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What Elements of Dramatherapy and Dance Movement Therapy Lend Themselves Particularly Well to Treating Social Anxiety Disorder?

BY SOPHIE HOLMES
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CONTENTS

<u>ABSTRACT</u>

This dissertation focuses on the use of Dramatherapy (DT) and Dance Movement Therapy (DMT) for treating Social Anxiety Disorder (SAD). During the dissertation, these forms of therapy are broken down into different techniques that are employed within both therapies, and if/how they are beneficial as a way of treatment for the proposed disorder. From reading numerous books, journals, and articles the insight into how different therapists use these techniques for their particular sessions is either directly transferable or has many outcomes that could be associated with SAD. This has been achievable by researching multiple Case studies and understanding the core of each process that is discussed. Using these forms of therapy, as a treatment for Anxiety, does not have as much evidence for its success in comparison with Cognitive Behavioural Therapy (CBT); however, this does not suggest it is not a positive method in treatment. Multiple studies discussed within this dissertation suggest that the use of DT and DMT, employ similar techniques that CBT uses, sometimes to a greater extent, and therefore it has been important to recognise where the different therapies push the techniques further and to what conclusion.

<u>LITERATURE REVIEW</u>

The literature I am reviewing within this work varies from research on specific aspects of the therapies that I find correlate with the other, to Case studies where these types of therapy have been used. It also is looking at work I have found correlates to my ideas and therefore works as evidence in supporting my hypothesis. I began my research into Dramatherapy (DT) and Dance Movement Therapy (DMT) by at a basic level beginning to understand the key processes each therapy uses. This ultimately started with *An Introduction to Dramatherapy* by Dorothy Langley, 2006. Langley describes the way in which a DT class is laid out; this includes different examples of warm-ups and practices that can be used, or have been used, dependent on the group or individual's needs. Exemplifying the possible structures has meant that I am able to understand how to use each idea and compare them

with either similar or dissimilar methods used within DMT. From Langley's' book, I found it necessary to follow up on the work of Sue Jennings as her work was very prominent within *An Introduction to Dramatherapy.*

Within the edited collection of *Dramatherapy – Theory and Practice 1,* Whitelock's essay mentions the Case study of Eileen who suffers from Anxiety attacks. Eileen took part in "Social skills group" that included work on assertion, and a drama group, "where her delicate quality of movement evoked favourable comments, as well as the intensive group" (Whitelock, 1994, p.209-232). The comment about her quality of movement created a keen interest for me to start looking into DMT more intently; however, I felt I needed to know more about DT before I could begin to create any sort of justifiable comparisons. I moved my research from here to looking at the works of Black, e*t al* 1997 *Psychological Trauma: A developmental approach,* and from here I then found the nine core processes of DT that are discussed by Jones (1996).

I have also been using the book *Drama as Therapy, Theatre as Living*, also written by Phil Jones. When he discusses the use of DT, he says that:

It uses potential of drama to reflect and transform life experiences to enable clients to express and work through problems they are encountering or to maintain a client's well-being and health. (Jones, 1996, p.7)

I moved from there to looking at Case studies, as they were fundamental to my research. These Case studies were proving that DT and or DMT have had consistently good results when they have been applied. Steve Mitchell's *Dramatherapy; Clinical Studies* is the first of a series of Case studies I have been looking into. Mitchell's edited collection *Dramatherapy: Clinical Studies* (1996) provides thirteen Case studies only one of which is directly relevant to my hypothesis. Although the patient of the Case study was not directly labelled as a person with Anxiety disorder, their behaviour presented with the research I have already done has suggested that this patient can have some suitability to my hypothesis. The next Case I then read, was a study published by *European Psychiatry* and entitled "The effectiveness of Drama Therapy on decreasing of the symptoms of Social Anxiety Disorder in children". This experiment documented by Anahi, Ddadsetan, & Sedghpour, stated that the "emerged findings can have clinical

application in prevention and treatment of Social Anxiety Disorder in children" (2009, p.1). After researching and learning of this experiment I was intrigued to see if DT would be as effective treating elderly people as it was children, as it gave my research more of a scope to work within. Johnson conducted his study within the setting of a Nursing home. Residents were anxious when discussing topics such as illness and death, however, when Johnson (1982, p.186) "paradoxically cut off emerging discussions about loss or death" residents began to emerge their pain indirectly through comical skits and/or jokes:

> Once the group was experienced as safe and I was not seen as aligned with their need for control, they did not hesitate to utilise the opportunity provided by the drama therapy group to express their feelings and seek consolation from others (Johnson, 1982, p.186).

 My research has led me to understand a great deal about DT and those with ideas that are imperative in helping it become a more prominent use of therapy:

> Because drama is an active and interactive art medium, in which awareness of all five senses is heightened, it has the effect of altering, if only temporarily, the depressive state in which clients typically enter the room. Over a period of time, with the gradual development of trust and group cohesiveness and the establishment of a safe, non-threatening, playful environment, clients in drama therapy begin to approach the difficult and crucial task of initiating contact and forming relationships. (Emunah, 1983 p.78)

Another source I have read *Process in the Arts Therapies* (Ann Cattanach) has been more engaging in terms of fulfilling my understanding of DT and DMT. The book gave interesting knowledge on DMT such as the first training course for DMT being established in 1985 to explaining the use of Play Therapy. The book also discussed DT and the ritual process and the theatre of self-expression. I have read A *Brief Literature review about relaxation therapy and Anxiety* (Pagnini, *et al*, 2013, pp.71-81) which has been useful in terms of offering me further associations to research based on Social Anxiety Disorder. Not only this, but the article discusses the "efficacy of relaxation-based interventions" (2013, p.72) which listed things such as yoga and movement in terms of treatment for Anxiety. Yoga and physical movement can often be found in DT and DMT. As this article put special emphasis on the necessity for relaxation, I found the next important thing for me to do would be to research ways in which the DT sessions and DMT utilise relaxation within their

sessions and adapt different techniques for relaxation to be a goal.

Websites that have broadened my research are those such as; Sanford's (2017) article on the "Yourstagedrama.com" which suggests DT is a method of treatment for Anxiety and depression, and the article I found online by Keith Whipple entitled Your Brain on Improv: Reach Optimal State with Seven Aspects of Spontaneity (2015) which discusses the use of Improvisation for Anxiety. Whipple states that when he was working with an adult female struggling with Anxiety she felt "more free playing a role" (Whipple, 2015). They also had an emphasis on playing games in which for these women, "the game replaced being critically self-conscious" and "released her from a self-imposed pressure". This was valuable to my research because of not only its findings about a method within drama being a treatment for Anxiety, but it mentioned the importance of Play, which is fundamental to a DT class.

My research has also required me to understand the traits and signs of someone suffering with Social Anxiety Disorder and the suggested ways of treatment. Beginning with Rachman's third edition of Anxiety, I have been able to understand the difference between having a social phobia and avoidant personality disorder to being someone who suffers with SAD. It was from my research in this area that I have been able to read up on CBT. I have read up on Social Anxiety disorder from a variety of books, articles, and websites. Another article that has helped to inform my research has been Social Anxiety Disorder (Stein & Stein, 2008) this article included a lot of interesting and important discussions which have aided my thesis.

I have also looked at the Case study "Effectiveness of complementary and self-help treatments for Anxiety disorders" (Jorm, *et al*, 2004) which has provided the interesting conception that other than Cognitive Behavioural Therapy (CBT), Exercise and other treatments such as relaxation training and Bibliotherapy have shown to have the best evidence of effectiveness. As I had read up on DT with both individuals and groups, I was intrigued to see if DMT was as flexible. I sourced the journal article entitled "The dance/movement therapy group in a psychiatric outpatient clinic: explorations in body image and interaction" which was very insightful. This article not only discusses why DMT is beneficial to be offered in a group, it also offers explanation to the connection of Neurobiology as well as DMT. It

was insightful in discussing the layout of the DMT group session that took place and more specifically how it was used as a treatment for patients suffering with Anxiety.

As I started to look more at DMT, I found that Payne *Creative Movement and Dance in Groupwork* (2003) would be a key piece of reading for my research. This mentioned many other works that benefitted as research to me. This research included works such as Laban's systematic categorisation of movement. Furthermore, there have been Case studies mentioned within this book which included that of Lesté and Rust, (1984) who have studied the effects of modern dance on Anxiety and Doyne, *et al* (1987) who "has demonstrated that this action of physical doing helps to release tension and depression" (Payne, 2003, p.3) Because of this statement and the many Case studies suggesting that physical movement releases tension and depression, I was keen to understand the benefits of using DMT and this has led me to Ritter & Low, (1996). 'Effects of Dance/Movement Therapy: A META-ANALYSIS' which looked at a collection of studies "evaluating the use of DMT on children, non-disordered participants, adult psychiatric patients, handicapped individuals, the elderly and patients with neuropsychological deficits" (1996, p.250). Similar to this research, I have also read up on a similar study named 'Effects of dance movement therapy and dance on health-related psychological outcomes: A meta-analysis'. (Koch, *et al*, 2014). Looking at meta-analyses is important for my dissertation as it gives me a better understanding of many previous studies and a broader scope of factual research.

I have also investigated the book *Dance Movement Therapy: A Healing art* (Levy, 1988). This book gives the names of American pioneers of Dance Therapy and therefore it has been fundamental to my research, as I am basing it around western culture and societies. These names included: Marian Chace, Blanche Evan, Liljan Espenak, Mary Whitehouse, Trudi Schoop and Alma Hawkins. I specifically looked into Trudi Schoop early on in my research as she combined dance, drama, and mime as she worked in a psychiatric hospital, so I believed she was vital to my research. She had many interesting theories one of which is stated:

> Schoop believes that who we are is reflected and manifested in our bodies. In addition, what happens in our mind has a concomitant reaction in the body and what happens in the body has a concomitant reaction in the mind (Levy, 1988, p.75).

She believes that our mental and physical states are aligned as if we wear our mental state and thus movement therapy is ideal as a form of healing. This book covers the differences and similarities of these pioneers which has benefitted my knowledge toward my final thesis.

I have also found the article entitled 'Effectiveness of complementary and self-help treatments for Anxiety disorders' (Jorm, *et al,* 2004) to really aid my research. Within this article they discuss many different Case studies of varied self-help techniques; however, they have a large section dedicated to the use of DMT. Within this section they discuss 4 Case studies where they have implemented DMT to reduce Anxiety and then have also documented five examples of case reports from Japan; however it is looking at a form of DMT called Dosa, which is not within my area of research. This article has given me significant amounts of Case studies beneficial to my research and the article not only gives evidence on the uses of DMT but also discusses the effectiveness of herbal remedies to the simple method of humour or nicotine reduction. From this article I was able to search the bibliography to find more relative research.

From what I have studied thus far, I am keen to begin the comparison of techniques that both styles of therapy I am studying use. I have found so far that both the areas put a special emphasis on the warm-up which is designed for the group, and I expected to find examples where if not the same "game" is used, the same outcome is intended and or achieved, which is discussed within the warm-up analysis. The research has also led me to the method of Play that both styles of therapy have demonstrated using, and the same with Improvisation. I aim to create sections of my work solely to the different components that create the therapy sessions and within each component discuss and evaluate each way the two separate therapies use them and manipulate them to work with their specific client. I aim to gain enough examples that I can base a conclusion from my findings of which is the most beneficial to the clients and how they differ as approaches in the medical world. From my evidence so far, there are multiple studies, which suggest maybe these forms of therapy, are the most appropriate for treating Anxiety and these are the findings I shall be using within my research. I hope to find more research that can aid

my findings but now I am going to be breaking up my research and looking into the separate components I mentioned earlier to begin writing my thesis.

Introduction

I am proposing to look at how both Dramatherapy (DT) and Dance Movement Therapy (DMT) can be beneficial to a person with Social Anxiety Disorder (SAD). I began this research by initially wanting to see how these therapies contrasted with each other and found that there were more similar techniques within the therapies than imagined. From finding this, I wanted to look further into the different methods within each of these therapies and understand why they could be labelled as different when the ideas and outcomes were so similar. I intended to also comment on the strengths and weaknesses of these therapies to be able to compare them with the current most prescribed forms of treatment.

Originally, I had decided to focus on specifically two types of Anxiety disorder, Generalized Anxiety Disorder (GAD) and Social Anxiety Disorder (SAD). After much consideration however I have decided to focus on just one area of Anxiety. Both GAD and SAD have an extensive wealth of research behind them; however, I personally think that the effects of treating SAD with DT and DMT will provide more interesting results. I believe this to be the case, as SAD could be comparable with stage fright when analysing the thought patterns and bodily responses, i.e. sweaty palms, fear of public speaking, nervousness etc. I shall provide an analysis of this further in the thesis. I investigated the hypothesis that DT and DMT were the most appropriate forms of treatment for SAD due to their multitude of techniques and format of sessions. To begin, I decided to research the current main treatments for SAD which I found on the NHS website (nhs.uk, 2017). This source stated that the treatments were CBT, Mindfulness training and Medication. After researching these current forms of therapy, I was able to begin to draw relevant comparisons, differences, and ideas about my hypothesis. I aimed to come to a conclusion from the evidence of my research, what would be the best form of treatment for SAD. I was interested to understand how this Anxiety could manifest in a person, whether the disorder was pre-disposed genetically or habitual and how this was displayed

within participants that I discovered during my research. I aimed to do this by looking at a series of Case studies, and studies on neuroscience to see if this had any involvement. If the research suggested that the behaviour in participants with SAD would be severely different from each other, I aimed to then see how DT and DMT would tailor their sessions to this behaviour and how easily the sessions could be adapted. If there were a possibility that these sessions were easily interchangeable in terms of technique and process, would this improve the treatments efficacy or hinder it?

Originally, when this research first began, I focused on understanding the difference in Anxiety disorders and how DT and DMT are currently being used. Following a UK based model on different types of Anxiety, *MIND* an organisation for mental health, states that the main types of Anxiety are:

- Generalised Anxiety Disorder (GAD)
- Panic Disorder
- Obsessive-Compulsive Disorder (OCD)
- Phobias
- Post-Traumatic Stress Disorder (PTSD) (Mind.org.uk, 2015).

Throughout my research, I found that different researchers would describe SAD as a 'Social Phobia'. I found this interesting as I felt that this insinuated SAD was more of a fear, like one fears the dark rather than a mental disability. Although this may not have been the intention of the researchers, I found it interesting that some would regard it as a disorder and others a phobia:

> You're disabled under the Equality Act 2010 if you have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities (Equality Act, Gov.uk, 2011).

I chose to base my research predominantly in the UK, which meant being able to explore the use of DT and DMT within different subgroups such as religion, wealth, and age. Doing this, I hoped, would give me diverse findings and thus a more fruitful investigation. I did, however decide to look at US based model *The National Institute of Mental Health,* to see if the main types of Anxiety would be the same. I did this to see if there were similarities in the main types of mental health issues amongst

western countries, and whether this was a result of culture, or if it was down to genetics, personality or maybe something else entirely.

The findings were similar:

- Generalized Anxiety Disorder

- Obsessive-Compulsive Disorder (OCD)

- Panic Disorder

- Post-Traumatic Stress Disorder (PTSD)

- Social Phobia (or Social Anxiety Disorder) (nimh.nih.gov, 2016).

After comparing these findings, I had chosen to specifically use GAD and SAD however as mentioned above, after revising, decided SAD would be more interesting for me as a researcher. I also felt I could relate to my findings, as a performer I understood the anxiousness of being watched and if this was even slightly how a person with SAD felt, I wanted to learn and understand more.

During my research, I looked at a variety of resources, such as Case studies. I read up on previous research identifying the results of "Effectiveness of Dance/Movement Therapy on Reducing Test Anxiety" (Erwin-Grabner *et al.,* 1999) and "Exploring death Anxiety with older adults through developmental transformations" (Smith, 2000). Although these studies were using the forms of therapies I was interested in, the disorders were not the aim of my investigation. Therefore, the results were not directly applicable, although some themes and ideas could be taken away. This was again demonstrated with the Case study "Playing with Gladys" (Oon P, P, 2010, pp. 215-230). There were similar traits to my chosen disorder, I.E selective Mutism, fear of public speaking. However, this was not specified as a result of SAD.

I decided to focus my research on studies from the 21st century, as it was where the most relevant and consistent research was found. It is likely that this is due to SAD replacing Social Phobia in the DSM-IV (Diagnostic and statistical manual of Mental Disorders) in 1994. This has since been revised, demonstrating the rise of understanding and knowledge about SAD.

Primarily, I was concentrating on Case studies from the USA and UK, and therefore the word Dramatherapy may be represented as one word or two within quotes due to

the countries spelling it differently. Aside from this, using these two countries allowed me to combine and compare results and helped me to focus more clearly on my investigation:

> In Western societies, Anxiety disorders were more commonly reported than in non-Western societies, including countries that are currently experiencing conflict. About 10 percent of people in North America, Western Europe, Australia and New Zealand were experiencing clinical Anxiety compared to approximately eight percent in the Middle East and six percent in Asia (Perderson, *et al*, 2015).

Although I was concentrating on the effectiveness of treatment within the UK, I did want to discover if there was any cultural impact on the diagnosis of SAD as mentioned earlier. I wanted to see if location had any input and if certain cultures were displaying more cases of diagnosed Anxiety than others. Overall, I aimed to understand and gain more insight into how the techniques of Drama and Dance Therapy could benefit someone with SAD and how well they stood up to scrutiny when compared with CBT and other commonly prescribed methods of treatment.

SOCIAL ANXIETY DISORDER

In the *American Psychiatric Association Manual 5*, the most recent and widely adopted definition of Social Anxiety Disorder (SAD) is "Fearful or anxious about or avoidant of social interactions and situations that involve the possibility of being scrutinised" (APA, 2013, p.190). Many now recognise this as an individual disorder, however previously, it did not have definition as its own recognisable disorder:

> Social phobia first was recognized as a separate diagnostic entity in the DSM system with the advent of DSM-III (APA, 1980). DSM-II (APA, 1968), for example, did not even specifically mention social phobias under the Phobic Neurosis category; nor was APD specifically detailed in that DSM version. In DSM-III, however, there were two fairly simple sets of criteria for social phobia, and an exclusionary category. Both fear and a desire to avoid were required in the first set of criteria (DiBartolo and Hoffman, 2014, p.9).

Although it has taken time in gaining its own individual status, SAD has always been prevalent. It has taken many forms, and manifests differently in previous research. For example, shyness could be a direct result of SAD, as could selective mutism, stage fright, performance, date Anxiety etc. As the definition of SAD has always

been evolving, research preceding 2013 may discuss SAD as a phobia or even without using the diagnosis at all.

For the purpose of this research paper, it is important that the reader has some knowledge about SAD as it is fundamental to this paper. There is significant research on Anxiety and the different traits that define it. According to *Independent News:*

> Rates of depression and Anxiety among teenagers have increased by 70 per cent in the past 25 years. The number of children and young people turning up in A&E with a psychiatric condition has more than doubled since 2009 and, in the past three years, hospital admissions for teenagers with eating disorders have also almost doubled (Bedell, 2016).

This has also been confirmed by Nuffield Health who says "The experience of teenagers has changed considerably over the last 30-40 years, including a significant increase in the rate of Anxiety, depression and behaviour problems according to new research from the Nuffield Foundation" (Nuffield Foundation, 2012). With this recognized, it is then treatment that should be considered. Of course, every patient will require different treatment; someone might prefer to have medication as they find CBT too difficult, or not fast acting enough. Therefore, it is necessary to look at what are the common treatments and how they could compare with DT and DMT. This paper aims to consider alternative forms of treatment/therapies and the possibility that these treatments could be better. Within *The Wiley Blackwell Handbook of Social Anxiety Disorder*, Weeks (2014) mentions the Cognitive Model of SAD put together by Clark and Wells (1995). Within this model they noted four stages describing the effects of SAD and the reasons why exposure to the fear itself would not be enough to remedy this disorder:

> The first process begins when people with SAD enter a feared situation and judge that they may be in danger of being negatively evaluated. They then turn their attention inward and use interoceptive information as the main source of feedback about their performance […]

> The second dysfunctional process relates to behaviours that socially anxious individuals engage in to prevent negative evaluation by others. Clark and Wells (1995) refer to these behaviours as *safety behaviours* […]

> The third dysfunctional process described by Clark and Wells (1995) is that individuals with SAD often overestimate how negatively others evaluate their

> performance and predict the consequences of social failures to be far worse than is realistic […]
>
> The final dysfunctional process delineated by Clark and Wells (1995) occurs either before or after a social situation is encountered. Prior to engaging in a social event, many individuals with SAD frequently experience a period of anticipatory Anxiety in which previous negative experiences are recalled, and expectations of failure and images of the self performing poorly are evoked (Wong, Gordon and Heimberg, 2014 p.4).

Therefore, exposure would not be enough to cure this disorder as it would seem that the stages go on prior and post the 'traumatic events' that a person with SAD will be evaluating.

Boden *et al* (2012) wanted to test the hypothesis that if they worked on changing maladaptive thoughts about themselves, they would change the outcome of cognitive behavioural therapy for SAD. "Changing maladaptive cognitions is a primary focus of the best researched and most widely supported psychotherapeutic treatment for SAD, cognitive-behavioral therapy" (2012, pp.287-291). They concluded that:

> Our findings are consistent with the proposition that maladaptive interpersonal beliefs play a causal role in SAD and that CBT therapy can change these beliefs. However, we were not able to provide a direct causal test because we did not include sufficient numbers of repeated assessments to demonstrate temporal precedence (Boden *et al,* 2012 p.290).

Relating this to Clark and Wells, we can see that from the stages, it is a significant amount of Maladaptive thought and therefore changing the way the patient thinks about themselves will aid their treatment. It is clear that this would need to be a focus within a DT and DMT session. Another model looking at SAD is Rapee and Heimberg 1997. "According to the model, one reason this mental representation of the self as seen by the audience is distorted is that individuals with SAD have a bias toward attending to external cues in the social environment that signal threat or negative evaluation" (Wong, Gordon, and Heimberg, 2014 p.6).

> Rapee and Heimberg (1997) also hypothesized that individuals with SAD also preferentially allocate attentional resources to monitoring and adjusting the mental representation of the self as perceived by the audience. This is in addition to the attentional resources needed to engage in the social task at hand. Consequently, social performance suffers as attentional resources are taxed, and the poor performance only serves to confirm negative mental

representations of the self (e.g., that one is socially unskilled, awkward, etc.) (Wong, Gordon and Heimberg, 2014 p.6).

It is clear that there are different models to understanding SAD and it is dependent on how you view the disorder to how you would tailor the treatment.

"For the other cognitive-behavioral models, cognitive biases and negative core beliefs are a central driver of the maintaining processes of social Anxiety, whereas for interpersonal models, interpersonal functioning fulfils this role" (Wong, Gordon and Heimberg, 2014, p.16).

Another fundamental part of SAD is safety seeking behaviour. Many researches have addressed this. Salkovskis, P.M mentioned "By preventing disconfirmation of threat-related cognitions, safety seeking behaviour may be a crucial factor in the maintenance of Anxiety disorders"(1991, p.6). Salkovskis described safety behaviours as: Safety behaviours are defined as overt or covert acts intended to manage or avert a perceived threat and increase the person's sense of safety." This suggests that perhaps it is not just maladaptive thoughts about the self that maintains SAD but the safety behaviours. If as a Dramatherapist or Dance Movement Therapist, we were able to define to a patient where they are engaging in safety seeking behaviours and that they are not necessary, and structure our therapy sessions to working on pointing them out alongside work on maladaptive cognitions, it is possible that the structure in place for these types of therapy would be more beneficial than CBT, Medication or any other currently prescribed treatments.

Medication

Medication is one of the leading treatments prescribed for a person suffering from SAD. "The onset of benefits occurs much more rapidly with the medication treatment than the psychosocial therapy" (Rodebaugh *et al.,* 2004 p.889). Though there are several types of medication available, Selective Serotonin Reuptake Inhibitors (SSRIs) are the most popular. These are often the first type of drug tried for persistent symptoms of SAD (NHS, 2018). There has been a collection of research considering the benefits of using medication for treatment of SAD. For example, Federoff and Taylor (2001) completed a meta-analysis where their results suggested that pharmacotherapies were better than CBT treatment. In their research, SSRIs and Benzodiazepines had larger effect sizes than CBT did. A large part of the

success of medication for treatment for SAD and most mental health disorders is that medication is fast acting. Where therapy takes time and effort from the patient, medication is a simple alternative that relieves immediate symptoms and can stabilise the condition for a period of time. Although it is recognisable that medication is faster acting than other therapies, it is not always the best option. Liebowitz assessed long term outcomes after receiving Phenelzine and CBGT. After six months of maintenance and six months of follow up, 50% of the participants from the medication Phenelzine relapsed compared with the 17% of the CBGT group. From this research, it is plausible to suggest that if a person were to take part in both modalities of treatment, they would benefit from the fast-acting nature of medication, alongside the prolonged effectiveness of CBT therapy. In 2012 Hoffman suggested:

> At present, no clear evidence shows that combined pharmacological and cognitive behavioural treatment is more effective than singe modality treatment. The choice to begin one modality rather than another, or to use combined treatment, therefore often relies on clinical judgement about individual patients (exg, drug treatment might be advisable in a patient who was too anxious or depressed to begin psychotherapy, or did not complete psychotherapy homework) (Hoffman, 2012 p.1121).

According to the NHS website, there are eight types of SSRIs prescribed in the United Kingdom. These are as follows: "Citalopram, Dapoxetine, Escitalopram, Fluoxetine, Fluvoxamine, Paroxetine, Sertraline, Vortioxetine." SSRIs work by allowing more serotonin messages to pass within the brain. This is achieved by inhibiting the cells from absorbing the serotonin and making it more available to the rest of the brain. "Serotonin is the key hormone that stabilizes our mood, feelings of well-being, and happiness" (Serotonin, Endocrine Society, 2018).

Jakubovski *et al.*, completed a study looking into the effects of SSRIs and serotonin norepinephrine reuptake inhibitors (SNRIs) for treating Anxiety disorders. "The greatest treatment benefits were observed for Social Anxiety Disorder for both medication classes" (2019, p.198). This study mentions that not only was medication found more successful for SAD than any other Anxiety disorder, but also CBT had similar effects:

> There are two possible explanations for the greater treatment gains of both CBT and SSRI/SNRIs reported by subjects with SAD: either patients suffering from SAD do in fact experience greater treatment gains, or alternatively, rating

scales of SAD in adults are more sensitive to changes compared to other Anxiety disorders. It is also possible that differences in subject characteristics between Anxiety disorders such as duration or severity of illness, past medication trials, or a greater willingness to tolerate side effects may help explain these findings (Jakubovski *et al.,* 2019 p.208).

SSRIs have been found to be more successful than any other medication. Zohar *et al.*, concluded that "In the cases of OCD and social phobia, SSRIs are almost always preferable" (2000, p.46). Other researchers have concluded similar findings, and it is due to the SSRIs ability to reduce the symptoms and make a debilitating disorder, more manageable at a faster rate compared with other therapies. "Selective serotonin reuptake inhibitors (SSRIs) are commonly prescribed to treat these disorders, and require 3–6 weeks of chronic treatment before improvements in the symptoms are observed" (Dankoski *et al.*, 2014 p.2928). When looking at pharmacotherapy, it is important to look at the side effects of using prescribed drugs. There is more evidence to suggest that other medications have more severe side effects, however it has been noted that there are some experiences of side effects within the treatment. For example, Ferguson (2011) found "During long-term SSRI therapy, the most troubling adverse effects are sexual dysfunction, weight gain, and sleep disturbance." Interestingly, within this research Ferguson noted "observed side effects reported for a single drug may vary considerably depending on the psychiatric condition studied". The example he defines is that people with OCD would document the side effect of headaches; however, headaches are more prevalent in this disorder. Although there is mention of the side effects above, from this piece of research, Ferguson makes clear that the side effects can often be a result of the dosage of drug. If there is a side effect such as headaches or nausea, this is attributed to the amount of SSRI they are receiving which can then be altered. "Most SSRI side effects are dose related and can be attributed to serotonergic effects" (Ferguson, 2011, p.22). In 2013, it was documented that "a significant proportion of patients with SAD fail to respond to the initial SSRI administration, there is no standard approach to the management of SSRI-resistant SAD" (Yoshinaga *et al.,* 2013, p.2).

Overall, it is clear that there is enough research to suggest that medication is efficacious in the treatment of SAD. The side effects of the drugs are not considered a major implication due to them often being averted by dosage change. It is noted of

course that there is the possibility that the SSRIs are not going to be effective for everyone and that usually if this is the case, CBT will be offered as an alternative 'second base treatment'. This dissertation aims to see if the benefits of using DT and DMT would outweigh the benefit of CBT as a second base treatment and possibly medication at first base.

Cognitive Behavioural Therapy

According to the NHS website, as well as Mind Charity (A leading charity organisation in supporting treatment of Mental Health disorders) Cognitive Behavioural Therapy (CBT) is one of the most common forms of treatment for those suffering with Social Anxiety Disorder (SAD). CBT is a form of therapy that focuses on the participant and therapist unravelling worries and issues the participant may have, by thoughtfully put in place strategies. The therapist aims to help the participant acknowledge where thoughts become unrealistic and unhelpful, and begin to break down the problems into smaller, more manageable thought processes. "CBT for Social Anxiety Disorder most commonly involves three primary components: In-session exposures, cognitive restructuring, and homework assignments" (Hope *et al.,* 2004, p.37).

In-session exposure is the technique aiming to confront participants in the boundaries of a session with encounters that they are uncomfortable with. Doing this in the session first, enables them to learn how to cope in these situations outside of the therapy. The situations that they are confronted with will of course generate fear and physiological arousal; however, it is with this technique that participants learn how to manage this.

Cognitive restructuring (CR) involves the therapist and participant working together to recognise where anxieties about social encounters are unnecessary and how to become aware of these thoughts. The therapist helps the participant to reconstruct their way of thinking, to see the encounters for what they are, thus minimalizing anxieties. "The goal of CR is to help patients view the world in a less biased, more

accurate way so that they do not see danger lurking in every corner of the social world" (Antony, *et al,* 2005, p.40).

The final common component in CBT as mentioned previously is homework. For CBT to be ultimately effective, participants must work on the techniques and exercises they have prepared in the sessions outside of therapy. It is the stage that requires the most work, as participants have to encourage themselves. "Homework typically consists of exposures to real life situations and patient directed pre and postexposure CR, helping patients learn to be their own therapists" (Antony *et al*., 2005. p.40). The therapist will advise the participant on ways to adapt their anxious behaviour and how to implement it into daily life. The participant is able to decide alongside the therapist their homework so that it is not too overwhelming, and step-by-step the participant will begin to improve. According to the NHS website, sessions of CBT tend to occur once a week or once every two weeks, and last between half an hour to an hour. "Cognitive Behavioural Therapy (CBT) is a talking therapy that can help you manage your problems by changing the way you think and behave" (NHS, 2011).

CBT is highly regarded for its efficacy in treatment for many disorders in particular, SAD. It has been widely researched and compared with other treatments and currently it is one of the most beneficial forms of treatment.

Norton and Price (2007) examined the efficacy of CBT across the Anxiety spectrum. "Results indicated that treatments that used CBT techniques showed significantly larger treatment out-come effect sizes that no treatment or placebo across all of the Anxiety Disorder. Taken together, these multiple meta-analyses indicate CBT is an efficacious treatment for adult Anxiety Disorders" (Stewart & Chambers, 2009, p.595). For CBT to be effective, the participant must practise and implement the guidance given by the therapist outside of the sessions. If this is not done, then the therapy is not going to be as effective and useful as it should be. Much like all therapy, CBT does require work outside of the therapy sessions and therefore the participant needs to be committed to getting better. The therapy is largely a talking therapy, and this can lead to speaking about things that the participant may find uncomfortable and somewhat invasive especially for someone with SAD. The therapy does take up a lot of time for the participant, it is not as 'fast acting' when

compared with medication. However, the therapist will be aware of this and know how to deal with any hesitance adequately.

Hoffman, *et al* compared another series of meta-analyses and found that there was a lack of research into subgroups. "No meta-analytic studies of CBT have been reported on specific subgroups, such as ethnic minorities and low income samples" (2012, p.436). This can be recognised as another limitation of CBT as it does not hold up enough evidence to suggest its effectiveness as a therapy for these sub-groups. This does not imply that CBT would not be successful for these subgroups, just the lack of substantial research. Although Hoffman found a lack of research into subgroups, there has been substantial evidence for its efficacy in many countries:

> Since the first study in the 1980's, there have been at least 10 other scientific studies that have investigated whether the treatment procedures described in this manual (or very similar) reduce S.A and S.A.D. These studies have included hundreds of participants and have been conducted in the United States, Australia, Great Britain, the Netherlands and other European Countries (Hope, *et al.,* 2004).

Hope *et al's* manual described is a "comprehensive approach" to CBT. Throughout the chapters, step by step the reader self teaches CBT, ranging from CR as discussed before to consolidating progress made, and essentially understanding "how what you do and what you think work together to keep you from overcoming your fears" (Hope*, et al*, 2004, pp. 10-11).

Researchers found in one instance, that CBT continued to help participants after therapy sessions subsided and they were only meeting for follow ups:

> CBT for Social Anxiety Disorder evidenced a medium to large effect size at immediate post-treatment as compared to control or waitlist treatments, with significant maintenance and even improvements of gains at follow up (Gil, *et al* 2001, cited within Hoffman 2012, p.430).

CBT can also be referred to as CBGT which implies it is Cognitive Group Therapy. CBGT follows a similar structure as mentioned before, with the in-session exposure, reconstruction of thoughts, and homework. However, this therapy is done in a group setting. The layout of the session is as follows, "This intervention is typically administered by 2 therapists in 12 weekly 2.5-hour sessions to groups of 6 and consists of several distinct, but interwoven, treatment components" (Hoffman, 2007,

p.193). CBGT can be considered effective due to the immediate social nature of the session. As there are other participants there, there is an opportunity to begin overcoming social anxieties. The first couple of sessions will be focused on the practise of reconstructing negative cognition and understanding that this is common with the disorder. It is proposed that when CBGT is delivered, it is more successful than when administered as a solo therapy. This was also found to be the case with Conventional Cognitive Behavioural Therapy (CCBT) "The intervention differs from CBGT primarily in that it includes specific social skills training in addition to the conventional cognitive restructuring exercises and exposure tasks. Furthermore, the Roleplays are shorter, and the treatment is 2 sessions longer than CBGT" (Hoffman, 2007, p.194).

CBT suggests that the body and the mind are linked together, feeling tense and displaying tension are direct results of one another, i.e. you are feeling stressed, you are sat hunched up with shoulders tight. "CBT is based on the concept that your thoughts, feelings, physical sensations and actions are interconnected, and that negative thoughts and feelings can trap you in a vicious cycle" (NHS). There are techniques employed within CBT such as relaxation techniques and breathing control that can work to aid this, and when the patient understands the relationship between their mind and body, hopefully they will be able to premeditate their response and relax themselves.

Rodebaugh *et al.,* (2014) compared five meta-analyses that looked at the treatment of SAD. When they were comparing the studies use of CBT, they noticed that all shared similar interests across the meta-analyses however their methods were slightly different:

> Essentially, all CBT practises work on the same assumption that the client needs to experience a difference in the situation; the only disagree about what the nature of this difference should be. The technique of applied relaxation suggests that the experience of relaxation, rather than tension, in the situation is the most helpful difference. Social skills deficit models propose the use of social skills training on the assumption that clients need to experience acting skilfully, rather than incompetently, in the situation. In exposure plus cognitive restructuring, the assumption is that clients need to remain in the situation while at the same time, changing or forming a different relationship with their Anxiety -provoking thoughts by noticing what the situation is really like (Rodebaugh *et al*., 2014, p.890).

All of these different methods provided insight into the different ways to administer CBT. Rodebaugh *et al,* suggested from the research that ultimately the patient needs to experience the situations that make them fearful realistically. The patient will have maladaptive thoughts about the situation and their own behaviours, but it is paramount that they have the experience first, so that they can then build the skills and understanding effectively with the experience to relate to:

> If, upon experiencing the situation and their own behaviour as authentically as possible, clients find that they wish to make other changes (e.g., relaxing or acting more skilfully in the situation), they are more empowered to pursue such goals than they would have been before the experience. Until they have such an authentic experience, we believe it is very difficult for clients or therapists to truly assess what kinds of changes would allow the client to function best in the situation (Rodebaugh, *et al,* 2014, p.890).

Overall, CBT has much research behind it that advocates its efficacy in treatment for a multitude of disorders, one of which being SAD. Interestingly, there seems to be a lot of methods employed that are also used within DT and DMT.

DRAMATHERAPY

Dramatherapy uses a multitude of methods within its sessions. There are many important aspects to a successful DT session and within this section of the dissertation, some of these areas are explored. The chosen methods are those that maintain the most significant similarities and differences to DMT and ones that contribute toward the hypothesis that they could lend themselves successfully to treating SAD. It is evident from the research that the processes within DT contain the positive attributes that CBT does, and therefore could be organised within the proven beneficial structures of a CBT session.

Warm-up

Warm-up has been found to be prominent in both DT and DMT. The warming up / beginning of a session is also demonstrated in CBT. I intend to focus on *Creative Drama in Groupwork* by Sue Jennings when looking at the warm-up component of a DT session. Jennings states that the warm-up "may serve as preparation for the main business of the session, in which case the tone and type of exercises chosen

will need to be compatible with the main focus" (2010 p.26). A warm-up of some description is necessary for a therapy session whether it be DT, DMT or CBT. It gives the client the chance to ready themselves for the session, meet with the therapist and become engaged. It is a tool to meet the group if it a group session and to introduce the participant to the session and inform them of what will entail. "On occasion, a high level of Anxiety may be noted at the beginning of the session, and some work on breathing and relaxation may be chosen to occupy the warm-up phase" (Jennings, 2010 p.27).

Within Jennings book, there are 115 different styles of warm-up given. Warm-ups 31 through to 45 are dedicated to Breathing exercises which will play a big part in DT sessions. This could be considered a relaxation technique which as mentioned earlier is also employed in CBT. The breathing warm-ups mentioned such as warm-up number "35: Breathe in through the nose, wait for a count of four and blow out through mouth, taking care not to let your breath out in a rush" (2010, p.38) allow for the slow calming exhalation. This aims to calm the participant within the space, to take time to familiarise the environment and allow the participants to relax for the session "remember that developing breath control can help with panic attacks and asthma as well as being good for general well-being" (Jennings, 2010, p.38). In DT, the relaxation warm-ups can be as simple as activity "2.1 Relaxation and Deep Breathing" (2010, p.52) where the participant sits or lies on the floor with a blanket and focuses on their breath and they become more relaxed:

> Relaxation is an effective therapy for dental phobia, test Anxiety, panic disorder and generalised Anxiety disorder. In partic-ular, there is no strong evidence to indicate that validated expo-sure-based or efficacious drug treatments are more effective than relaxation. However, although relaxation lowers symptoms relative to those in wait-list controls, it may be less effective than other behavioural treatments for small-animal and specific phobias, social phobia, post-traumatic stress disorder and obsessive-compulsive disorder (Jorm, 2014, p.37).

Movement is also a key factor of warm-up in DT. In fact, dance is explored within DT more so than Drama is within DMT. Page 58 activities 2.7 "Dancing in the Circle" is a warm-up that could be used for both DMT and DT. The title of this warm-up is explanatory for the warm-up itself is simply stepping rhythmically within a circle; and the suggestion is to use Folk music due to its basic rhythm. From the earlier

research on SAD we can posit that a participant will be negatively evaluating their performance and us CBT suggests their body will be tense and reflecting their personal mood. They may feel they are being watched and judged negatively and therefore it is vital that they are reminded that this is not done to assess their dance ability, in fact just to get the mind and body working together and to warm them up for the session and relax their bodies. In addition to this warm-up there are several more such as "Dancing with Materials" (2010, p.69) and "The Dancing Queen" (p. 71) all of which use of movement and can have the same outcomes of relaxation and warm-up of the body, as well as improving rhythm.

The warm-ups 1 through to 15 are dedicated to giving examples of "warm-ups to WARM!" Prior to giving the reader the potential activities, Jennings has given a quick prelude "People need to be able to stretch their limbs, yawn and generally free their bodies for movement" (Jennings, 2010, p.35). This is then followed by suggestions such as "wrap one hand over the other and do a gentle stretch forward" or "twist gently from the waist". It is important that the participant is fully warmed up in the space due to the possibility of later physical work.

DT gives a wide range of game style warm-up and it is evident that using game as a warm-up method is useful. Other than the obvious physical benefits from playing games, Jennings emphasizes the team building and cooperation skills that are fundamentally being built. Jennings notes that playing such games within a group therapy session can lead to some anxieties and therefore advises it is important "to encourage them to be playful and find their own creativity" (2010, p.73). A game that is then described is "Tree Tig". This game involves the group splitting up and half "becoming trees". The other half is chased around and plays the game of Tig. However, the only way to avoid being caught is to hold on to a member of the "trees". From my own experience, this game is a good team building game as it allows the participants to begin to bond and feel more comfortable with the rest of their group. It will hopefully mean participants become fully engaged within the game and momentarily do not self-evaluate and just immerse themselves within the Play. This may be unlikely due to the nature of SAD and therefore it will give the participants an experience to look back on and understand their maladaptive thought

patterns and negative perception. If, however, this is not appropriate for the group, there are alternative ways of playing that are given below the method of the game.

As mentioned as an additional outcome to playing these warm-up games, getting to know each other as well as the session leader is a benefit. This is important in the early stages of the session. Within a group session, most of the activities within the warm-ups are working on the relationship between everyone within the session. For example, a large amount of the warm-ups are partner work or team games and therefore a sense of getting to know one another is enforced through this. Later in the session, especially when participants are sharing their personal stories, it is important that they feel comfortable with other group members and therefore a continuous bonding experience is favourable.

In Jennings book, there are examples of warm-up games aiming to familiarise participants with each other, if it is a group session. The name game warm-ups are an example of this. For example, one warm-up is described as a game of throwing a soft ball to another participant and saying their name as you throw the ball (2010, p.37). Other examples of name learning warm-ups include "beat your chest vigorously and shout your name" or "say your name and a food you like that starts with the same letter: "my names is Mary and I love Melon". Using food or alliteration games as a way to remember names is a clever tool that is not uncommon when a group is in their first meeting. The association of names with food shall aid as an effective tool in remembering names in a positive way. By using these name warm-ups, members of the group will become a lot more comfortable with each other and the leader of the group.

Within DT, Improvisation and spontaneity is practised within sessions. Therefore, it is important that during the warm-ups the leader is making sure that the participants both individually and as a group are warmed up and focused. Within DT impromptu behaviour is recommended when the participants take part in activities such as Roleplay or creation of movement to a piece of music on the spot. These examples will seem daunting to any participants, especially those with SAD, and therefore this is why in therapy sessions, the warm-ups combat this expected hesitance. J.L Moreno developed an ideology that is important within this dissertation to understanding warm-up within impromptu work. Moreno worked with actors and

found when doing activities that included spontaneity and impulsivity, similar issues that could arise within a DT session were noted. "He suggested that a person was often at war with themselves about whether or not they were doing the right thing, and hence, that they often appeared stilted, tentative, or simply inauthentic" (Howie & Bagnall, pp. 35-44). According to earlier research, this is also the way a person with SAD will feel and therefore the work Moreno has consequently constructed could be directly applicable in the treatment process. Moreno suggests there are four main concepts of warm-up he found to be successful,

the four stages are as follows:

> 1. The group warm-up process – Warm-up as process applied to groups of people to generate a certain level of spontaneity that would enable them to engage collaboratively with the group leader and with one another.
> 2. The group warm-up state – Warm-up as a heuristic for determining or measuring the preparedness, or the level of spontaneity of a group.
> 3. The Individual warm-up process – Warm-up as a process applied to an individual to prepare them, or by an individual to prepare themselves, in some specific manner or as a response to a context
> 4. The individual warm-up state – Warm-up as a heuristic for determining or measuring an individual's total state of functioning, or state of being, at a moment in time, or context (Howie & Bagnall, pp. 35-44).

Utilising these steps of warm-up could be directly applicable within DT, DMT and CBT.

Jennings advises that using warm-ups that involve Roleplay can in fact help people to feel more comfortable and "start feeling more confident about exploring roles" (Jennings, 2010, p.49). This would be helpful within a DT class, and within Jennings book, Roleplay is a key method within their sessions as it is a tool for exploration into feelings and comfort. These warm-ups that are given are beneficial to participants because the majority involve participants working in pairs or more, which is necessary in overcoming disorders such as SAD. The above stages mentioned by Moreno can be used as a structure within DT when planning warm-ups for participants. They give a clear example of a layout which is especially useful to a therapist laying out their sessions.

Vocal warm-ups can be an excellent device for those suffering with SAD because it is allowing them to become comfortable using their own voice. "Most commonly, Social phobics fear how they portray themselves in social situations and in turn, how

this is 'read' by others" (Rachman, 2013, p.172). Details of vocal warm suggest warming up with a "hum" and continue on to using sounds such as "la la" or "ooh ee". Within the DT vocal warm-ups, Jennings describes other warm-up techniques such as recalling nursery rhymes and mimicking popular entertainers' voices. If this is performed within a group therapy session, already this is tackling the fear of public speaking. Mind and body connection are an important part of treating SAD. It is fundamental to CBT and is no different within DT and DMT. Stanislavsky the pioneer of the psychophysical actor training mentioned "in every physical action there is something of the psychological, and in the psychological, something of the physical" (Stanislavsky & Benedetti, 2008). Bearing this in mind, it could be advantageous in the overcoming of SAD if the therapist puts emphasis on making sure that the participant maintains relaxed form and overcomes stressful and negative cognitions.

Jennings also provided us with a sub-category of warm-ups centred on feelings. "Of course, all the other warm-ups will involve our feelings to a greater or lesser extent. However, the following techniques help people to clarify the expression of their feelings in appropriate situations" (Jennings, 2010, p.47). Jennings then begins to list different exercises' that she recommends such as activity, 94 "Choose something that has made you sad in the past and share it with the rest of the group. See if other people have had similar feelings of sadness". Identifying and sharing things that make participants nervous and or uncomfortable could be again pivotal in treatment for SAD because it is highlighting again where thoughts are irrational and unhelpful. Being in a group discussion about this may also be supportive and reassuring for a participant, as they often lack personal validation and assume, they are critically judged by others. "Most commonly the disorder makes the person fear public speaking. Cognitive theory suggests the core of the disorder is Anxiety that results from a lack of confidence in one's ability to convey a favourable impression to others" (Rachman, S, 2013 p.172). From this research we can see that the principle areas that Jennings find important to a warm-up are Relaxation, physical warm-up, voice, games, Roleplay and feelings. When observing this, we can postulate that all of these techniques will be efficacious in the long-term treatment of SAD. It employs an array of techniques that will involve the participant learning relaxation techniques, being involved in public speaking and assessing their own performance. It doesn't suggest they will do any of this in a positive manner to begin with, however as

mentioned previously, it has been hypothesised that a participant needs to authentically experience feared situations to then learn and grow from them. If these warm-ups suggested are anything to go by, they will certainly be the foundation steps in overcoming SAD.

PLAY IN DT

One of the key aspects of a DT session that posed interesting ideas was Play. It would initially seem that Play is an implementation that would be designed for younger participants, and that using it for a treatment for Anxiety would be difficult and complex to achieve. Within this work, research found *Drama as Therapy: Theatre as Living* by Phil Jones was a leading source in understanding Play within DT.

This section of the dissertation will describe the use of Play as a treatment for SAD. Firstly, by unpicking Play within Dramatherapy, then touching on the history of Play and using some other sources, Case studies and information where Play has had positive effects.

As Jones comments himself:

> Our understanding of Play has shifted. A number of different fields have re-examined Play – from biology, psychology and psychotherapy to anthropology, from economists and large marketing companies to educationalists (Jones, 1996, p.169).

Play has always had considerable influence on Drama and vice versa:

> Evreinov speaks of this close relationship between Play and drama in his discussion of the Soviet Malachie-Mirovich's work on the educational value of toys: 'All children have the ability to create a new reality out of the facts of life"… "The child plays naturally, without instruction, creating their 'own theatre', proving that 'nature herself has planted in the human being a sort of "will to theatre" (Jones, 1996, p.167).

Children have been vital to the research and understanding of Play within theatre and therefore many Case studies and examples are based around children. Jones observes, "It is interesting to note how many key figures within the development of Dramatherapy began their initial thinking and work in the areas of Play and dramatic playing with children" (1996, p.167). This is of importance however, because a lot of child study is conducted through the use of Play, and furthermore "Play has a great

deal of relevance to the therapeutic use of drama" (Jones, 1996, p.167). The most important area however has been the impact that Play has on a child's education. "For educationalists Play is a way of learning about, testing and making sense of the world, exploring the self and its relationship to the environment" (Jones,1996, p.171). As it is made clear within Jones book, Play is seen as its own separate area to drama and its own form of drama. "In this way Play develops many of the functions and capabilities which are present in drama". It has been considered that SAD is a disorder that develops over time and sometimes begins from childhood. This could be a result of multiple factors such as bullying, preferential treatment, negative feedback etc.; however, this will be discussed further on within this paper. With this acknowledged, it is plausible to suggest that if DT was integrated within a school environment or educational setting, whether this be Play Therapy or other, we could minimise the possible amounts of SAD and potentially other mental health disorders from flourishing into adulthood.

Within Jones' book, many Case studies are described. One in particular 'The Bear and The Fox' (p.173-174) demonstrates a child's use of Play during a therapy session. Within this Play, the therapist and the child use puppet animals to understand a difficult relationship between mother and son. It is clear that through the use of Play, the child has found meaning and has begun to understand what is happening around him. "The creation of meaning in Play is crucial to all three areas of Dramatherapy identified" […] "playfulness and the general process of playing, the developmental framework and Play content (1996, p.174). This Case study in particular discussed how the characterisation of the puppet animals may be interpreted as "Anxiety over fears of being overwhelmed by anger" (1996, p.174). As we can see, the child is using these puppets as a way of displaying his own thoughts and feelings whilst disassociating any personal responsibility. The child is masking this through Play, and we can see it could be helpful to someone with SAD, as it can lead to them revealing their insecurities and core beliefs. Within this Case study, the child mentioned they have issue in forming relationships. Similar to this, SAD can lead to a person being unable to forge relationships or anxieties about doing so. As the Case study has suggested, "in a sense the playing enables him to master his feelings and to test out a new way of dealing with his feelings" (Jones, 1996, p.174). This method of Play has encouraged the child to enact a new way of processing

feelings and how they could possibly be interpreted by others. SAD could be eliminated if a participant feels they are aware of how the situation/their performance could be interpreted by others.

Another study within Jones' book is "The Falling Man" (1996, p.168). In this Case study, children's use of Play is described when dealing with witnessing a traumatic event. The teachers of this group of children recorded that they played different versions of the scenario – a falling man – as a way for the children to "accommodate the experience, to deal with the stress and shock, to adjust to and accept the death they had witnessed and the fears it caused in them" (1996, p.168). It is evident that the children needed to use Play as a form of healing and coping, to address their feelings together and as the staff said themselves "Simply to talk about the experience would not have allowed the depth of participation and the working through of feelings and fantasies in enactment" (Jones, 1996, p.168). People with SAD could benefit from this because they can use Play to really portray how they feel in an uncomfortable encounter through the use of Play. A person with SAD could simply be walking down the street when they begin to worry that other people are watching them and evaluating them. Through the use of Play, they can address these daily implications without feeling like they are over-exposing themselves. Often, public speaking is something that they really struggle with, and therefore to understand their Anxiety through Play, their mind might be distracted on the task of playing rather than the fear of taking part. This can be supported by the Play shift, also described as the "Fulcrum of Dramatherapy's use of Play" (1996, p.177). "Piaget (1962) has said that in Play, the individual's interest is transferred from the goal to the activity itself -- to enjoyment of the pleasure of Play itself" (Jones, 1996, p.177). SAD can be considered as a consuming fear usually of how a person views himself or herself, and therefore if they transfer their interest into the Play activity, they can find themselves becoming more comfortable. "Whilst many forms or structures of real-life are retained in playing, the intention is different" (1996, p.177). As Jones makes clear to his reader, it is wrong to assume that Play is conducted in the same way a child plays outside of a Dramatherapy session. The Play is set up "within specific boundaries and frameworks which differ from those in which the child will usually play" (Jones, 1996, p.176).

Jones describes how the activity of finding playfulness itself, can be therapeutic. Once playfulness and Play are established, it opens the gateway to spontaneity and creativity however allowing the group or individual to find this playfulness is mandatory to the therapeutic success of the session. In David R Johnson's article, 'Developmental Approaches in Drama Therapy', Johnson presents a Case study about a group of young people suffering from Schizophrenia undergoing Dramatherapy. Johnson discusses how in the beginning, he gave structured sessions with time limits and participation rules, and there subsequently was an anxious tone to the group, "Despite this structure, the group atmosphere was often Anxiety-ridden" (Johnson, 1982, p.184). He describes how participants felt uncomfortable and did not seem as involved. This could be directly associated with the characteristics of SAD, however this contrasted to the group two years down the line. Johnson describes his position as a facilitator evolving, allowing the group to make their own decisions and the sessions often "engaged in open-ended Improvisations" and "there was more open conflict among members, more expression of feeling, and yet a much greater sense of intimacy and security than before" (Johnson, 1982, p.185). This is providing evidence that allowing the group to slowly take control of the sessions and discover the appropriate atmosphere can lead to successful contribution and positive energy within the group. This can be achieved from the use of team building exercises mentioned previously within the warm-up.

Similar to how warm-ups must be tailored to the group or individual in question when beginning a therapy session, the Play and practice is no different. It is important that the therapist gages what Jones refers to as a "Play language" (1996, p.178). Once this is established, the therapist can then decide on the most appropriate form of Play process. "In some work the activity is mainly focused in Play activities, in others there can be a mixture of Play and more developed dramatic activities such as Roleplay" (Jones, 1996, p.179). Another key factor in creating successful Play within a Dramatherapy session is Play space. "Griffing (1983) considers that in preparing for Play an adult needs to provide four things: (i) time, (ii) safe space, (iii) appropriate materials, and (iv) preparatory experiences" (1996, p.180).

Finding the space required is both physically and emotionally essential for participants suffering from SAD. Having a safe space to unwind and become intimate will be essential. "Singer (1973) has said that physical space and privacy are prerequisites for imaginative Play skills to develop" (p.180). Whilst the Play is underway, it is necessary to remember that the therapist will always be present and that the Play process has been deliberately set up, therefore even though there is similarities between the Play inside and outside of the therapeutic boundary, the differences still create the Play shift mentioned. It is important within these settings to limit the playing, to make sure that although the participant is given the freedom to play, they understand that there are certain limits. For example, "The preservation of the Play space is described by Bixler as setting limits in which the client should not destroy property other than the Play equipment, to attack the therapist, to stay beyond the time limit, to remove toys or equipment, or to throw them out of the room (Bixler, 1949, 1-11)" (1996, pp.181-182).

Setting these limits is imperative within the session as it is a means for control for the therapist and also as a safety tool for the participant. The set boundaries will also create a constant for the participant and they will understand that everything that they do within a session is aiding the treatment and treatment progression of their SAD. Jones suggests that there are key aspects within the Play-Drama continuum. To summarise this continuum, Jones has given us five bullet points.

- Sensorimotor Play
- Imitative Play
- Pretend Play
- Dramatic Play
- Drama
  (Jones, 1996, p.185).

The different points are all part of a developmental process that all aid in Dramatherapy. Jones mentions that it is important to understand this developmental process of Play whilst acknowledging "two specific areas: Character and object usage" (1996, p.185). If using these developmental stages as a guide, the therapist can begin to notice the growth of a participant in terms of willingness and ability to

play within a session. "The work becomes the creation of conditions or situations which can help the client to develop further or differently in terms of developmental levels – to enable the client's growth through entering into new levels of Play" (1996, p.193).

Play and Drama are a developmental continuum that requires participants to fully engage throughout each stage. Each stage is unique in aiding a participant and sometimes it is the Play process, which is the most advantageous. Jones points out "for some clients this process forms the main therapeutic benefit within Dramatherapy" (1996, p.194). Using Play as a tool for not just therapy within drama but education, social skill, adult practice, intellectual development has been widely researched and it would seem that from the results, it is now understood to be a useful tool in teaching. Using Play in Dramatherapy allows the participant to create meaning and to understand material at a deeper level. Play encourages spontaneity and freedoms that will all be instrumental to a person suffering from Anxiety.

Referring back to the information about CBT we can see how the method of Play can be utilised within the in-session exposure frame of CBT. A participant can use Play to break down their issues into separate parts and work through them piece by piece which again is a format that is explored within CBT. We can see that Play has many efficacious methods in the treatment of SAD, however as mentioned a lot of the current research is based on childhood studies. This could be an indication that more research is necessary on Adult Play Therapy as a treatment for SAD. But furthermore, if these therapies are implemented at a younger age, there would hopefully be a corresponding decline in adult mental health disorders.

It is conceivable that playing would be one of the most effective tools in treatment for alleviating SAD. From not only the fun nature of Play, but from the way the games will allow for trust, and distract participants making them realize that the distress is arbitrary. From the research, it is made imperatively clear that the space in which sessions should take place are large and accommodating and furthermore do not change. From the consistency of space becomes a safe atmosphere for participants to begin to explore and understand. Within these parameters there are set time limits and rules that will be enforced creating even more dependency on the sessions. It is important that the therapist understands the playfulness of the group or individual

before asking them to join in on any activity and this is mandatory in both styles of therapy. Play has been established in numerous cultures long before it was acknowledged as beneficial. It helps advantage education, social skill, independence and much more. Play is a massive part of drama and Dramatherapy Its' many different forms for example Roleplay, Improvisations, etc., exist outside of Dramatherapy and drama itself in everyday life, and therefore open it up to being beneficial to both adults and children. Overall, it is concluded that Play within DT and DMT is a positive method in the treatment of Anxiety disorders, however from the given Case studies; SAD would be the most effected.

<u>ROLEPLAY</u>

From the research into CBT, warm-up and Play, we can see that Roleplay is often implemented within these modalities. Roleplay is an integral part of DT and arguably the most valuable part. Roleplay can be used in individual and group session and tailored to meet the needs of the group. Within this essay, the use of Roleplay not just within the session but also within everyday life will be examined. The essay aims to integrate knowledge about Role Theory and Roleplay and apply this to the therapy sessions evaluated. Ideas from practitioners such as Robert Landy and Rudolf Laban are examined, and further practitioners have been referenced and acknowledged. The role of the participants and therapist will also be examined and a conclusion on how this method can be designed to benefit participants with SAD will be specified. "Dramatherapy's approach to role in both theory and practise has been strongly influenced by thinking in theatre, psychology, psychodrama, dramaturgy and anthropology" (Jones, 1996, p.199).

Roleplay is integrated into many of our lives. Many argue that Roleplay is vital to our development. For many, it is a fond childhood memory imitating those around us in fun childhood games such as playing 'mums and dads' or 'teachers' so on. It can be considered a way that as children they make sense of the world around them by playing in these different roles. "Wilshire (1982) has echoed Evreinov's (1927) ideas concerning essential nature of drama in human development. He places role taking and imitation in a context of learning" (Jones, 1996, p.204). Understanding the oppositional criteria of Ecstasy and Rationale is critical for the understanding of role. Ecstasy and Rationale refers to the state in which the participant experiences their

Roleplay. An example given that best describes Ecstasy and Rationale follows: "Being rationale means placing priority on how aware a participant is during the experience whilst ecstasy suggests being completely absorbed by the role." Johnson and Johnson describe below a "strictly rational process" (Jones, 1996, p.201).

> The role taker stays fully aware of the reason for the activity, and is open to cognitive learning processes. The work is skills orientated, role playing is a tool for 'bringing a specific skill and its consequences into focus, and this is vital for experimental learning (Johnson and Johnson, 1987).

Jones describes additional elements that must be addressed when understanding the importance of role within a Dramatherapy session. These elements involve role entry and the exploration to change. Role entry can prove difficult to participants as it is asking them to become another identity they do not know. It will be challenging for a person to experience this new persona. However, once this individual allows himself or herself to comply with the role, "the temporary change of identity gives permissions and alters the experience of self and others in a way which is seen to help bring about differences and change" (Jones, 1996 p.203)

Role has other important qualities, which make it so fundamental to Dramatherapy. "The act of consciously transforming their own identities into a variety of make-believe identities may hasten the decentration process, thereby promoting perspective taking and a number of other cognitive skills." (Johnson, *et al,* 1987 p. 102). Perspective taking and cognitive skill is massively crucial to a participant with SAD. If a person can consider and understand alternative reactions, then they may begin to control their anxious tendencies. From the research on role and Roleplay, naturally it led to Robert Landy who has been described as "A core approach to Drama Therapy" (Young, 2018, p.14). Within Landy's role theory, he comments on the paradox:

> In that when an actor takes on a role in a Play, the enactment of the role allows the actor to both be that role and not be that role simultaneously. This paradox, of both being and not being, serves as an answer for how to exist in an internal and external world that is filled with paradox and polarization (Landy, 1993, p.11).

"One's role system generally grows in complexity with age, and a central assumption of Landy's work is that roles can be modified at any stage of development system"

(Korman, 1994, p.390). An explanation of role theory is simply that throughout life, an individual will play many roles interchangeably. It is the swapping of these roles that allow us to feel a sense of balance, however an inability to change between these roles can result in confusion and "psychological limitations" (Young, 2018, p.14).

This could explain how SAD prohibits a person from changing between an introvert to a public speaker as an example. This also suggests that when in a Dramatherapy session, the role of a Dramatherapist is to help an individual learn to "integrate the role and counterrole within ones system" (Young, 2018, p.14). Learning how to balance the shift between roles may be useful to a person with SAD. Furthermore, through the use of Roleplay a participant can work on portraying scenarios where they do not employ safety behaviours. In doing so, they are experiencing scenarios that are possibly going to happen in the future and they can conceptualise the positive outcomes. Within Landy's book review it is suggested that "the role system is continually in flux, changing according to experiences, and therefore it is impossible to ever view it objectively" (Korman, 1994, p.390).

As this research is covering the uses of Roleplay for treatment for SAD, it is important to see exactly how Roleplay can be used to treat this disorder. "Roleplay would be used to try to establish the most effective techniques to deal with these problems. The playing of roles would be used to try to establish and practise a new way of behaving and dealing with others in social situations" (Jones, 1996, p.207). From this, the skills that the individual learns will be transferable to real life and he or she can practise this. Roleplay within Dramatherapy is different to the way we understand Roleplay within drama and theatre. Within Dramatherapy, the Roleplay is specifically chosen by the Dramatherapist and has therapeutic benefit as its main goal rather than the creative performance. "A problem may present itself in role terms, but the Dramatherapist would consider the spectrum of dramatic processes and expressive languages to find a way to express and work with the problem or issue" (Jones, 1996, p.209).

"The traditional Roleplay is a part of the process which Dramatherapy draws on, but it is not the only or main role process which is used" (Jones, 1996, p.209). Dorothy Langley suggests that within Dramatherapy, "our roles and how we feel we perform

in them are a very sensitive area and consequently not something we can reveal easily" (Langley, 2006, p.103). Therefore when engaging in Roleplay games especially within a therapeutic setting it is important to remember "the risk of exposing ones insecurities is a real one" (Langley, 2006, p.103). As SAD involves a person negatively assessing their own performance, it will be vital to make sure that post 'performance' there is a healthy discussion of what has been revealed and 'done well'. This is the same for CBT therapy as well as DMT.

Langley suggests that we contain many distinct roles that similar to role theory, are interchangeable. The roles that Langley provide are as follows: "Physiological Roles", "Activity Roles", "Social Roles", "Fantasy Roles" and "Role Conflict". Role conflict is the assumption that if roles from other categories coincide, if we cannot prioritise one as being more important than the other, then it creates unrest within us. Fantasy roles are roles we initially played as children for example mother or doctor however as adults we have diminished of, although we do retain some for example the fantasy of being a dancer. Social roles are those we play inside of our community for example, speaker or listener. Examples of Activity roles include that of driver, cleaner, and gardener. These tend to be doing roles. Finally, there is the Physiological role; this is the role that is necessary to an individual's survival. This includes being "the breather" (Langley, 2006, p.96). Langley has given these examples of role and then has built her own opinion of how Roleplay can integrate all of these different types of role humans are. Langley suggests that for successful Roleplay "I feel we need to start with the basis of all drama which is Play. My approach is from non-competitive games to role games which develop into fantasy Roleplay and finally role activities to prepare for reality" (Langley,2006, p.108). Sue Jennings comments on role being a part of her Dramatherapy Sessions. "We are already in role as therapist and they are in role as client coming to a Dramatherapy session. We have to be very careful that the essential supportive 'being there' for the client does not become endangered if we take on other sorts of role as well" (Jennings, 1990, p.95). It would seem that Roleplay is a significant part to the session, as mentioned above, the Dramatherapist is as importantly in role as the client. The Dramatherapist must take on roles and join in with the Roleplay, especially when working with an individual. "By virtue of consciously working in-role, the dramatherapist differs radically from the over-distanced stance of many of her

colleagues. The Dramatherapist does not, and cannot, remain permanently over distanced if she is to effectively enter into the one-on-one drama" (Landy, 1992, p. 101). Roleplay is another tool employed within Dramatherapy because it allows participants to work through their problems and work on this outside of themselves. For example, for this current research, participants might Roleplay with characters that do not suffer from Anxiety and work through how they could react to what they view as uncomfortable. "By involvement in Roleplay in Improvisations clients can structure and adapt situations to their own lives" (Langley, 2006, p.24). It is useful to use Roleplay within the sessions because then participants may feel the freedom to choose how they portray their feelings. "The idea of spontaneous action does not refer to being out of control or lacking appropriate boundaries. It is more a question of being sufficiently free of past and future to act freely in the present moment" (Jennings, 1994, p.117).

As pointed out within Johnson's 'Principles and Techniques with Drama Therapy', "The actor must utilize more of his own resources to create and maintain a coherent role-identity. He draws upon memories, habits, mimicry and also more intangible aspects of his own personality, both conscious and unconscious" (Johnson, 1982, p. 85). This may make the task of Roleplay daunting for someone with Anxiety, as a person struggling with this will have severe insecurity about how they portray themselves. Within the same piece of literature, Johnson describes an example of how Roleplay can be used to subconsciously and consciously be parts of our own personality. Within this Case study, we are given description of Andrew, a man who has been hospitalised for four years due to illnesses including depression and disorganised thought. He is being told he must leave the hospital soon and therefore he is under severe stress. During the Roleplays, Andrew plays either the master in which Johnson the mistreated slave or the president when Johnson was under his command. This Roleplay continued for a while with consistency in the roles up until a few days before Andrew was sent home to visit. Close to this time Andrew asked Johnson to play the President whilst he played the slaves being emancipated. After Andrews visit home, he refused to return to the hospital and remained AWOL for over ten days. Johnson believes that the role reversal so close to his departure from hospital maintained significant meaning. Johnson makes clear that the changing of role "did not indicate a major change in his personality structure" and "Andrew was

not consciously aware of his wish to leave the hospital until two days later" (Johnson, 1982, p.86). This as summarised by Johnson, "Shows how both relatively stable traits and more transient, unconscious, thoughts combine to determine the particular content of a person's Roleplaying" (1982, p. 86). This is another indication of how vital Improvisational Roleplay can be in the healing process that Dramatherapy has. Johnson also indicates that there can be issues when looking at Improvisational Roleplay and script work. He comments on how "each actor 'clings' to his own characterization in order to feel secure in the Improvisation" (Johnson, 1982, p.88) and by doing so creates what is known as the "impasse" where participants often find themselves repeating themselves and there is little action achieved. Even though Johnson acknowledges Spolin's ways of avoiding Impasses: "Keep the ball rolling" "Maintain a point of concentration", it is evident that he agrees that the author who is "allowing impasses to develop and then helping the actors understand how they fell into impasses, and how to creatively work through them" (Johnson, 1982, p.88) is a better course of action. This can be seen as having real therapeutic benefit because "often the impasses reflect problems which clients have in other real-life relationships" (Johnson, 1982, p.88). From this, naturally it was important to understand the method of Improvisation within DT.

IMPROVISATION

Improvisation, similarly, to Roleplay, will be a daunting task to participants suffering with Anxiety disorders, therefore when taking part; the relaxation and breathing techniques learned from the previous warm-up will be important. "One of Stanislavsky's first discoveries was that muscular tension limits the actor's capacity to feel as well as move. A body totally free from tension is essential for stage creativity" (Gordon, 1987, cited in Frost & Yarrow, 2015, p.145).

> The improvisatory act focuses on the gathering of energies, the freeing of possibilities of articulation, an alertness of giving and receiving and the establishment of connection. It has to do with developing wholeness through developing the sense of self (Frost and Yarrow, 2015, p.217).

Through Improvisational tasks a person can work on Anxiety related situations. Often through Improvisation a participant will reveal insecurities without realising and it is this revelation of the subconscious that will help a participant to handle their Anxiety,

to understand it and to learn from it. This can be achieved in both DT and DMT, but this Improvisation can be linked to having similar methods to CBT, in terms of revealing a person's Psyche and pinpointing exactly where the Anxiety came from.

Frost and Yarrow mention the many benefits of using Improvisation "Improvisation activities help to discover, unblock or tune up the psyche and the body, which evidently has implications for performance of any kind" (2015, p.217). Relating this with SAD, suggests that Improvisation can help a person to handle their anxieties when public speaking, or even simply having a conversation. If we view the phrase 'for a performance of any kind' as fitting to social exchanges as well, then we can understand how working on Improvisation skills can help as treatment for SAD. Within *The Handbook of Dramatherapy,* examples of Improvisations are detailed. One example that has stuck out in particular for possibly being useful to participants with SAD is the Royalty Improvisation. It is described as asking participants in turn to sit on a "throne" wearing a crown and a cape and make requests to the other people playing "courtiers" (Jennings, 1994, p.70). Doing this simple task of Improvisation is a not only creative and fun but beneficial to the participants. "They may feel reassured by the structure of the Improvisation which ensures that the role is temporary and will pass on to someone else" (Jennings,1994, p.70). Furthermore, it was noted that "even the more timid usually find it possible to make some request, maybe non-verbally, and so have the experience of being boss for a moment" (Jennings p.70). This would be an excellent use of Improvisation to use with a group struggling with SAD, as this game is allowing them to feel like they are in control when they give their orders, whilst acknowledging that it is a game that will come to an end. "One of the advantages of Dramatherapy is that the emotional content of an issue can be worked with indirectly" (Jennings, 1994, p.71). Working indirectly with SAD could be more beneficial that the steps of CBT such as exposure technique because it is less invasive and almost self-taught. Within Dramatherapy, Improvisation can require a group to create larger Improvisations. It is commented as a "group process" (Jennings, 1994, p.71). It allows a group to understand themselves and each other better within the group and create some interesting relationships with both character and self. Doing so may bring out interesting characteristics in a person, as commented someone who is usually quiet may take on a loud and dominant personality and want to organise a group in the

Improvisational tasks. "Change arises in the context of a shared interest in an act of joint creation, rather than by facing the need for change head on" (Jennings,1994, p.71).

Improvisation seemingly lends itself very well to the treatment of SAD as it provides the possibility to explore impulsivity and genuine fears and emotions. With SAD tending to cause worries in the lead up to a social exchange, this Improvisation technique will hopefully teach participants how to handle themselves in future social encounters without fear of scrutiny.

MOVEMENT

As explained earlier on in this thesis, movement in Dramatherapy is vast. Within a Case study discussed in Jones' article, we hear from Lily Levy, who discusses her experience with client Grace. Grace was showing symptoms of depression and disturbed sleep due to her son being hospitalised for the second time. When Levy asked Grace to describe her relationship with her son, Grace commented that it was difficult; he has become a burden and describes their relationship as the poem about an albatross and a sailor. Within this poem, the Injured albatross although strong, weighs down the sailor. Levy asks Grace to act out the sailor and the albatross through movement. They begin by mirroring and then Grace takes off flying as the albatross. Eventually Levy asks Grace to become just the Sailor, and after a short while she does. After the task ends Grace Bursts into tears "I am a bad mother". In a follow up interview between Johnson and Levy, Levy says "I see that, by talking, she tells me how she feels, but by embodying the characters, she has the experience and feels it in the 'here and now.' Embodying allows her to get in touch with her emotions and to express her wildest fantasy." (Jones, 2009, pp.99-101)

Using movement in this way is a technique that really sets apart DT and DMT with other treatments such as CBT.

> This is a paradoxical process. On one hand, Grace is at a distant from herself when she embodies the characters physically and as such increases her fantasy: she becomes someone else's identity. On the other hand, this distance, allows her to experience herself in a different way, she starts observing herself and being emphatic with her pain and hurt. She gets more

involved with her emotions. She is more able to feel and think in a more integrated manner (Jones, 2009, p.100).

Within the same work, we are told of another Case study regarding at Christine Novy's work with women who have come into "conflict with the law" (Jones, 2009, p.101). Within her work, she uses relaxation techniques followed by movements that are developed through sculpting. Doing this and using Roleplay similarly to how Levy used it had a positive effect. During the following up interview between Johnson and Novy, they discussed a participant's reaction to the task:

> Well, Lynne described the non-verbal processes as providing her with an emotional language, a way 'to speak from inside.' She said that verbal language was like a mask that she had used to hide behind to avoid judgment and being rejected. She felt that it was the spontaneous quality of the non-verbal processes that helped her see behind the mask (Johnson, 2009, p.102).

From research on SAD we can see they harbour similar feelings to the ones Lynne has described, they try to avoid judgement and rejection. If they were to take part in more movement-based tasks which are unique to DT and DMT, there is potential to develop a new way of exploring their fears and anxieties in a controlled setting.

When discussing the importance of movement in Dramatherapy, it is essential to refer to Phil Jones' nine core processes: in particular, Embodiment. "Embodiment in Dramatherapy involves the way the self is realised by and through the body" (Jones, 1996, p.113). It is evident that through using the body in movement and gesture, participants are more available to the present; they are living in the moment so to speak. "The acted-out embodiment of an issue involves a bodily experiencing of the material in the present. It means that through embodiment the client presents and encounters issues in the 'here and now" (Jones, 1996, p.113). This is not assuming that embodiment links directly to movement like running or dancing, rather it is "the client's physical encountering of material through enactment and combines the knowledge to be taken from more abstract reflection" (Jones, 1996, p.114). Dramatherapy aims to use embodiment to aid people in becoming more confident in using their body. A person who lacks control over their body and is struggling to communicate with others would most definitely benefit from using this type of Movement. It is also relevant as all of the therapies mentioned within this essay

comment on the mind and body relationship. It has previously been mentioned that the body directly responds to emotions and therefore this method of movement can relax a participant and put them more in tune with their bodies.

<u>STORIES</u>

Creating stories and storytelling are examples of other methods within Dramatherapy. Participants can occasionally relive their memories and past experiences through stories. These stories may not be delivered as stories in the stereotypical sense; with a clear structure rather than be performed as poetry or Play or tale. Using all of the categories within this paper, participants can use them to show and or tell their stories or create stories to help them understand their feelings and maladaptive thoughts. Dorothy Langley's *Introduction to Dramatherapy,* highlights the importance of using story making and storytelling. Langley references Gersie (1997) and her "Structures", which "contributed to the theoretical understanding of storymaking as dramatherapy" (Langley, 2006, p.96). The structures that Gersie proposed were the foundation of her work requiring her participants to "draw or tell or act out a six-part story" (Langley, 2006, p.97) the structure was as follows:

1. the landscape
2. the character
3. the dwelling place
4. the obstacle
5. the helpmate
6. the resolution. (Langley, 2006, p.96)

Further therapists used this structure and Casson (2004) decided to combine this with the works of Lahad (1992). Lahad asked his participants to create a storyboard using these stages, and Casson's participant reflected "I liked it when John and I did an exercise together with an imaginative story: and this [story] did me good and my mind was refreshed after I did it, but first nervous and surprised with myself" (Casson, 2004). Using this may be beneficial to a participant suffering from SAD for several reasons. Firstly, this can be used as an individual or group task. The need for verbal input is significantly less than other methods already mentioned. Individuals do not have to worry about how their personality is being reflected as this

is a story they are being asked to make up. It is from their imagination, which may seem more comfortable for a participant than talking about oneself, regardless of if the characters are reflecting themselves. Ann Dix (2015) ran a Dramatherapy workshop for boys who had witnessed domestic violence in the home and Bill Radmall (1997) for those with Anorexia. Ann Dix (2015) found that the boys she worked with although did not spend much time focusing on the relationships with their fathers, some of whom were in prison, were more interested with relationships with their mothers. Dix concluded that the boys stated that the workshops had made them feel the happiest they had felt in a long time, which demonstrates the effectiveness of working with storytelling. Within Radmalls' article, he discusses the story-making task that he set. "the group individually constructed a map of the personal passage they were currently making, showing the three stages of before, during and after" (Radmall, 1997, pp.2-4) Doing this task, was allowing the individuals participating to create a journey for themselves in the form of storytelling. Doing this task was described having "Heavy concentration" which resulted in one participant crying. The said participant used this task to associate the "monster" with her husband, which was said to feel very "freeing". It would seem that using story telling within Dramatherapy, has the ability to lift burdens from the participant, they can express freely in the creative side of story making and work to becoming happy and healthy again.

As mentioned previously, within Dramatherapy, the stories do not have to take a conventional structure, however Watts (1985 p.6) suggests that using traditional stories is in fact beneficial for its classic beginning, middle, and end. "The structure of the myth or old tale provides the safe passage, enabling us to negotiate rough seas, hear the siren's song, meet the three headed dog and return, safe, Sometimes stirred or even uncomfortable, but with the possibility of greater awareness." (Watts, 1985, p.6) Other benefits of using classic stories and tales within a Dramatherapy session are then listed by Crimmens (2006). Crimmens suggests that using these stories were beneficial for the therapist as it was an excellent source that was plentiful. There are not just multiple stories, but many of them can be related to the group or individual in question by some means or another and also a lot of stories are familiar due to the popularity of storytelling within education and so on. Crimmens further advises that using these stories will be more beneficial to those

who are younger not just developmentally but mentally also. For adolescents and adults, it is insinuated that the best way to use stories is to be devising them and allowing the participants to decide on content and structure. Crimmens work however is based on students within special education and therefore this may not be the case outside of these boundaries. Story making within Dramatherapy is an excellent source of creativity. Within storytelling, the involvement of all other aspects covered within this thesis can be incorporated and in most instances of Case studies have been in some way. The use of Roleplay, singing, imagery, acting, Improvisations and much more are deployed by Dramatherapists for the maximum potential a participant can reach with their story. The stories these individuals make can hold not just metaphorical meaning but direct and obvious and therefore it is necessary for the therapist to always be involved, watching and listening so that they can draw on the activity to explore the necessary feelings. Just like all the other exercises described, it is important that the Dramatherapist plans the session and story in conjunction with the group and does not push the participant/s to divulge any information too quickly.

THE THERAPIST

The importance of the Dramatherapist is evidently profound. The Dramatherapist leads the sessions, sets the boundaries, and organises the material to be used within the session. With all this responsibility, it is necessary that the Dramatherapist understands that they themselves must seek a source of therapy and creative outlet. When being a Dramatherapist, it is important to nourish the hunger for creativity. Jennings (1990) so accurately says "Dramatherapists need to remind themselves constantly that they are first and foremost creative artists within the theatre and drama art forms which include actor, director, scenic designer, and writer and that the art form is a constant renewal of creativity for the therapist as well as client" (p. 130). Therefore, consistently following the need for creativity is imprinted within: "An artist is an artist because they *have* to be" (Jennings, 1990, p.130).

Sue Jennings describes a training group she set up and the importance of it. Within this training group, Jennings asks participants to explore the scene "journey through a forest" from *A Midsummer Night's Dream,* as she believes that "The forest is a powerful symbol for therapeutic journeys; forests contain mysteries, darkness, hiding

places, shadows, creatures…Forests are places of encounter and change"
(Jennings, 1990, p.131). Jennings had her participants explore images of the forest,
for example the setting and the creatures that inhabit such a place. From this, the
participants chose a creature mentioned and began to develop them individually.
Jennings notes that "several groups emerged" (1990, p.131). These groups included
"Creatures of the earth, creatures on the earth, creatures of the air and of air and
water" (1990, p.131).

From this, masks were made, and characters were established. Following the
previous task, the group worked on the forest creating a set, with a waterfall and
trees and leaves. The group then focused on the relationships of the families that
lived around the forest, what they might think and feel if they were to run away to the
forest due to the difficulties at home. After this, they returned to exploring their
character within their forest. On the final day of the workshops, Jennings asks the
members to take down their forest and de-role from character, as it was "Important to
distance from the week's experience" (Jennings, 1990, p.133). During the
experience, Jennings had asked participants to keep a diary, and once the set had
been disbanded, the group were to read through the diaries as themselves. Jennings
noted that there was difficulty separating the group from their forest and characters,
and hence there were issues feeling connected to their ordinary self. Jennings
decided to bring in a small coffee table and ask the group to reconstruct the set out
of pipe cleaners, plaster and paint. Then again, it was asked to be built as a smaller
two- inch version. Jennings comments that the group were "Meticulous about detail
and wanted every feature re-created" (1990, p.133). The reasoning for this, which is
a perfect rationale for a Dramatherapist to take with them, is as stated "the enormity
of the week's experience needed some reduction to make it manageable so that we
could walk away from it" (1990, p.133). As a Dramatherapist, it is necessary that one
can be involved completely with a participants work and story, in fact the participant
needs this to be able to trust within the work, however, the Dramatherapist must be
able to then separate themselves from this work, from the role within and see what is
happening before them so they are able to continue to positively benefit the person
they are treating:

> Dramatherapy, like all other therapies, makes considerable demands upon
> the therapist who may become over-involved, overlook some important point,

or have undermining doubts about their own usefulness. It is difficult, if not impossible, at times to be objective about one's work and the opportunity to explore it regularly, in confidence, with an appropriate person is an invaluable and essential component of good practise (BADth, 1994, p.6).

Langley suggests it is important to have a co-therapist in the room whilst the therapy session takes place. It is confirmed how necessary this can be especially when dealing with a group. Langley gives the example of having a group therapy session made difficult by a specific individual struggling and needing attention or leaving the room during the session in a negative mood. If a co-therapist is present, this can be avoided, as there is someone able to help with individual needs whilst the group are focused on another task. It is further made clear that the role of the group facilitator should not be involved with an individual whilst working with a group. If an individual does need one on one help, that they have help from a co-therapist on hand for them. Langley comments on personal experience, "My time is limited by the number of sessions for which I am employed. If I spend too long with one individual, then the balance is disturbed and other groups may be affected" (Langley, 2006, p.193) Langley further makes an interesting statement that the role of Dramatherapist and Drama teacher are different yet do maintain some common ground. "Being a teacher implies the teaching of skills toward a certain standard and self-knowledge is secondary to the learning of those skills. Therapy employs the skills primarily for insight and the resolution of conflicts and has secondary benefits in personal growth" (Langley, 2006, p.190). Interestingly Langley quotes Brightwell (1979) "It is impossible to be both teacher and therapist to the same pupil. There is a need to define roles." Langley believes that to be a teacher is more theory based whilst the therapist is the physical doing and testing of the theory. "The Dramatherapist is the link between artist, therapist and the medium of drama" (Langley, 2006, p.199).

DANCE MOVEMENT THERAPY

Dance Movement Therapy (DMT), similarly to DT uses a variety of methods within its sessions. DMT can be defined as "The psychotherapeutic use of movement and dance through which a person can engage creatively in a process to further their emotional, cognitive, physical and social integration" (Cattanach, A, 1999).

There are many important aspects to a successful DMT session all of which are designed to promote this objective. As the dissertation is a comparative piece, the same methods of DT that were mentioned will be analysed, thus a more concise judgement can be made. Similar to CBT, DMT bases itself on the premise that the mind and body are linked:

> Schoop believes that who we are is reflected and manifested in our bodies. In addition, what happens in the mind has a concomitant reaction in the body and what happens in the body has a concomitant reaction in the mind. For this reason, postural attitudes and physical alignment are reflective of one's mental state. Furthermore, through the body and senses, one formulates a mental picture of reality (Schoop and Mitchell, 1974).

If this is accurate, it would seem that a person with SAD is having difficulty formulating this picture and subsequently needs DMT to work on their bodily response. Therefore, the following work will assess the benefit of using DMT as a form of treatment for SAD.

<u>Warm-up</u>

Using Helen Payne's *Creative movement and Dance in Groupwork,* a comparison of warm-up methods shall be examined in line with Sue Jennings DT warm-ups. Payne describes warm-up as "a starting-point and to integrate them as part of the overall programme which the clients are involved in" (Payne, 2003, p.69) which is underlining the importance of the beginning of the session which Jennings has also done. Payne describes 35 types of warm-up in her book and again these all have different aims and outcomes. Beginning with her breathing exercises, Payne describes "BREATH 1" where the group are lead to relax their bodies and allow their breath to "drift out slowly through the nose" As we can see from looking at CBT, DT and now DMT, working on breathing and relaxation is vital for the treatment of SAD because as the participant becomes more anxious and uncomfortable, remembering these breathing techniques will slow their physiological arousal and allow them to concentrate on calming the body down. DMT has its own variation of relaxation warm-ups, such as "Massage" (Payne 2003, p.97) that requires participants to sit or stand in a circle and massage the person in front. This warm-up is intimate and will begin the bonding experience of a group session. It shall further begin to release the tension in the body.

As mentioned in DT, the use of stretching is vital within a warm-up and that is no different within DMT. Of course, there is the element of stretching for the later physical activity, but furthermore "numerous studies have reported that aerobic exercise may be an effective treatment for depression" (Doyne *et al*.,1987, p.748).

As mentioned in DT, there are demonstrations of warm-ups to warm. Payne has her own interpretation of these types of warm-ups, one example being "CRAB FOOTBALL". Essentially this is played as a normal game of football following the same rules however within this exercise participants must be on "all fours, stomachs uppermost; only pass or shoot with feet". A game like this will not only have the benefit of physically warming the body, but it also involves teamwork and Play which all lend themselves well to the treatment of SAD. Within DMT, one of the warm-up games provided is the "NAMEGAME 3 (SILLY WALKS)" (2003, p.82). Within this game there are a number of things the participants must do, such as finding different partners, inventing three different ways of walking and learning each other's names. The primary aim of this game is to integrate the group members with each other and also acts as an effective tool in helping them learn names. All of this, including the name games within DT will be enhancing participant's social skills and aiding them with valuable 'authentic experiences' to utilise in the future. Within the given name learning warm-ups, "NAMEGAME 1" and "NAMEGAME 2" are both described. Although having similar structure, both the games have different aims and additional outcomes. In the first game, the aim is simple "to learn all names" whereas the outcomes are "1. Linking movements together. 2. Performing a movement phrase for others." And in the second game the aim is "to ground group in the present" and the outcome is "Recognise and learn the names of people in the group." Having clear aims and outcomes explained to the participants will set a clear goal for them and make the task more manageable than for example them having to keep going until every name is learnt.

Many of the warm-ups given such as "SHAKING OUT" work on the relationship between mind and body, and therefore the outcomes from such exercises are "The participants become aware of own bodies and their physical sensations" or in "STRETCH 1" the outcome is "Awareness of sensation and articulation in body." As

mentioned previously, all three therapies highlight the importance of the relationship between the mind and body; however, the foundation of DMT is built on this understanding. "Movement can stir the feelings just as feelings can stir and be reflected in movement" Payne, p.9). Within the DMT sessions there is always movement, however, what can be commonly categorised, as dance is not always the typical movement within the session. "Dance occurs through purposefully selected and controlled rhythmic movements; the resulting phenomenon is recognized as dance both by the performer and the observing members of a given group." (Kealinohomoku and Blacking, 1979 p.21). This is why it is important to understand it is Dance Movement Therapy rather than just dance, as the movement requires less understanding of dance structure and encourages more spontaneous movement and expression. This is necessary to the session and must be pointed out to participants, so they are aware that their dance ability is not being assessed. Unlike Jennings, Payne does not specify warm-ups integrated with feelings, rather states that, "The activities presented here will therefore need to be amended to relate to clients: specifically to their intellectual, spiritual, physical, and emotional developmental levels" (2003, p.69). In Payne's book, although there is not a great deal of warm-ups that are solely based on role or feelings, it does have a large portion dedicated to things such as rhythm, body control and balance. Regardless, the DMT warm-ups provided seem to put more prominence on rhythm. "RHYTHM 1" through to "RHYTHM 4" (pp.101-103) are all examples where practicing and repeating rhythms is going to be beneficial to the partaker. These warm-ups involve practice, such as everyone accompanying claps to the number of syllables in a member's name, followed by the "whole group copies the clapping of each name three times as participants clap their own names out around the circle" (2003, p.102). Further work on rhythm and balance will enable a participant to begin to attune to their bodies and also to focus within the space.

PLAY

Specifically concentrating on Ann Cattanach's *Process in Arts Therapies* we are able to see how Play can be used within DMT. DMT has been considered an effective tool for alleviating stress and tensions in many countries. Dance can come in many forms and is often referred to by dancers as a way of expressing innermost feelings

and as mentioned earlier in the Movement section within DT "a new language". Cattanach refers to one style of dance in another culture "trance dancing is felt to relax the tension for everyone in the community, not just those entering a trance" (Cattanach, 1999, p.156). Movement has been used in many different forms, from trance to stylized Dance; however, the final product can be summarised as a tool for calming its participant. Dance Movement Therapy in particular can also have educational and social performance enhancing features due to the therapeutic nature behind it. Within Cattanach's book, we are given a Case study of a child named Frank from DMT therapist Sara Bannerman-Haig. Frank is a young adolescent with severe development delay who attends a school for the 'Severe and Profound Learning Disabilities' (Cattanach, 1999, p.62). Frank shows similar symptoms to SAD, for example Frank has difficulty with social interaction. Frank has been referred to DMT classes that he has attended once a week in half an hour session for the past two years. During Frank's early DMT sessions you could see that he felt uncomfortable and unsure and therefore similar to Dramatherapy, the participant must have a consistently routine space to be in. "the space has to be large enough to accommodate free movement and expression and it needs to be safe" (Cattanach, 1999, p.163). Bannerman comments on how some of the movement Frank displayed could have been "an opportunity to work through important developmental movement stages at a later point in life" (Cattanach, 1999, p.166). This was commented after the observation of Frank "Playing and experimenting through the manipulation of his body" (Cattanach, 1999, p.166). If SAD is a trait that is learnt in the earlier stages, then using DMT, a participant can explore aspects of social interaction through movement to gain confidence at a later age. On top of the Play through the manipulation of the body, in the same way Dramatherapy has contained props such as the puppets described earlier, Bannerman has stated that numerous props such as "balloons", "bouncy ball", "elastic" and "percussion instruments" (Cattanach, 1999, p.167) were all at Franks disposal. Bannerman suggested that "the props gave Frank something he could communicate through and from this point onwards our relationship began to develop more" (Cattanach1999, p.166). This development within the therapist and participants relationship is key to the sessions progression and furthermore, the use of props acted as a buffer to the relationship which would be useful in a session tailored to SAD. Cattanach quotes Winnicott on the importance of Play:

> Playing implies trust…Playing involves the body…only in Playing is the child free to be creative…and it is only in being creative that the individual discovers the self-bound up with this is the fact that only in Playing is communication possible (Winnicott 1979, p.54 cited within Cattanach 1999, p.166).

More games between Frank and Bannerman are described, however one in particular mentioned is the use of Fabric in which Frank chose the fabric to begin playing with but after a short time of waving it in the air, Frank collected the fabric and decided he wanted to play a running game instead. Bannerman believes that this was a development for Frank and that the props were "a facilitating agent enabling Frank to initiate his own Play, in this case a running game" (Cattanach, 1999 p.168). Due to the freedom of Play Frank was allowed, the confidence in Frank was growing. "By the development of the relationship through DMT Frank was able to feel held, and integration of the ego could begin to take place. There was a development in his body awareness which enhances connections between body and mind, instilling confidence" (Cattanach, 1999, p.169). After one year of DMT, "Frank's movement Play began to demonstrate a clearer symbolic element to it" (P. 172). In this case it would seem that the games had effective results in terms of successful therapy, and therefore it could be used intentionally for a treatment of Anxiety, especially after long periods of time like this case when the client only becomes more comfortable and confident within the sessions. Play is now used as a source of therapy for all ages since therapists began to understand the benefit of using it. Many perceived Play to be specialised for children, however this has been challenged and is now accessible to all. "Winnicott moved the focus from the Play (as symbolic representation of the internal world of the child) to the experience of playing" (Ogden cited within Saragnano *et al*, 2015, p.24).

It is necessary that the therapist does not solely concentrate on the games being played and trying to find a subconscious meaning from this rather than to appreciate and work with the participant in their playing:

> Not only the contents of a game are important which so interest child analysts as communications about unconscious fantasies, but also the entire complex process by which a child or adult transforms unconscious contents, brings them to fruition, renders them digestible and makes them partially or wholly conscious (Winnicott, 1979, p.50).

Ferro (1999, p.272) also underlines this aspect, maintaining that the child and the adult construct something new and that they invent new meanings when playing together, and that it is the presence of the other that is the matrix of creativity. (Saragnano *al*, 2015, p.35). Bion found that when treating a group suffering from Neurosis, a broader version of Anxiety, showing symptoms of depression, obsessive behaviour and hypochondria, that even though this psychological impairment is stereotypical to make a person introverted, "there was a readiness, and at times an eagerness, to discuss both in public and in private the social implications of personality problems" (Bion, 1978, p.24). Bion considered this and concluded that "perhaps this is because he is seldom put in an environment in which *every* member is on the same footing as regards interpersonal relationships" (Bion, 1978, p.25).

IMPROVISATION

Similarly, to using dance and movement when improvising for DT, DMT does the same. DMT requires participants to be involved with improvising not just dances and movement sequences to music, but when mirroring with partners in warm-up games and creating images through the body. Payne analyses that "movement can be classified into three types: functional or instrumental, quantitative; and qualitative" (Payne, 2003, p.28). Functional is described as being like picking up a cup, quantitative, running fast in sport and qualitative being the expression of moods. Not all clients will feel comfortable or even know how to create a sequence of moves and especially when working with anxious participants, the last thing to do is expect them to create a routine. Therefore, Payne suggests that "it may be possible for them to improvise, then select and link movements together" (Payne, 2003, p.29). Another example of Improvisation Payne explains is "a jumping dance" (2003, p.30). This can begin by the group doing many different types of jumping. "The group can be guided to improvise, then select some favourites or non-favourites to organise and master" (2003, p.30). Doing this exercise is valuable because Payne underlines that the jumps chosen could reflect their mood. "Their range may be extensive or restrictive" (2003, p.30). Payne also states, "Creative dance Improvisations and unconscious free associational movements are fundamental to this form of therapy, whether it takes place individually or in groups" (2003, p.8). As described further, the

movements often result from "self-initiated movements which arise out of interactions, feeling and opportunities" (Payne, 2003, p.9). Similar to the other techniques used within a session, the structure is no different. The leader will allow the participants more control as the sessions develop but in the early stages, the amount of Improvisation and the material that sources the Improvisation will be chosen specifically.

ROLEPLAY

Dance Movement Therapy also uses role and Roleplay as a part of the therapy. Looking at research from both Dramatherapy and Dance Movement Therapy it is evident immediately that there is more research for role and Roleplay within Dramatherapy. However, this could be due to the later development of the therapy in the United Kingdom. Within Payne's work, *Creative Movement and Dance in Groupwork* it is easy to find examples of exercises' and tasks that requires forms of role and Roleplay. Pages 182-183 both contain instances where the development of theme has required Roleplay. "Quality 11" is the name of the first exercise and this asks participants to pretend and imagine they are entering the circle "walking on eggshells" in "Quality 12" the participant is to imagine they are the water in a waterfall, they can decide the speed and force of the water however they adapt speed after time. Roleplay is not an example of the individuals taking on characters, rather than using their personal experience and memories to form the role.
The benefit of using role within this form of therapy is not different to DT. The participant is able to develop new skills in performance and furthermore there is the possibility that they find it easier to display their concerns through this form.

MOVEMENT

Dance Movement Therapy uses multiple forms of movement to create its therapy. These forms include running, jumping, stillness, and breathing and of course dance. There are many other forms that this therapy takes however all have the same goals. "Dance movement therapy is concerned with personal growth through body-mind interaction, and expression. It is based upon the essential belief that one's movement expression reflects one psychic state" (Cattanach, 1999, p.157). There are multiple things that a therapist must plan for when organising a session and that

applies to Dramatherapy as well. However, in this therapy as movement is the main source of communication, it is necessary to remember the following factor: "The dance movement therapist works very much to on a body level he/she must be particularly aware of the delicate and sensitive issues of touch and physical contact, and provide adequate 'holding' and 'handling' in the physical sense as well as the emotional sense" (Cattanach, 1999, p.161). A reason that using movement can be better than verbal tasks is that it allows us to demonstrate memories we may find hard to articulate.

"DMT, which concerns itself with bodily relationships, has the ability to connect with past bodily memories in order to work through these primitive body experiences" (Payne, 2003, p.104). A person with SAD may be able to re-experience a memory of unease, and work through these bodily memories for example their breath control and or stiffness, and therefore alleviate future tension. It is mentioned that the body can remember specific tightness and positions, and that this can be explored with a Dance Movement Therapist to alleviate these pressures:

> Symbolism and the use of the body as metaphor are fundamental to the approach. It embraces elements from dance, which include rhythm, space, and energy. Creative movement (based on Laban's principles), rather than prescribed steps, is the basis of the approach, although task orientated or developmental movement approaches are also utilized depending on the population (Payne, 2003, p.42).

From this, we can see that the movement allows the participant to live within the present; their mind is focused on moving their body to tell their story or show their thought process. The use of movement is the tool for those who suffer with communicating verbally and in terms of DMT; this movement is a direct example of their Psyche. "The dance therapist places special emphasis on encouraging dramatic movement metaphors that express the hidden and symbolic aspects of the self" (Levy, *et al*, 1995 p.3). It is important that the therapists learn not to assume all movement maintains a representation of feeling as this can be criticised as being based off of their own experience. It is more important to view the quality of movement in regard to having therapeutic impact. From looking at the way in which movement can be used as treatment, it can easily be aligned with having strengths and weaknesses for treating Anxiety. Anxiety can leave a person's body feeling very

tense and stiff and this therapy can work through this and help a person to become more relaxed. As a person who struggles with social skills stereotypically, Dance Movement Therapy may be useful as it is considered a pre-verbal therapy.

STORIES

DMT also thrives off the use of story making/telling. It is not hard to imagine a person dancing as a way of telling their story, however, in DMT; it is not just about the dance. Mollie Davies (2003), has researched Dance and Movement in early childhood, and has emphasised the use of story as a stimuli and basis for child's dance and movement sequences:

> In relation to effective learning at the Foundation Stage the guidelines propose:
> - Offering a range of stimuli for movement, such as action rhymes, stories, music and props (Davies, 2003, p.183).

Another example where DMT has actively chosen to use story making and telling as a method in their sessions is discussed within Lee, *et al's,* (2013) Case study Dance/movement therapy for children suffering from earthquake trauma in Taiwan. Within this Case study, the participants were required to create movement in groups of four that represented certain themes from the disaster. They were then asked to put these together forming a story. Within this example, the participants were able to use other sources including puppets, and fabric to help with the creative and sharing process. "After the children played with the stretch fabric, we discovered that their movement and interaction effortlessly unlocked their creativity and imagination" (Lee, 2013, p.153).

Using story within DMT again seems beneficiary to helping the healing process. Shim*, et al* (2017) reports another Case study where they used Dance Movement Therapy for people with chronic pain. In this Case study each session had a different theme and within Week 3 the theme was creating a story about their pain. The objective of this lesson was "Choreographing and performing a movement-based narrative" (Shim, *et al,* 2017).

> Many participants mentioned the experience of creating and performing the movement-based narratives as a way of achieving an autobiographical integration. Participants were able to place their pain experience in the context of their overall life trajectory, which helped them to experience a sense of acceptance and a comprehensive perspective on life as well as a positive outlook for the future (Shim, 2017, p.33).

Although in many cases the Case studies within Dance Movement Therapy have not been directly linked with Anxiety, the results and conclusions can be affiliated to this research. The exploration of theme that story telling can do within a session is beneficial to multiple types of participant not just those suffering from Anxiety.

THE THERAPIST

Dance Movement Therapy only became recognised as a method for rehabilitation in the United Kingdom in the 1940s:

> By the 1940's a definite dance therapy movement had begun, paralleling that in the US. However, dance therapy at that time was seen as distinct from psychotherapy and it was not until the 1970s that a second wave of DMT pioneers began to experiment with the psychotherapeutic applications of dance and movement (Meekums, 2002, p.8).

It is possible that this contributes to the current difficulties in training to become a Dance Movement Therapist. Universities that offer this training programme as a full-time course are limited to just The University of Hertfordshire however over places such as Roehampton offer similar alternatives. Other difficulties for Dance Movement Therapy that arise that have been discussed in the "16th International Panel of the American Dance Therapy Association" (Capello, 2011). These difficulties include Dance Movement Therapy being predominantly used by females. Interestingly in countries such as Japan and South Korea, the field being majority feminine was not the case. In fact they found the sessions were mostly run by males and that male participants found this to be more comforting, however the conclusion behind this was that in these countries, the males are usually in higher power situations and expected to be working to earn money for families whilst the women took care of their families. Apart from these two countries, out of the others, the majority found that female Dance Movement Therapists relatively outnumbered them. This was not something that was as emphasised in the research about Dramatherapy.

At another panel, Dance Movement Therapists were asked what led them to this profession and of all the results, in particular France's Corinne Ott response stood out to this research: "Ultimately, she believes her commitment to the work is based on the potential for personal growth, her desire to obtain unique tools to guide others, and to experience the daily joy of dance" (Capello, 2014).

A limitation of being a Dance Movement Therapist currently is highlighted below: "Dance/movement therapy (DMT[1]) is hardly an emerging discipline, but issues of professional identity still loom large over its practitioners, and are highly relevant to professional development, training programmes, types of supervision, processing of session, and choice of personal therapy" (Vulcan, 2013). Even though this form of therapy is becoming more esteemed, it is a slow process and still has not been fully recognised for its benefit within the therapeutic field. Emphasised during the 2011 panel mentioned above, Germany's Schankula reported from working in a hospital that "staff members who had a personal background of physical activity (sports, running, ice skating, skiing, climbing) seemed to acknowledge the value of dance/movement therapy and support his work more positively than those who did not" (Capello, 2011). It would seem that if a person were not aware of the positive effects evoked by physical exercise, they could not value this as a valuable therapeutic method. "He also reported that some psychiatrists felt that nonverbal therapies, in general, may evoke fear and that the physicality related to dance/movement therapy may be "too much for patients at the beginning of treatment" (Capello, 2011).

A role of the therapist within DMT has been discussed at length within the panels mentioned above. However, a study that has impacted this research paper was the 'Focusing on Positive Affect in Dance/Movement Therapy'. Within this research, the study focused on using positive affect within the movement therapy rather than negative effect:

> This qualitative study investigated how a small sample ($n = 3$) of dance/movement therapists consciously attended to and employed interventions to address positive affect within adult dance/movement therapy (DMT) groups" (Gordon, 2014, p.60).

Through exercising techniques in positive effects participants relayed that:

These effects spanned the physical, emotional, cognitive, and social realms. They included smiling, laughing, experiencing their body as a resource, and feeling hopeful, pleasure, grateful, accepted, strong, and relaxed but alert" (Gordon, 2014, p.68).

It would seem that in this scenario the role of the therapist was ensuring positive behaviour and reaction to the work, which seemed to overall benefit the participant.

COMPARISONS

Beginning with the research from warm-up there was an early indication that these therapies have multiple similarities in their methods. Both therapies warm-ups employed the use of games and team building exercises. From the research it seemed that both therapies also covered similar areas of warm-up regarding relaxation and breathing, as this was significant to both their sessions. They had versions of warm-ups to warm which again highlighted different potential outcomes both directly and indirectly valuable. The structure of the sessions also consisted of similarities. The sessions both required a warm-up, an introduction to theme, a main body, and a cool down/reflection. This structure is mirrored within CBT also. This structure is so paramount to the therapies because as discovered, the importance of routine and structure is crucial to a tailoring the session to SAD.

Play has such a larger role within these therapies than first realised. Play has so much research and interest in it that it created its own form of therapy. There are so many aspects to using Play that must be considered for example the Play shift, the environment, and the Play atmosphere. Play has cultural considerations that must be recognised, for what one may observe as Play, another may not. The Play atmosphere is something that must be addressed early in the sessions to make sure that no boundaries are crossed too early on. Play has been adapted to being accessible for all ages and using Play within therapy makes DT and DMT more interesting:

> While using a particular arts medium in therapy, Dosamantes-Beaudry (1997) indicated that the various mediums all share an arts-based process approach to healing that encompasses the following steps: (a) facilitate the conditions that help to promote the emergence of creative "potential space"; (b) encourage clients to regress and to become immersed in the creation of

illusion making, pretend playing, and the novel manipulation of objects, symbols, and metaphors that they derive from their own experiences and imaginations; (c) help clients work through the various meanings contained in their symbolic and expressive behaviour (Lee, 2013, p.156).

From the research, I would postulate that is one of the most beneficial parts of the therapy sessions. Improvisation can demonstrate to participants, the skills of holding spontaneous conversation, how to implement reasonable judgement and understanding of a situation and once again give the authentic experience that it is suggested that participants require in order to learn. Improvisation like Roleplay allows the participant to become something else and doing so allows them to observe and empathise with their feelings. Furthermore, Improvisation means they can think spontaneously and have a degree of freedom of thought that they previously did not have. Although the exposure technique within CBT has a level of spontaneity, it could be presumed that the emphasis on improvising is not priority. From the facts stated about SAD and the successful traits of CBT, it is fair to suggest that practising social situations and social cues will be the most beneficial in treatment which is evidenced in CCBT.

All the mentioned therapy sessions can be delivered as solo therapy and group therapy. Although there are extensive positive attributes to the delivery in a group session, especially for treating a social disorder, one Case study from DMT, found:

> At times, they had found it difficult to be attentive to other group members or to themselves during the interaction. Pair work, sharing experiences verbally, and telling about one-self in the context of the present experiences was difficult especially at the beginning of the DMT process. It was particularly burdensome to speak about what one perceived in the body and how one felt in the body. Finding and creating one's own movement were felt at times to be difficult (Pylvänäinen, 2018, p.42).

 As stated, this is a relatively new form of therapy and therefore people who have SAD will struggle with the consistent work on the mind and body relationship, and how to understand it as theirs is under acknowledged.

The role of the therapist makes clear that the participants require the therapist to join in and demonstrate what is required of them. The leadership that the therapist begins with is altered over time and the more trust within the relationship, the more control the participant begins to feel they have, and this is unique to these therapies.

Both therapies have many methods that could arguably be the most important. Many of these methods are demonstrated within each therapy. This therefore suggests that the therapies could be used interchangeably as they do not differ so much. It has supported the preconception that DMT focuses more so on movement than DT; however, DT does still highlight the importance of movement. This is also mirrored with Roleplay. Interestingly these therapies yield similar structure and conclusion; however, there is more research and evidence surrounding DT.

CONCLUSION

Regarding CBT, Heimberg and Becker commented that "in a sense, the group becomes a theatre in which feared situations are dramatically enacted, starting with situations of moderate difficulty" (2002, p.131). This quote highlights the similarity that CBT has to DT and DMT. If we follow the three main steps of CBT and put them in place to structure a DT and DMT session, there ultimately could be a better solution to the treatment of SAD. For example, the goal of cognitive restructuring is "to help patients view the world in a less biased, more accurate way so that they do not see danger lurking in every corner of the social world" (Hope p.40, 2004). Using movement within Roleplay or story telling could allow participants to enact their fears about the social world, and then this can be discussed with other group members and with the therapist to highlight the irrational thoughts and phobias, and then there could be a Roleplay session involving working on a new way of thinking and behaving. There are techniques learnt within the warm-ups of the proposed therapies such as breathing and relaxation techniques that are also taught within CBT. This again can be viewed as a similarity of technique. The "in-session exposure" is attributed to the group setting as this alone is a social encounter which will initially cause fear. Exposing these groups to feared situations within the parameters of a therapy session will enable the participants to find a preferred method of handling them before real life experiences concur.

There is plenty of research to suggest that art therapies can reduce mental health disorders such as Anxiety, depression, PTSD. However, from this research I can see that a lot of the methods involved would be easier accessible to a younger audience if the sessions were delivered in a school setting. This conclusion is made because

both therapies have argued the importance of a safe and constant space, regular meetings, and a group that you are comfortable with. Furthermore, many of the Case studies have been concluded from children and they seem to be efficacious when treating this age range. If these therapies were to be administered when a child begins high school and implemented within their school routine, there could be significantly less amounts of mental health disorders prevailing within adults. Furthermore, the therapies have a more fun element within them, making them suitable to be added to a school curriculum. If SAD does begin from an earlier age, then using these therapies as a person develops could be more beneficial. It will deliver important guidance and advice on handling stressful situations and experiences and ultimately this will aid them in the future with social events such as job interviews and meetings. I believe that CBT could also be administered from a young age; however, I would stand by the premise that delivering DT and DMT within the structure of A CBT session may be more beneficial. I conclude this as it is possible that children may struggle to verbally articulate their experiences appropriately, whereas they may find it easier to demonstrate through other mediums like the children in previously mentioned Case studies such as Frank.

If a person is diagnosed with SAD and requires treatment well into their adulthood, I believe that the current treatments are going to be more beneficial. Not all people especially with SAD are going to be willing and able to fully involve themselves within these types of therapy sessions, especially if they have no interest or willingness to take part in something labelled as Drama and Dance.

It is plausible that combining DT and DMT with medication could be very advantageous as it means that the initial symptoms and fears are kept minimal by the fast-acting nature of the medication, and then eventually the dosage could be changed as the benefits of DT and DMT are reaped. Consequently, a person is gaining important skills from a more social version of therapy and will have longer lasting effects.

Overall I set out to test the hypothesis that DT and DMT would lend itself particularly well to treating SAD and that they would be better than the current prescribed treatment of medication and CBT. From the research, we can see that this has been considered, and that there are many aspects within these therapies that are tailored

to encouraging social interventions, and practise of Anxiety management. There has not been enough substantial research to prove that combining therapy forms would be successful, however there is definitely room to research this further as it would seem very probable and research does lend itself to this hypothesis.

From what we know of CBT, I cannot draw the conclusion that DT and DMT are better in terms of treatment for SAD, however we can see that there are many similar traits and beliefs within these therapies that interchangeable ideas and methods are not deemed as surprising. In the future, it would be interesting to see if administering these forms of therapy in earlier stages of life as mentioned before would have any influence over the amounts of mental health disorders diagnosed, however as of present, this is difficult to say.

Reflecting on this work, and assigning it to the present, it is clear to see we are in a time where mental health disorders are only becoming more prominent, there is no reason why DT and DMT are not made more accessible. These therapies can be administered in a group setting which will enable participants to not only be seen in bulk, meaning more treatment, but the participants can now understand that they are not alone in their disorder, which can be quite lonely. This kind of treatment can be located in workplaces or educational settings due to the versatility of the treatment and therefore employing the therapies into accessible settings means we could see a positive improvement on the mental health of our communities.

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Appendix

A List of Warm-up's from Helen Payne's *Movement and Dance in Groupwork.* Referenced Page: 16.

1. *CRAB FOOTBALL*
2. *BODY SENSATION 1*
3. *BODY SENSATION 2*
4. *BALANCE 1*
5. *BALANCE 2*
6. *LOCOMOTION 1*
7. *LOCOMOTION 2*
8. *LOCOMOTION 3*
9. *BODY BOUNDARY 1*
10. *NAME GAME 1*
11. *NAME GAME 2*
12. *NAME GAME 3 (Silly Walks)*
13. *SHAKING OUT*
14. *BODY CONTROL 1*
15. *BODY CONTROL 2*
16. *FLOOR PATTERN 1*
17. *FLOOR PATTERN 2*
18. *LEVEL 1*
19. *VOCAL*
20. *BREATHE 1*
21. *BREATHE 2*
22. *BREATHE 3*
23. *BREATHE 4*
24. *GENERAL SPACE*

25. *STRETCH 1*

26. *STRETCH 2*

27. *MASSAGE*

28. *RELATIONSHIP 1*

29. *RELATIONSHIP 2*

30. *PERSONAL SPACE 1*

31. *RHYTHYM 1*

32. *RHYTHYM 2*

33. *RHYTHYM 3*

34. *RHYTHYM 4*

35. *BODY CONTROL 3*