The focus of this section is to give details and personal knowledge of the directive I created, *Emotional Layering*. I will describe the entire layout of the group and reasoning behind why certain aspects were useful. This section is divided into the following subsections: creating the “color glossary,” the art, and closing. Reiterating this directive within the thesis will also assist in my finding around why tissue paper and glue were so useful for this population and setting. My hope is that this detailed account of how I ran this group, with the help of academic research, can guide other art therapists to run the *Emotional Layering* directive with similar or other populations experiencing similar problems with emotion regulation and identification.

Each group session began with an introduction of each member, their pronouns, and an icebreaker involving something that was of interest to the group (favorite ice cream, favorite artist/ music genre, favorite movie, etc.). The reason I did this every group I held was because there were always new clients coming onto the unit and it was important for clients who had been a part of the group before to have some structure. The repeated framework, or structure of the group, gave clients who had participated in the

Emotional Layering directive before, a sense of control because they are aware of how the therapeutic space is held (Wiess & Bensimon, 2019).

Creating the “Color Glossary”

Once introductions were concluded, I began a discussion focused on colors and how they linked with specific emotions. The first example I gave came from the 2015 Pixar movie entitled *Inside Out* (Rivera & Docter, 2015). As previously described in the literature review, the movie followed a young girl navigating her life with the help of five emotions living in her head (Fugate & Franco, 2019). Each character/ emotion had their own color that represented them; Anger was red, Disgust was green, Joy was yellow, Fear was purple, and Sadness was blue. The discussion about this movie helped the clients visualize the relationship between color and emotion.

The group then moved onto creating our “color glossary.” The “color glossary” involved eleven basic colors that were able to be recognized in the English language: black, grey, white, brown, red, orange, yellow, green, blue, purple, and pink. I also needed to make sure I was able to give the clients those same colors mentioned as the material, tissue paper. I will further discuss modifications that were used during some of my groups, in the results section. As a group, we matched different emotions and/or feelings to the colors. There was also some discussion about emotions, specifically, I reminded the clients about the purpose of the glossary and to think about “positive” and “negative” emotions/ feelings in relation to a color. As Liebmann (2008) mentioned, I wanted the group to recognize multiple emotions that could be expressed within their art, even if they were contradictory (i.e. blue for sad or blue meant calm in the same image).

After conducting this group a number of times, I noticed many of the clients went right to the “negative” emotions such as sad, angry, depressed, and/ or hopeless, because those were the emotions they were experiencing in that moment. Because of their emotional state, it was difficult for them to comprehend “positive” emotions like excitement and love. I also reminded the group that the emotions they were experiencing were not *wrong* they just *were*. The words “positive” and “negative” combined with emotions held a lot of weight for clients in an inpatient setting. It was important as an art therapist who was using colors to nonverbally discuss emotion with clients in a group setting to acknowledge that whatever emotion a person was feeling individually, was safe to bring forward to the group.

From my observations, each group usually had the same emotion(s) linked to each color, but I found it beneficial to build the “color glossary” as a collective each time, because it built a sense of community and like-mindedness within the group. Some of the words in the glossary below that are in quotations were not essentially emotion words, but they were words the clients associated with color. For example, yellow to some of the clients meant, “slow down” because they thought of a traffic lights. The list below reflects the common emotions/ feelings connected with colors that I collected from my groups over the course of the year:

Black: grief, despair, seclusion, whole, “fancy” (black tie events)

Grey: neutral, dull, comfortable, tired

White: purity, void, emptiness, “good”

Brown: dirty, foul, natural

Red: anger, passion, love, danger, “stop”

Orange: optimistic, warning, anxious

Yellow: joy, happiness, cheerful, sick, “slow down”

Green: youthfulness, grounded, balance, jealous, envious, disgust

Blue: calm, soothing, depression, sadness

Purple: independent, creative, fear, “royal”

Pink: silly, kind, playful, sickness

Developing the “color glossary” was a key part to this intervention because it provided the guidelines for the nonverbal communication that was created in the art by the clients. It was also important to recognize within the group that some individuals might not have matched exactly with the emotion listed under a specific color. For example, a client might have felt the color blue was a grounding color for them instead of the color green. The important aspect to remember was the ability to match an emotion with a color. If a client “saw” an emotion in a different color that was acceptable because they were still linking the two areas. As the art therapist, the glossary supplied a basic understanding of what a client had been going through or was going through during the group, without the need to use talk therapy.

The Art

The group was then directed to reflect individually on the past day, the emotions that may have come up for them, up until the moment of the group session. Using only one piece of construction paper, many colors of tissue paper, and glue, each client layered the tissue paper to represent the emotions they had experienced. For example, if a client had been angry when they first woke up, the first layer they would do would be the color red. If they were happy after that because they had a good meeting with a clinician, they

layer yellow. If the client were then sad to be in the art group, they would layer blue on top of the other colors. Reflecting on their emotions for the day and creating art in the process, the art re-exposed the client to what they were experiencing in a safe way (Fugate & Franco, 2019).

Tissue paper was primarily chosen as the collaging material because of the limited amount of materials I could bring onto the unit that were deemed safe. There was no access to scissors or certain magazines due to the use of staples in the binding. Another I reason I chose to use collage was because of the therapeutic nature that collage brings into art making. Collaging allows for the patient/ artist to embody what they have created in a direct, hands-on art process (Chilton & Scotti, 2014). Collaging the tissue paper allowed the children on the unit to manipulate the paper that best suited how they wanted to express their emotion(s). It was also a nonthreatening form of art making. Adolescents specifically are continuously worried about creating a visually pleasing image when they hear the words, “create a piece of art.” With collage, specifically with tissue paper, there was no need for perfection and no critical review of the art (Miller, 2012).

The use of color and line to identify certain emotions was a way to create a nonverbal conversation about what the client was experiencing. Nielsen, Isobel, and Starling (2019), conducted a study based on using color and identifying emotions. The art therapist conducting the study looked for visual themes, including one of the common markers for depression, which was described as, “... bold movement in black and/or red... The images were created with intensity and intention to communicate violence and distress.” (p.167). The clients were able to nonverbally communicate the feelings they were holding and built community with peers who were working through the same crisis/

emotions, noticeable when the same colors were expressed within the art. The directive allowed the clients on the unit to practice empathy and exposed them to sharing/identifying emotions in a safe way.

Closing

Once the art was created, the group came back together and placed the artwork on the floor, in the center of the group. As a group, we then walked around the pieces so we were able to get a better view of each individual piece. Once everyone had viewed all of the works, the clients sat in chairs around the art. I then introduced the group to using the language “I am the one who...” This language I borrowed from my art therapy supervisor, who is a Board Certified Dance Movement Therapist as well as an Art Therapist, because it allowed for the clients to take ownership of what they were saying/feeling in the moment instead of projecting their feelings onto other’s works. For this directive, I did not ask the clients to discuss the process of their work, but instead to find commonalities between the works as a whole, whether it was with the use of color, movement, or process. The link of color and emotion at this point became something that does not need to be discussed, but is witnessed by the group.

Results

I created the *Emotional Layering* directive at the start of my internship, once I realized how many children and adolescent clients on the unit were struggling with verbalizing their emotions. Because my site was a short term facility with the goal of having children and adolescents discharged between seven to ten days, I was able to run this group a number of times with many different clients, battling different psychological diagnoses, alongside poor emotion identification skills. I collected a number of

observations of how clients responded to the group, as well as my own observations of how the materials benefited the clients.

Structure

After the closing of each group, I asked the clients why they thought this exercise was important/ useful for healing and good mental health. I asked such an open-ended question to see what exactly the clients took away from the experience, and to challenge them to reiterate what was discussed at the beginning of group. This discussion reminded the clients about the importance of identifying emotions, even if it was nonverbally through art making, as well as another layer of structure within the group. This repeated framework, or structure of the group, assisted clients in having a sense of control within a vulnerable setting because they were aware of how the group would be run (Wiess & Bensimon, 2019). This aspect further assisted clients in the practice of identifying emotions because they were aware that their art would be speaking for them, rather than having to verbalize to an entire group of their peers, which could seem rather intense for children and adolescents on a locked unit (Hatkevich, Penner, & Sharp, 2019).

Changes and Modifications

Art therapy has always been prided on the flexibility it provides to clients (Riley, 2001; Liebmann, 2008; Moon, 2016). At my site, I always needed to be prepared with back-up plans or modifications if there was difficulty with locating materials or clients were not actively participating in the group.

Although my unit was a short term, inpatient, crisis intervention program, with the goal of placing clients in a more suitable environment within seven to ten days of their admission, there were some clients who would be on the unit anywhere from three

weeks to five months. As a result, there were often times when I would run a group where one or multiple clients had already participated in the *Emotional Layering* directive. I would receive the classic, teenage angst response of, “Ugh... again?” Instead of opening the group with a discussion of *Inside Out* (Rivera & Docter, 2015) and colors and emotions, I would ask the group why participating in the directive more than once was useful in their healing. This challenged the clients who had been a part of group before to share the knowledge they had learned about emotion identification skills and regulation with the newcomers on the unit. Once there was a basic understanding of the directive, I would challenge those clients who had completed the directive in the past, or those open to a more thought-provoking process, to reflect on a different/ or more challenging day they had, and use that as the inspiration for their art. I recognized clients who were more involved with their treatment plans and open to the opportunity for growth. It was a safe way to explore and identify larger emotions (i.e. depression, fear, loneliness, even suicidal thoughts or self-harming behaviors) they had experienced, while still having control over what was “told” to the group. I was lucky enough to have some of the group participants share the story they created in their collage with me in private settings. They voiced that the extra challenge within the group, allowed them to access a difficult experience, and process safely how that experience affected them.

I never had much difficulty with acquiring materials, specifically for the *Emotional Layering* directive, because it was just tissue paper, which is very inexpensive, and glue. Some days, however, I would experience a low supply in specific colors, such as black, blue, and/ or red. Those were the three colors that I noticed clients would constantly use in their art making. Because of this, I needed to make some modifications

to the process. I would not remove those colors from the “color glossary,” however, I would use construction paper as a collage material, in addition to tissue paper. Because the construction paper was not transparent like the tissue paper, it added a different element to the art making process. After the beginning discussion and before moving into art making, I would inform the group of the added material of construction paper due to the shortage of all the colors needed with the tissue paper. I would ask them what the difference between tissue paper and construction paper was and how it could alter the representation of their emotions in their art. Many of the clients recognized that the construction paper would be able to “conceal” or “cover up” the emotions held on the paper. It was an added “layer” that could hide the deeper emotions clients could have been experiencing. Once the group created the art and we came back together for the ending discussion, I would ask clients if they had used construction paper, if they used it to conceal an emotion they were not ready to process yet. This gave clients the practice within a group setting to feel vulnerable, without fully sharing the emotion they had concealed (Liebmann, 2008).

Discussion

Developing the *Emotional Layering* directive and fine-tuning it over the course of my internship greatly assisted in my education, language development, and understanding of the importance of expressing and understanding emotions. Within my research, I found emotional competency skills (Buckley & Saarni, 2006), emotion regulation (Ciarrochi, Heaven, & Supavadeeprasit, 2008; Rolston & Lloyd-Richardson, 2019), and the use of color to communicate nonverbally (Liebmann, 2008; Miller, 2012; Moon, 2016; Fugate & Franco, 2019), were important aspects that were research that supported

the directive. During normal development, children and adolescents are exposed to a number of changes, both internally and externally. When trauma, family system changes, and/ or mental health issues are mixed in with developmental factors, healthy development of emotion skills can suffer (Liebmann, 2008). When clients in crisis are brought to an inpatient setting and given skills and groups to be a part of, it is quite remarkable to see first-hand how clients use all of those tools to better themselves and their health. Working with young people, specifically adolescents, can be a daunting task for some, and I found this quote used in Miller's chapter, (2012) which she quoted from Satir (1988), useful in better understanding where they are at, as well as being aware as an adult that we might not be so sure either:

“Adolescents are not monsters. They are just people trying to learn how to make it among the adults in the world, who are probably not so sure themselves.”
-Satir (1988, pp. 315-316)

Final Thoughts on Materials and Art

Although tissue paper and glue seemed like they would not supply much of a therapeutic benefit for clients, the two materials became exactly what my clients needed to better understand their emotions. Without scissors, clients were able to rip and shape the tissue paper while embodying the emotions they were experiencing earlier in the day and throughout the directive (Miller, 2012). I was able to witness clients exposing themselves to certain emotions through the use of ripping and gluing paper in a safe setting. The semi-transparency of the tissue paper allowed the clients to understand and illustrate that emotions are always changing. Many of the clients on the unit experienced hopelessness and felt that nothing could change. During the discussion part of the group,

I was able to ask clients as a whole why this directive was useful. Tasking them with reflecting on the day and how their emotions changed supplied them with a small amount of hope that the severe emotions they were experiencing could be changed.

When considering how emotions can be addressed in other expressive therapies, the one area I continuously considered was the value of having tangible objects to reflect upon. With art therapy and the *Emotional Layering* directive, every client was able to look back and reflect on the emotions they were experiencing and the experience of sharing those emotions on one piece of paper. I am not insinuating that other expressive therapies are lacking or not as effective, however for clients in such a critical place in their lives, tangible objects tied with positive, therapeutic practice, can be extremely useful.

Fluidity of the “Color Glossary”

In my opinion, the “color glossary” was a huge, if not the core, part of the directive. Without the “color glossary,” there would be no common language amongst clients. The “color glossary” was a scaffolding of common knowledge and language relating color to specific emotions. It was also something that was not concrete. Because we created the glossary at the start of each group, it brought clients into the present, shared, group space. The “color glossary” also endorsed anonymity within the art, which allowed clients to not feel completely vulnerable sharing emotions, as well as provided a nonverbal understanding of what peers were experiencing in the group (Miller, 2012; Moon, 2016; Fugate & Franco, 2019). This assisted in building a sense of community within the inpatient setting. Some of the therapeutic qualities that were achieved in art-based group settings, according to Bruce Moon (2016) were, “Making art in a group

setting creates a sense of ritual that provides psychological safety and promotes interpersonal emotional risk-taking... Making art in the presence of others reduces isolation and creates a sense of community... When members of a group make art they create shared experience in the present... Making art in a group setting promotes positive regard for other members of the group” (p.8-9). I believe creating the “color glossary” together at the start of group, then making art in the group setting, and sharing individual pieces together, met most, if not all of the qualities Moon mentioned.

Limitations

Due to the rules and regulations of this inpatient unit, I was not able to do any first-hand recordings of clients discussing their works, or the art they created. It would have been even more helpful in my research to have full first-hand accounts from clients.

Each time I ran this directive, it was with groups of about fifteen to twenty children and adolescents. Not only was that a larger group for art making but it required me to be primarily focused on holding the space and supporting clients as the group leader. As a result, I was never able to make art with clients during the group. This could have enriched the experience more because it would have built on the therapeutic relationship. Making art with the group would have also removed the hierarchal aspect of group leader and group members (Moon, 2016).

This directive was not originally created as a study, but rather to educate clients on emotion identification and regulation skills. There was no option to make this into a research study because of the inpatient unit I was working on. I also have not applied this to other populations and do not know how this directive would affect adults or older adults. It would be important to recognize, if an adult or older adult was doing this

directive, and to be even more sensitive to underlying trauma and a deep-rooted, underdeveloped understanding of how to express emotions. I would recommend breaking this group in half; focusing on the “color glossary” and developing the identification with color first, then moving into the art making, layering of emotions, and discussion in another session. I believe splitting the group into two sessions would help in not overwhelming clients with too much psychoeducation and allow for a slow process and adjustment into sharing emotions.

Conclusion

We, as human beings, develop the ability to regulate our emotions through learned experiences from family, peers, social environment, media and societal and cultural norms (Buckley & Saarni, 2006). Other factors include moral disposition and biological development (Saarni, 2000). We first develop our emotional intelligence, the ability to correctly understand and express emotion; then emotional competence, how to positively identify emotions in social settings; then emotion regulation, the ability to manage emotions correctly when engaging with others and coping with challenging circumstances, using EIS, emotion identification skills (Buckley & Saarni, 2006; Ciarrochi, Heaven, and Supavadeeprasit, 2008). Emotion regulation is usually managed unconsciously, without the mind feeling overwhelmed. If someone does not experience typical development, had poor attachment to a caregiver, and/ or experiences a trauma, it could lead to difficulty expressing emotion, or maladaptive coping skills (Perez, Venta, & Garnaat, 2012; Rolston & Lloyd-Richardson, 2019). Prior to my internship, I had not been exposed to many children or adolescents who had developed such poor coping skills

to handle the emotions they were experiencing. I wanted to be sure I could assist them in their recovery and restart their emotion skills.

I never thought art therapy, or the directive I created could become as useful as it was. The few occurrences I had of clients who shared their personal experience of the *Emotional Layering* directive and verbalized the emotions they put into their art, are the little victories I will hold with me to continue my work practicing emotion identification through art therapy. Similar to the directive Miller (2012) mentioned in her writing, I was able to witness how collaging tissue paper was useful in self-expression. The simplicity of the materials, matched with the challenge of identifying emotions was all my clients needed to metaphorically “dip their toes” into the emotion identification pool. The final art piece provided a tangible object allowing clients to reflect on their emotions and experiences (Liebmann, 2012). With the research that supported the use of the *Emotional Layering* directive, the inspirations of an animated movie (Rivera & Docter, 2015), and the support of my supervisor, I have the passion to continue developing my goal of increasing emotion identification skills through art making and assisting clients in safely verbalizing emotions. At the end of the movie *Inside Out* (2015), the characters realized feeling sad was better than feeling nothing at all. To feel emotions can be overwhelming, but practicing how to handle and process them, is a part of being human.

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THESIS APPROVAL FORM

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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.

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