

RESPONSE-BASED DRAMA THERAPY: A VIABLE OPTION FOR YOUTH
EXPERIENCING ANXIETY

A Thesis Submitted

By

Laura E. Brown

Bachelor of Arts, University of British Columbia

Kim R. Sholinder

Bachelor of Education, University of British Columbia

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We accept this thesis as conforming to the required standard.

John Gawthrop, M. A., Advisor

Dr. Allan Wade, Ph.D., Senior Faculty

Date Approved

Date Approved

Abstract

This project outlines the motivation for and creation of an eight-week response-based drama therapy group for youth experiencing anxiety, as the predominant treatment modality presented

in community based mental health settings is CBT-based. The manualized group as presented throughout the group design was well received by the adolescent participants. While the authors consider the benefits to utilizing a response-based approach with drama therapy techniques, they further outline recommendations and limitations of using a manualized group such as this.

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The inspiration for this project is a response to the response-based community and ideas. Not only have we been motivated to create a manualized group for youth based on these ideas, we also plan to engage with them in our professional practice as counsellors.

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Chapter One: Introduction

In the field of counselling psychology, the dominant body of empirical research maintains that cognitive behavioural therapy (CBT) is the best way to treat the symptoms of what the American Psychiatric Association (APA) refers to in the Diagnostic and Statistical Manual, 5th ed. (DSM-5) as “anxiety disorders” (Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; Linden, Zutraegel, & Baer, 2003; Peris et al., 2015). However, despite the widespread empirical studies by researchers promoting this perspective, recent research shows that at least one third of anxious youth who participate in empirical studies for the use of CBT do not respond positively to treatment (Hudson et al., 2013; Miller, Short, Garland, & Clark, 2010; Podell et al., 2013). While CBT has maintained a reputation for being a “silver bullet” for diminishing people’s emotional distress, researchers have recently affirmed that its effectiveness may actually be dwindling as a viable therapeutic modality (Johnsen & Friborg, 2015). This indicates that further research surrounding other treatment options for youth experiencing anxiety is needed, as CBT is the predominant method of treatment presented in some community-based mental health settings, as cited in the following literature review.

Response-based practice (Wade, 1997) is a set of ideas that an increasing number of helping professionals have put to use across diverse contexts (e.g., Bonnah, 2008; Weaver, Samantaraya, & Todd, 2005; Yuen, 2007). Whereas CBT maintains the deterministic assumption that there exists a causative relationship between thoughts, behaviours, and emotions (Padesky & Greenberger, 1995), response-based practice assumes that people’s experiences of distress are responses to, and resistance against adversity (Coates, Todd, & Wade, 2003; Wade, 1997). A response-based perspective on an emotional experience like anxiety stands in stark contrast to that of CBT, which supports the bias expressed in the DSM-5, positioning anxiety (and a host of other emotional experiences) as problematic and pathological, and therefore in need of a cure. Rather than regarding anxiety as an emotional “problem” caused by irrational beliefs, a response-based practitioner is interested in the contextual elements people respond to with feelings like anxiety. These contextual elements include adverse experiences themselves, a person’s own responses to the adversity, and the social responses the person receives to both the event and their own responses (Richardson & Wade, 2010). This approach lends validation to people’s knowledge and understandings, helping them “experience themselves as stronger, more insightful, and more capable of responding effectively to the difficulties that occasioned therapy” (Wade, 1997, p. 24). In this way, a response-based approach to therapy can help to diminish a client’s experience of anxiety and other forms of distress.

For the purposes of this project, we have used the term “drama therapy” to encompass the use of dramatic techniques within a therapeutic setting with adolescents. In order to better identify the strategies employed within our group model, it should be noted that there are distinct differences between drama therapy and psychodrama: another therapeutic modality that draws on theatrical principles. Langley (1998) notes that drama therapy involves the use of drama or theatre techniques as a specific intervention to support and bring about change in participants, whereas psychodrama is group therapy using theatre techniques and terminology to bring about change. Although these differences seem subtle, psychodrama has a more distinct structure and a specific set of tools to use within the group framework (Langley, 1998). Drama therapy on the other

hand provides a more fluid and flexible structure through which to utilize dramatic technique to facilitate dialogue and change (Weber & Haen, 2005). Although techniques from both models have been used throughout the group design, we took a primarily drama therapy approach, in that additional dramatic techniques were employed without the predominant use of theatrical language.

Government funded mental health agencies often maintain lengthy waitlists because of high levels of community demand and small numbers of staff on clinical teams. For this reason, group therapy modalities, such as drama therapy, are often preferred within these contexts, as they offer a significantly greater rate of service than individual therapy. Saanich Child and Youth Mental Health (CYMH) in Victoria, BC is one such agency. Not unlike the community-based mental health organizations described above, CYMH uses the principles of CBT almost exclusively in its programming for children and youth. This is evidenced by the “toolkit” provided on the agency’s website outlining the many CBT programs and online resources offered to their clients and their families (Welcome to CYMH, n.d.). Having acknowledged the agency need for interventions based on theories outside of CBT, we posited that a program that employs elements of both response-based practice and drama therapy could offer youth experiencing anxiety a creative and progressive alternative to what is more widely available.

We hypothesized that the use of response-based language in a drama therapy framework would help adolescents understand their anxiety in ways that are supportive of them experiencing less distress. Specifically, by engaging in drama-based activities that elucidate the contextual factors the youth are responding to with anxious feelings, we anticipated that they would gain new insights that validate their emotional responses and contest the notion that anxiety is the result of irrational beliefs, which require cognitive and behavioural restructuring to change. The overall goal of our response-based drama therapy group was to provide alternative ways of treating anxiety within a community mental health setting. Our hope was to promote and encourage the use of expressive arts therapies with a response-based orientation, and to create a manualized version of the group that can be run by other clinicians who may not be as familiar with these models of therapy.

The group was designed using response-based language, which served to validate anxious feelings and acknowledge the many creative ways in which youth deal with situations in which they feel anxious. The drama therapy elements of the group offered dramatic activities to facilitate the enactment of these moments, while contesting the pathologizing of the youth, and identifying new and existing responses that may be helpful to address these anxious feelings in similar contexts in the future.

The purpose of the project at hand was not to assess whether the group effectively addressed and decreased adolescents’ feelings of anxiety. Rather, it outlines and explicates the creation of a response-based group within a community mental health agency, thereby providing changes in available anxiety treatment programming for youth in the community of Victoria, BC. We will discuss the ways we underwent the approval process and subsequent client recruitment process within the community mental health setting in the ethics section of this document.

As a means of better understanding the current needs for research on a group design such as this, we conducted a thorough literature review. Within this review, we considered existing research on adolescent anxiety and common treatment options. Further, we explored recent research on the design of group therapy models, as well as alternative treatment options to evidence-based

practices, such as Response-Based Practice and Drama Therapy.

Chapter Two: Literature Review

Significant numbers of today's youth have been diagnosed with anxiety disorders, with reported rates as high as 10-20% in both primary care settings and the general population (Podell et al., 2013). Some researchers suggest that remission rates for youth who do not receive treatment for such disorders are low, and that youth diagnosed with an anxiety disorder are at a higher risk for problems in adulthood, including ongoing experiences of depression and substance use (Podell et al., 2013). Given these findings, ongoing research is focused on how remission rates for youth diagnosed with anxiety disorders are influenced by various therapeutic approaches.

Considering the ease of conducting empirical evaluations of evidence-based counselling approaches, the majority of this research has consisted of measuring the effectiveness of CBT (Kendall et al., 2008; Peris et al., 2015; Karatas & Cokcakan, 2009). For instance, of the fifteen studies that we reviewed, thirteen measured the effectiveness of CBT in promoting relief from anxiety symptoms in youth (Cartwright-Hatton et al., 2004; Chamberlain & Norton, 2013; Flannery-Schroeder & Kendall, 2000; Huberty, 2012; Hudson et al., 2013; Johnson, 2010; Johnsen & Friborg, 2015; Jónsson et al., 2015; Karatas & Cokcakan, 2009; Kendall et al., 2008; Linden, Zubaegel, & Baer, 2003; Miller et al., 2010; Peris et al., 2015; Podell et al., 2013; Seligman & Ollendick, 2011). A great number of these studies also focused on the use of CBT in group counselling for youth diagnosed with anxiety. Research suggests that the long-term efficacy of the use of CBT for youth diagnosed with anxiety disorders is limited (Podell et al., 2013).

As previously mentioned, CBT is the predominant therapeutic modality evaluated for youth diagnosed with anxiety disorders, and this is consistent when reviewing the literature surrounding therapeutic groups to address anxiety (Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008; Flannery-Schroeder & Kendall, 2000). Empirical data assessing the efficacy of alternative therapies for use with adolescents, such as narrative or solution-focused therapy, are limited, and in the few situations these topics are reviewed, the therapeutic techniques are often used in conjunction with cognitive behavioural strategies (McGuinty, Armstrong, Nelson, J., & Sheeler, 2012; Bond, Woods, Humphrey, Symes, & Green, 2013; Karatas & Cokcakan, 2009). In an overall search of current literature on adolescent groups addressing anxiety, CBT continues to dominate the search results (Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; Kendall et al., 2008). Therefore, we expanded our literature review to include available research evaluating the use of adult group treatment, and treatment of adolescent co-morbid anxiety/depression resulting in self-harm, both of which highlighted further empirical data surrounding evidence-based methodologies, such as CBT, and dialectical behavioural therapy (DBT) (Johnson, 2010; Ingen & Novicki, 2009; Wood, Trainer, Rothwell, Moore, & Harrington, 2001).

Further, we noticed a significant lack of research on the use of other therapeutic modalities for youth experiencing anxiety. Specifically, we were not able to find any research that looked at the effectiveness of using response-based practice with youth experiencing anxiety. Considering the heavy focus on CBT and limited research on other potentially helpful therapeutic approaches, we see a need for the development and evaluation of other therapeutic modalities with youth who

have been diagnosed with anxiety disorders. Because of the current lack of research and development, we propose the use of drama therapy techniques within a response-based, group therapy framework for youth experiencing anxiety.

Anxiety

As Stone (2010) aptly put it, “Anxiety goes back to our very beginnings” (p.3). Few would argue against the notion that anxiety is very much a part of the human condition, spanning both time and culture. It has been the subject of philosophical exploration since time immemorial, and a focal point for contemporary scientists and researchers across disciplines (Stein, Hollander, & Rothbaum, 2010). However, it was not until the dawn of modern psychology that the notion of “anxiety disorders” came to be (Stein, Hollander, & Rothbaum, 2010; Stone, 2010).

Although anxiety has been part of the human experience for all of recorded history, it did not appear in medical documents in reference to mental illness until the early 18th century (Stone, 2010). While the fields of psychology and psychiatry as we know them today had not yet come to be, there was nevertheless a distinction being made between so-called “normal” states of distress in relation to life events, and “extreme” or “excessive” responses to adverse experiences (Stone, 2010). Conceptualizations of anxiety at this time focused more around somatic symptoms, causes, and cures, until the dawn of psychiatry in the early 19th century, which positioned anxiety as a sickness of the mind (Stone, 2010). From there, anxiety was regarded less and less as a symptom of other mental illnesses, and more as its own class of pathology (Stone, 2010).

The dominant perspective of contemporary psychology and psychiatry today maintains 12 distinct anxiety disorders, which include Separation Anxiety Disorder, Selective Mutism, Specific Phobia, Social Anxiety Disorder (Social Phobia), Panic Disorder, Panic Attack Specifier, Agoraphobia, Generalized Anxiety Disorder, Substance/Medication-Induced Anxiety Disorder, Anxiety Disorder Due to Another Medical Condition, Other Specified Anxiety Disorder, and Unspecified Anxiety Disorder (American Psychiatric Association, 2013). A fundamental assumption of all 12 of these disorders is that the person with the diagnosis is responding unreasonably and therefore pathologically, to some aspect of her/his life. Although this is the dominant discourse of the helping professions and popular culture, critiques of this perspective abound. For example, Ussher (2013) remarks how the DSM has historically been used as a technology for pathologizing femininity, with its implicit bias against emotionality. She outlines how the DSM implicitly privileges experiences and responses that align with characteristics of masculinity (such as a stoic or “non-emotional” disposition), at the expense of women. LaFrance and McKenzie-Mohr (2013) critique the biomedical foundation of the DSM’s conceptualization of people’s distress, acknowledging that while it has its appeal as a legitimizing authority for the problems people experience in their lives, it inevitably positions people as pathological and in need of fixing, rather than looking at context and circumstance. Cosgrove and Wheeler (2013) draw attention to the distinct relationship between the pharmaceutical industry and the field of psychiatry, and remark on how the invention and conceptualization of mental health disorders like anxiety benefits the industry, which in turn funnels huge amounts of money into the pockets of gatekeepers who hold authority in the psychiatric field. All of these critiques call to question the legitimacy of pathologizing human emotional distress, which includes people’s experiences of anxiety.

According to the Mental Health Commission of Canada (MHCC) (2015), between 2011 and 2012 11.6% of Canadian adults reported that they were presently experiencing an anxiety or mood disorder, and had received a professional diagnosis of such. Furthermore, the MHCC stated that in Canadian youth, this number is 4.4% lower, resting at 7%. To put this in perspective, the incidence of diagnosed anxiety disorders compare to asthma at 11.1%, obesity at 29.4%, diabetes at 0.5%, and hospitalized injuries at 18.1% (Public Health Agency of Canada, 2011). Given these figures, although anxiety disorders are certainly not on the high end of the disease spectrum, there are a significant number of Canadian youth who carry such diagnoses. Given that 7% of Canadian youth receive diagnoses of anxiety disorders, it is relevant to consider what it is that youth are anxious about. Many children and youth experience anxiety in situations in which they are required to perform, receive evaluation, or when they anticipate being judged (Kearney, 2005). To an outside observer, this may look like shyness, social withdrawal, or introversion (Kearney, 2005). It is for this reason that group and exposure therapies with a CBT basis are regarded as “best practice” within the realm of treating youth experiencing anxiety (Huberty, 2012; Jónsson, H., Thastum, Arendt, & Juul-Sørensen, 2015; Kearney, 2005). A more in-depth description and discussion of those methods will follow in the proceeding sections.

CBT Research

The medicalization of anxiety has proliferated a broad range of treatment options intended to diminish its prevalence for those experiencing it in “excessive” ways. In the present day, the most widely favored of these treatment options are evidence-based talk therapy modalities stemming from cognitive behavioural roots (Martin, 2011), and anti-anxiety pharmaceutical medications. The following is an overview of the research found on the efficacy of using evidence based therapeutic approaches with youth diagnosed with anxiety disorders. While current empirical research supports the use of CBT in the treatment of anxiety disorders in youth (Podell et al., 2013; Peris et al., 2014), it should be noted that at least one third of youth participants do not respond to treatment (Podell et al., 2013). Given these findings, researchers are interested to learn what potential factors influence the efficacy of CBT (Podell et al., 2013). Podell et al. (2013) sought to determine how therapist variability influences the outcomes in CBT with children. These researchers used the data collected from a multi-site treatment study to assess how a therapist’s level of competence in delivering CBT and maintaining the integrity of treatment correlated with outcome rates. The participants in this study ranged in age from 7-17 and engaged in a CBT program named “Coping Cat”. Podell et al. found that the therapist’s approach was a significant predictor of youth outcomes. In particular, it was established that when therapists engaged in a collaborative “coach” style, adhered to the program guidelines, and had a longer history of clinical experience, participants reported fewer anxiety symptoms at the end of the treatment (Podell et al., 2013). As concluded by Podell et al., “The findings highlight the importance of therapists using an individualized collaborative and flexible approach, while maintaining fidelity to the treatment manual” (p. 96).

In addition to research determining how therapist variables influence the efficacy of CBT treatment with anxious youth, studies have also been conducted to examine which specific CBT interventions are most likely to produce positive results (Peris et al., 2014). In particular, this study sought to highlight the change processes of CBT by examining the targeted outcomes of specifically timed CBT components.

Peris et al. (2013) analyzed the findings from a multi-site Child/Adolescent Multimodal Study (CAMS) study that gathered weekly outcome assessments. Participants included children and adolescents between the ages of 7 and 17 who met the DSM-IV-TR criteria for Separation Anxiety Disorder, Social Phobia, or Generalized Anxiety Disorder. The researchers measured how the introduction of cognitive restructuring, exposure techniques, and relaxation training related to a progressive rate of change in anxiety symptom severity and overall global functioning. Findings from this analysis suggest that youth engaged in this CBT treatment program experienced the greatest rate of change from cognitive restructuring and exposure tasks, while relaxation training resulted in little positive change. Further, it was found that younger participants benefited more than older counterparts to exposure tasks.

Beyond the analysis of specific outcome measures and therapist variability in the use of CBT with anxious children and youth, researchers are also interested to learn how parental involvement can influence the efficacy of this therapeutic intervention. For instance, Manassis et al. (2014) aimed to determine whether active or limited parental involvement is preferable for outcome rates for youth engaged in CBT treatment. These researchers analyzed individual participant data from a previous study in which parents had limited involvement or were actively involved in CBT treatment. The type of active involvement was also compared, as a portion of parents engaged in a process of transfer of control (TC), in which the therapist teaches parents how to use contingency management (CM) in order to support their children to engage in exposure tasks (Manassis et al., 2014). Findings from this study suggest that “active parental involvement, regardless of type, was not associated with differential changes in clinical severity, anxiety symptoms, and internalizing symptoms between pretreatment and post-treatment compared with child-focused CBT with limited parental involvement” (Manassis et al., 2014, p. 1169). A measurable difference, however, was found during the one-year follow-up, as remission rates were higher for youth whose parents were actively involved in the treatment process with an emphasis on TC or CM (Manassis et al., 2014).

Beyond CBT

As previously mentioned, CBT is the most widely researched treatment of anxiety-based concerns for youth. Furthermore, the research surrounding the use of alternative methods for clients experiencing anxiety, such as Narrative Therapy or Solution Focused therapy, are typically used in conjunction with CBT, and empirical research supporting the benefit of these approaches on their own in working with adolescents experiencing anxiety is minimal.

In one of the few studies exploring the use of narrative therapy with children and youth, McGuinty, Armstrong, Nelson, & Sheeler (2012) considered narrative strategies, such as externalizing problems and creating metaphors with youth experiencing anxiety. The study looked at the efficacy of using narrative approaches with youth diagnosed with co-morbid Autism Spectrum Disorder (ASD) and Anxiety Disorder because of the lack of empirical research on the use of specific anxiety interventions with this particular population (McGuinty et al., 2012).

McGuinty et al. (2012) accounted for the positive effects of using narrative techniques with this population by stating, “Person generated metaphors, based on personal autistic experience and that are literal and concrete, can shift the person into the action stage of the therapeutic process and potentially out of autistic anxiety” (p. 11). Despite potential benefits of using narrative strategies in group or individual therapy with children and youth diagnosed with co-morbid ASD

and anxiety, the authors primarily reflect on the use of narrative practices within a CBT framework. They advise that although CBT groups appear to have substantial evidence supporting their success with children experiencing anxiety, there is little research exploring the use of CBT with children who also have been diagnosed with ASD. A significant limitation in the McGuinty study is that clients were left to make their own behavioural and psychological changes.

Although there are many ways of approaching work with anxiety, the research evenly favours problem-focused and pathologizing modalities. For example, in one of the few studies available, Giorgiades (2008) conducted a case study of Solution Focused Therapy (SFT) interventions with youth responding to violence. This longitudinal study also assessed the long-term 'consequences' of experiences of violence. It directed this assessment in five intervals within a four-year period. This case study also examined how effective the use of SFT via email counselling would be with young people. In this study, effectiveness was operationalized as academic performance, psychosocial adjustment, wellbeing in the family system, and mental health status. This study explored the use of SFT with young people and highlighted the ways in which SFT questioning and client-directed interventions can be utilized with this population. It also demonstrated how SFT would be used with children and youth who have experienced violence, and how incompatible such an intervention would be.

Response-Based Practice

The first peer-reviewed paper describing the principles of response-based practice was published in 1997 by a Canadian family therapist named Allan Wade. Since then, Wade and other authors have published over a dozen papers that draw and expand on these principles (e.g., Carriere & Richardson, 2013; Coates & Wade, 2007; Richardson & Reynolds, 2012). The focus and purpose of these articles has largely been to further develop the ideas that inform response-based practice, and to demonstrate their application across diverse contexts.

Wade's (1997) seminal paper introduced readers to his perspective on the merits of a response-based approach to psychotherapy by way of the use of case studies. He explains that this orientation to therapeutic work facilitates the process of "[engaging] persons in a conversation concerning the details and implications of their own resistance" (p. 24). It should be noted that a reader unfamiliar with the assumptions of a response-based perspective might presume that he is referring to "resistance" with a negative bias. While that is the prevailing disposition within many psychological theories (Beutler, Moleiro, & Talebi, 2002; Freeman & McCluskey, 2005; Newman, 2002), Wade clarifies, "I intend...to convey the view that resistance to violence and oppression is both a symptom of health and health-inducing. I do not intend to imply the existence of 'unhealthy' or 'maladaptive resistance'" (p. 23-24).

In that first paper, Wade (1997) makes it clear that, for the therapist, attuning to resistance is at the heart of response-based practice. He goes on to define resistance as,

any mental or behavioural act through which a person attempts to expose, withstand, repel, stop, prevent, abstain from, strive against, impede, refuse to comply with, or oppose any form of violence or oppression (including any type of disrespect), or the conditions that make such acts possible. (p. 25)

He adds, "Any attempt to imagine or establish a life based on respect and equality, on behalf of one's self or others, including any effort to redress the harm caused by violence or other forms of oppression, represents a de facto form of resistance" (p. 25). The subsequent sections of that

article explicate and elucidate how he generally enters into conversations with clients in ways that draw forth their accounts of resistance to adversity and oppression. While that article is doubtlessly important within the scope of the spread of response-based ideas, it was a seminal paper that requires empirical evaluation of the efficacy of response-based interviews with people experiencing distress. Given the nature of that paper, all accounts of the benefits of the response-based approach are anecdotal, as part of the case studies.

Subsequent articles have seen these ideas applied in much different milieus. For example, Coates and Wade (2004; 2007) apply the response-based assumption that people actively respond to and resist adversity and violence in their analysis of descriptions of violence and victims' responses. Using examples of text from court documents (2004), as well as other diverse accounts (2007), Coates and Wade demonstrate how language can be used to conceal violence, obscure and mitigate perpetrator responsibility, conceal victims' resistance, and blame and pathologize victims. These "four-discursive-operations" (Coates & Wade, 2004, p. 503; 2007, p. 512) are a development on Wade's (1997) original idea that when people are subjected to violence and adversity, they resist. The formulation and presentation of these four operations are a testament to the importance of language from a response-based perspective, as it is through an attention to language that the therapist draws forth and honours the client's accounts of resistance. While Coates and Wade (2004; 2007) provide a foundation to analyse language from a response-based orientation, these articles are limited as theoretical contributions to the body of literature. This is not to denigrate their importance within their given context, but to acknowledge that empirical studies with greater depth and breadth have yet to be conducted by them or other researchers.

Richardson (2006) relates response-based principles to Metis tactical responses to oppression and racism in Canada. Although this article is not explicitly about the theory behind response-based practice, nor is it an empirical study of its effectiveness in therapy, Richardson, details how a response-based lens is useful in making sense of how Metis people have tactfully crafted a distinct identity within Indigenous and European Canada. To this end, she affirms how response-based practice is part of a handful of theoretical orientations that "help contain and contextualize a series of identity processes that relate to Metis experience in particular and to colonized Aboriginal peoples in general, as well as to victims of violence and racism" (p. 57). She goes on to state, "Response-based understandings of human behaviour offer important insights into the social and interactive processes of Metis identity creation in a climate of social oppression and violence" (p. 57). Whereas Wade's (1997) first paper on response-based practice focuses on individual conversations that take place behind the closed doors of a therapy room, Richardson (2006) applies these ideas to the broader context of a people's collective responses to oppression and indignity. While Richardson's (2006) application of response-based practice to broader systemic issues serves to expand on and highlight the theory's flexibility across diverse contexts, this article is another example of the pervasive non-research and non-practice-based body of literature on response-based practice.

Out of the entire body of literature on response-based practice, the article that most closely approximates the project at hand is by Richardson and Wade (2010). In this article, the authors describe a program they developed called Islands of Safety: "a model and process designed in conjunction with Métis Community Services in Victoria, B.C., based on a focus of human dignity and resistance, safety knowledges of women and Indigenous peoples" (p. 137). In short,

Islands of Safety is a program designed to aid Indigenous communities in restoring safety, respect and harmonious relationships in the wake of what is often called domestic violence. Richardson and Wade outline the theoretical assumptions that went into the creation of the Islands of Safety program, all of which refer back to principles of response-based practice. While the article serves as a descriptive platform for the program, it also offers the greatest breadth in terms of the extent to which it covers response-based concepts, when compared to the canon of existing response-based literature. While the primary focus of this paper is to explicate the Islands of Safety model as an anti-violence intervention, it also serves the secondary purpose of concisely compiling the core tenets of response-based practice in a single article. Like the other response-based articles described above, this one provides the ideas and rationale that inform the program at hand. Richardson and Wade (2010) do not venture toward an empirical evaluation of the use of response-based principles in the implementation of the Islands of Safety model.

Unlike what academics and clinicians in the field of psychotherapy refer to as “evidence-based approaches”, response-based practice has not received the same formal validation from the academy in the form of empirical research-based studies outlining its usefulness and efficacy in practice. There is presently a dearth of empirical research exploring the effectiveness of response-based orientations to therapy in either individual or group settings. It therefore follows that there are no existing studies outlining the clinical applications of a response-based approach with youth experiencing anxiety, how response-based principles might translate into group therapy work, and how it might be paired with expressive arts therapies. While this project was not evaluated for its efficacy at this time, the unexplored research has highlighted an opportunity for creating an alternative manualized approach. We believe that such a project has the potential to be measured for its efficacy in the future.

Drama Therapy

The limited availability of research surrounding additional means of addressing anxiety with young clients is discouraging, as even these research based theories seem to provide limited long term efficacy, as the underlying reason for anxious responses is rarely considered in full (Peris et al., 2014; Podell et al., 2013). Therefore, we sought to examine other means of addressing these concerns, as drama therapy is well known for its efficacy in working with youth with behavioural challenges (Pitzele, 1991; Leveton, 2010; Cossa, 2006). Furthermore, drama therapy is often employed as a means to engage reluctant youth in therapy, as it allows a more fluid and symbolic means of addressing concerns (Cossa, 2006). The following articles highlight the use of both drama therapy (used in both individual and group format) and psychodramatic principles with youth.

First, in considering the use of drama therapy and psychodrama to address anxiety, we explored the potential benefit of incorporating arts-based therapies into a group setting to treat anxiety related concerns. Irwin (1986) highlights that healing through therapy is “found in the dynamic and growth-enhancing process that takes place in therapy when the focus is that of empathic listening, understanding, and helping” (p.348). She further addresses the benefit of the arts in the therapeutic process by stating that there are multiple forms of communication possible through the arts, and that there is not a requirement of words or a verbal exchange of ideas and feelings in order for healing and transformation to occur. Irwin emphasizes that drama provides a supportive therapeutic intervention, as it gives clients room to act out their stories as they

happened, and experiment with alternate realities that have not yet happened, all within a space that encourages clients to reflect and examine their interpersonal and contextual exchanges that contribute to their feelings of distress. She expands on this by asserting that the use of drama therapy provides valuable diagnostic and assessment information, which “enables the observer to glimpse individual’s psychosocial and psychosexual level of development, including character and self-image” (p.350). Finally, and perhaps most crucial to our own research is Irwin’s understanding that drama therapy allows clients to explore “not-real realities,” which means that “opportunities exist to try on and rehearse new behaviours in a protected environment” (p.351). This concept is paramount in providing a response- based drama therapy approach in which responses to contextual factors are deeply analyzed and reflected on within a group setting. Kellerman (1987) examined multiple outcome studies to assess the effectiveness of using psychodrama with various student populations with a multitude of different mental health concerns. Kellerman assessed 23 outcome studies, published between 1952 and 1985. The author summarizes these findings in tabular form and interprets the results as a whole. The limitations of these studies were addressed, and it was still concluded that psychodrama remains a viable alternative to other therapeutic approaches. Kellerman also considers the use of psychodrama in promoting behaviour change in adjustment, anti-social, and related disorders, asserting, “we may conclude from this review that student populations often benefited from participating in psychodrama, improving in, for example, socialization, self-actualization and psychological stability” (p.461). Therefore, despite potential limitations of psychodramatic group therapy, the use of participant’s “memories of specific happenings in the past, unfinished situations, inner drama, fantasies, dreams, [opportunity to prepare] for future risk-taking situations, or simply unrehearsed expressions of mental states in the here and now” (p.459) provide opportunities to support and facilitate change. Although dated, this examination provides intriguing results, indicating increased necessity for more current research on the advantages of employing psychodramatic techniques with adolescents, specifically addressing anxious feelings.

Additionally, authors Kipper and Giladi (1978) explore the use of psychodramatic techniques to address test anxiety with students. They challenge empirical researchers who assert that behavioural approaches are the most effective means of treatment, while also hypothesizing that “a structured psychodramatic method - a variant of psychodrama - is as effective a mode of treatment for test anxiety as the systemic desensitization procedure” (p.500). In order to test this hypothesis, Kipper and Giladi recruited 36 University level students who volunteered to be a part of the study. They then divided the 36 students into two groups, 14 of whom received structured psychodramatic techniques, with the other 12 participants receiving systemic desensitization (i.e., CBT). The structure of both groups followed a similar format, consisting of three to four participants engaged in the same number of group therapy sessions, beginning with one introductory session, leading to two practice sessions, and 10 treatment sessions, followed by one follow-up session. The study employed some of the key techniques often used in Moreno’s psychodramatic technique, such as Empty Chair, Role Reversal, and Double. Through this study, the authors affirmed that structured psychodramatic technique was as effective as systemic desensitization procedure (CBT), which, according to Kipper and Gilaldi, has been one of the most widely used modalities to treat test anxiety. Finally, the authors note some of the key differences in the psychodramatic approach versus the CBT approach. For instance,

psychodrama “adheres to dynamic concepts such as catharsis and spontaneity which are rejected in the behaviouristic theories” (p.503). Furthermore, “the structured psychodrama method may be used as a substitute for in vivo desensitization where access to the original anxiety-evoking situation is either difficult or impractical” (p.504). The authors assert that through psychodrama, “the client [has] the opportunity to experience an alternative, desired situation” (p.504).

Similarly, Karatas and Cokcakan (2009) conducted a more recent study to compare the effectiveness of psychodrama and CBT in decreasing aggressive attitudes and behaviours in youth at school. This study consisted of 36 students with the highest aggression scores on the Aggression Scale divided into three groups; two of which were control groups, and the third being the experimental group, with each group comprised of up to 12 students. The procedure applied CBT strategies to the experimental group for 10 sessions, and psychodrama for 14 sessions. The results determined that CBT decreased overall aggression scores in all areas except verbal aggression; whereas psychodrama decreased aggression scores in all areas except verbal-physical aggression. Overall, the study determined that both CBT and psychodrama continued to demonstrate positive effects on aggression scores in the 16 week follow up. This signifies the potential efficacy of psychodramatic technique alone, rather than in conjunction with CBT, as Kipper and Giladi (1978) indicate; however, both demonstrate overall positive results from embracing the use of psychodrama in group settings.

Kipper and Giladi (1978) and Karatas and Cokcakan (2009) both raise important points regarding the use of Psychodrama in group therapy settings. First, Kipper and Giladi (1978) identify that psychodrama and systemic desensitization technique produce similar results. Despite these findings, the research is outdated. Furthermore, they also consider psychodrama within the context of systemic desensitization techniques, rather than psychodrama exclusively, stating that “The psychodrama method (Moreno, 1946) stems from theoretical concepts that differ from those underlying the behavior therapy approach. In practice, however, it uses procedures and techniques which can easily implement the components described in the above principle of the extinction of phobias” (p.500). Fortunately, the more recent study conducted by Karatas and Cokcakan (2009) demonstrates that therapeutic modalities other than CBT principles used in group therapy can support positive change, as they considered the use of psychodramatic techniques exclusively. Although the research surrounding additional therapeutic interventions to support youth experiencing anxiety is limited, the study conducted by Karatas and Cokcakan (2009) affirms that psychodrama can provide support that is equally effective in working with youth experiencing behavioural concerns. Interestingly, Karatas and Cokcakan merely provide follow-up at 16 weeks, which raises the question of prolonged efficacy at 6 months to a year post treatment. Therefore, we assert that the same principles could be applied to supporting youth experiencing anxiety, and we challenge the assumption that CBT is the only effective means of supporting these youth.

In addition to the above research, Akinsola and Udoka (2013) consider the use of psychodrama with 567 children experiencing anxiety between the ages of 7-16, who have had exposure to one of three different parenting styles. The participants consisted of 275 males, and 292 females who experienced either authoritarian (restrictive and punitive with closed communication), authoritative (controls and limits with open communication), or permissive (few or no rules) parenting styles (p.246). The researchers administered three assessment instruments; the Children’s Social Anxiety Scale, Performance Anxiety Scale, and the Parenting Style Scale (p.

248). The study defines psychodrama as a therapeutic technique used in psychotherapy that includes group roleplaying, and spontaneous dramatization to find out more about a client's lived experience. The authors argue that, "psychodrama is based on the premise that spontaneity and anxiety are inversely related, such as the more spontaneous a person is the lower the person's anxiety" (p.247). Akinsola and Udoka conclude in their study that psychodrama was found to be an effective means of reducing anxiety in all of the children who went through this method of therapy. Therefore, this study demonstrates the potential benefits of the use of psychodrama with youth who experience anxiety, while also considering the contextual factors that contribute to a client's anxiety.

With regards to specific psychodramatic techniques, Holmes (1993) presents a clinical case study in which he utilizes "enactment" with a family in mourning. Holmes explains that enactment is a term used in psychodrama, family therapy, and psychoanalysis; however, enactment is a different processes in each of these fields, though these techniques can be used concurrently. Holmes states that enactment "is an essential feature of both psychodrama and family therapy" (p.1).

Furthermore, "enactment is a process that uses not only the verbal and nonverbal communications common to all psychotherapy but also, at times, dramatic actions and physical movement" (p.1). Holmes defines enactment in family therapy as "an encounter between family members in their here and now reality ... This here-and-now interaction of family members in the therapeutic session is a crucial feature of most family therapy processes, in which the emphasis is on the systemic relationships between people" (p.3). Enactment in psychoanalysis, on the other hand, "... involves both [therapist and client] in thoughts and feelings and sometimes in actions ... This relationship, however, is not symmetrical because the emphasis is placed on the patient's reactions and feelings toward the therapist as if he or she were an important figure from childhood" (p.4). Finally, Holmes highlights that enactment as used in psychodrama "is associated with the use of role reversals, doubling, and the employment of auxiliary egos. In these circumstances, there is a suspension of reality testing" (p.2).

Holmes' (1993) demonstration of the use of enactment within three different therapeutic theories emphasizes the potential for psychodramatic technique to further support and enhance the use of other therapeutic modalities. In the case of a response-based drama therapy group, enactment as a strategy would prove useful in highlighting the various social and personal responses involved in a client's experience of anxiety. Where Holmes' research is limited is primarily in the use of psychodrama to explore transference and counter-transference through psychoanalytic theory, as the benefit of psychodrama is the ability to position other group members in the role of significant people in the client's story, thus removing the therapist from fulfilling that role, and allowing the therapist to remain in a supportive, objective third party stance. Furthermore, the concept of transference/counter-transference removes client agency from their thoughts, feelings and actions, which contradicts response-based theory and drama therapy's ability to consider and reflect on personal agency during the group process.

The above research highlights the significance of using psychodramatic technique within a group setting with adolescents dealing with a variety of concerns; specifically, anxiety related. Though the data signifies the positive outcomes of psychodramatic group therapy, these techniques are commonly used within a CBT framework. It is our overall goal to provide a review of additional potentially viable means of treating youth anxiety. Though the research on drama therapy indicates a successful reduction of symptoms, further research is required to review and evaluate

the efficacy of such approaches.

Group Therapy

Throughout our research, we quickly identified the limited body of empirical data surrounding the use of different forms of group therapy with adolescents, including adolescents experiencing anxiety (Flannery-Shroeder & Kendall, 2000). Therefore, in developing our group design, we researched group therapy for multiple adolescent concerns, as well as groups addressing adult anxiety. Furthermore, as aforementioned, the dominant research surrounding group anxiety treatment is grounded in CBT (Johnson, 2010; Chamberlain & Norton, 2013; Van Ingen & Novicki, 2009). We therefore considered which adolescent therapy groups have been studied for effectiveness of treating adolescent concerns, as well as anxiety groups that have been tested and found to be advantageous for adults experiencing anxiety. The results continue to highlight the overall need to evaluate the efficacy of additional forms of group therapy available to adolescents experiencing anxiety, as CBT persists as the dominant approach to group therapy anxiety treatment.

Childhood anxiety disorders do not readily remit without treatment, and can often lead to longer term complications and associated mental health concerns later in life (Flannery-Schroeder & Kendall, 2000). Flannery-Schroeder and Kendall (2000) conducted a study hypothesizing that youth diagnosed with an anxiety disorder would see marked improvement by engaging in CBT in a group format as opposed to individually. They reasoned that because groups provide “opportunities for social interactions, peer mediation (e.g., peer modeling, peer and group feedback), leadership, and multiple exposures to feared interpersonal contexts, objects, and/or situations,” that group CBT would offer additional advantages during treatment of anxiety, such as peer reinforcement, peer modeling, and multiple exposures (p.252). Additional studies indicate that youth experiencing anxiety also experience social withdrawal and isolation (Hartup, 1983; Strauss, Forehand, Smith, & Frame, 1986), and that children who do not engage in social contact with peers experience more anxiety than those who do.

Flannery-Schroeder and Kendall’s (2000) study included 37 participants, aged 8 to 14, who were referred from multiple community resources across three American cities. This group was then divided across three trial groups, the first receiving individual CBT, the second receiving group CBT, and the third was a wait-listed control group. Eight doctoral candidates (two male, six female) facilitated the therapy from the Child and Adolescent Anxiety Disorders Clinic. Each therapist was trained in the manualized group procedure, including didactic presentation, role-plays, videotape observation, and discussion. The individual CBT treatment consisted of 18 weeks of 50 to 60 minute sessions, while the group CBT treatment consisted of 18 weeks of 90-minute sessions (p.259), though they both maintained the same CBT format. Although the authors originally hypothesized that the group CBT format would demonstrate marked improvement in overall anxiety symptoms, the results of the study demonstrated that because peer interaction and social skill development was not the primary focus of the group, social functioning only improved when connected to a client’s experience of social anxiety. However, the authors did identify that attrition rates were significantly lower in the group format than the individual, with an attrition rate of 31% for individual and 0% for group.

Due to the relatively limited scope of this study, further research on the efficacy of group therapy is needed. Moreover, as the study addresses the use of CBT, it would be valuable to consider the rates of group and individual success due to the therapeutic approach utilized, as the author’s

bias toward the use of CBT is evident in the results. With that said, lower attrition rates alone are intriguing when considering whether or not to take a group or individual approach to supporting youth with anxiety.

Contrary to the outdated assumption that suicidal thoughts and self-harm are the result of depression, anxiety is now considered a more significant precursor to these experiences in youth, as many fairly common worries that youth experience often lead to depressed and suicidal thoughts (Thompson, Mazza, Herting, Randell, & Eggert, 2005). Depression, however, was noted as a prevalent concern among self-harm cases, and predicts participant response to treatment (Wood, Trainor, Rothwell, Moore, & Harrington, 2001). Due to the limited availability of group therapy in treating youth anxiety, we extended our review of the literature to include groups available for youth experiencing suicidal thoughts and self-injurious behaviours. Wood et al. (2001) hypothesized that compared to routine care for adolescents engaging in self-harm, adding group therapy to their treatment would lead to a decrease in feelings of depression, and therefore a lower the risk of repeated self-harming behaviours. They conducted a quantitative study composed of 63 adolescents aged 12-16 randomly allocated between group therapy in addition to their routine care, or routine care alone. The youth had all been referred to the child and adolescent mental health service of a health district in South Manchester, England, following an incident and self-report of self-injurious behaviour occurring at least twice over the past year. The authors reasoned that the group would reduce the need for individual therapy, as it would address some of the common concerns prevalent with suicidal youth, such as poor peer relationships, and impaired problem solving (p.1247). The group design combined a variety of therapeutic modalities, such as problem-solving and cognitive-behavioural interventions, DBT, which is commonly used with youth experiencing suicidal ideation and self-injurious behaviour (Miller, 1999), and finally, psychodynamic group psychotherapy. Assessment measures included self-reported depressive symptoms, suicidal thinking, and repeated self-harm. Results of the study indicate that although youth's self-reported experiences of depression and suicidal thinking did not significantly reduce as a result of the group, there was a reduction in repetitive self-harm, with an "absolute risk reduction of 26%" (p.1251).

Despite the results of this study indicating the reduction of overall self-injurious behaviour, the group design itself continues to utilize CBT and DBT principles to treat adolescent concerns. Though Wood et al. (2001) assert that therapeutic techniques across multiple domains were employed in the creation of the group, the similarities between CBT and DBT are striking (James, Taylor, Winmill, & Alfoadari, 2007; Miller, 1999). This is further evidence of the need to research additional methods of treating adolescent concerns that include a deeper contextual analysis of anxiety related problems.

As previously mentioned, there is limited research indicating the success of group psychotherapy treatment for adolescents experiencing anxiety (Flannery-Schroeder & Kendall, 2000); however, due to the more significant body of literature indicating the efficacy of group therapy for adult anxiety, it might be reasonable to suggest that youth experiencing similar concerns engaging in similar groups, would have a similar outcome. With that said, the following study conducted by Van Ingen and Novicki (2009) examines the effectiveness of CBT groups in a college counselling center.

Participants were of college age, between 18-31 years, and participated in an initial screening by psychologists specializing in anxiety disorders. All participants required a DSM-IV-TR

diagnosis of one of the following anxiety disorders: panic disorder, social phobia, obsessive-compulsive disorder, or post-traumatic stress disorder. The measure used for assessment of progress was the Disruption of Function Index, however, the author's did not mention the validity of using this tool (Van Ingen & Novicki, 2009, p. 246). The group's objective was to increase the management of participants' anxiety symptoms, rather than elimination, with a primary focus on academic performance impaired by participant anxiety. Treatment occurred over a minimum of 20 weekly, 90-minute group therapy sessions utilizing cognitive behavioural interventions, such as exposure, ritual prevention, cognitive restructuring, psycho-education, deep breathing, social skills training, and cognitive-behaviour modification. The results of the study demonstrate significant improvement by the end of the 20 weeks, with assessment measures collected via paired pre- and post- t-tests.

It is important to note, however, that despite our goal to identify anxiety groups using alternative therapeutic intervention, CBT remains the most researched modality, while still having a relatively limited body of literature employing CBT strategies in practical, client-based treatment settings (Van Ingen & Novicki, 2009). Furthermore, a notable limitation of this study was the researcher's allotment of psychopharmacological services for group participants. As Van Ingen and Novicki (2009) note "psychopharmacological services were provided for clients who entered the group therapy treatment program already medicated, who reported severe depressive symptoms that might interfere with CBT, or whose initial anxiety was severe enough to interfere with CBT" (p. 245). This begs the question of the efficacy of CBT with participants experiencing extreme anxiety, as well as the point at which a client's anxiety becomes too "extreme" to treat using talk therapy rather than prescribed medications. Therefore, this article raises a number of questionable biases that inhibits its overall validity in considering the efficacy of group CBT in treating anxiety.

The above research demonstrates the widely researched use of CBT, and more importantly highlights the demand for research evaluating additional therapeutic interventions. Fortunately, as our group design integrates the use of drama therapy techniques, there is a growing body of literature pointing to the efficacy of psychodrama with adolescents. Though many of these psychodrama groups are designed for adolescents with behavioural concerns, they continue to consider the likelihood that the participants are entering the group with feelings of anxiety (Cossa, 2006; Karatas & Cokcakan, 2009). See above for a more extensive overview highlighting the efficacy of youth engaging in psychodrama and drama therapy groups is provided in the drama therapy section of this literature review.

Conclusion

The literature outlined above reads like a review of CBT, thus indicating the extensive research available for anxiety treatment options based on the principles of CBT over other forms of treatment. Despite our efforts to highlight and evaluate additional treatment modalities for youth, the research is even more limited when assessing group adolescent anxiety treatment. This realization is somewhat troubling, as the research studies evaluating the use of additional therapeutic modalities with youth are often still used concurrent with CBT, thus limiting the ability to discern between a CBT bias and the potential benefit of alternative methods of therapeutic support.

As contextual factors appear to be rarely addressed throughout the above research, our project

considers the potential benefit of utilizing response-based language within a drama therapy framework in order to consider the contextual factors contributing to youths' experience of anxiety. This provides room to discuss anxiety in terms of a response to contextual factors. Furthermore, the drama therapy framework encourages exploration of social responses and alternative personal responses in a safe setting that decreases the potential fear and risk of failure (Irwin, 1986). Drama is helpful as a treatment modality precisely because it gives individuals a chance to play out their own fantasies and preconceived notions (Irwin, 1986). This concept provides the basis through which a response-based group using dramatic play becomes a potentially viable alternative to addressing young client worries, as the youth are given space to both discuss and rehearse their own responses, the social responses of others, and to reveal the more complex context through which anxious moments occur.

Chapter Three: Methods and Methodology

Background Information

In order to encourage active participation in the response-based content and discussion, the group employed drama techniques, which serve as gateways to discussion and exploration. Many of the activities suggested in the group outline are "lower risk" so that those who fear "traditional" drama games (i.e. performance) will not be required to participate in that manner. The use of drama therapy in groups "helps participants to reanimate their psychological and social problems, rather than just talking about them" (Blatner, as cited in Karatas & Cokcakan, 2009). Similarly, the group therapy context is superior to individual therapy in "... the provision of social learning, developing social support, and improving social networks ..." (Yalom & Leszcz, 2005, p.232). Furthermore, the use of drama therapy techniques with adolescents experiencing anxiety supports the development of interpersonal relationships while dealing with worry-inducing puberty related difficulties (Karatas & Cokcakan, 2009). We therefore anticipated that the suggested activities would provide a forum to discuss the contextual factors that support anxious responses, as well as creative means through which to imagine and replay preferred outcomes.

Participants

For the purposes of this group, we chose to target a demographic of youth between the ages of 11-14, as the Child and Youth Mental Health (CYMH) facility where our group was held had very few programs available for this age group. Research, however, indicates that anxiety is the most frequently occurring mental health concern for children and adolescents, and many people who experience anxiety during childhood report that it becomes more acute as children age, if left unaddressed (Beesdo, Knappe, & Pine, 2009; Canadian Mental Health Commission, 2015; Public Health Agency of Canada, 2011; Podell et al., 2013).

The group was open for screening through CYMH three weeks prior to the start date. The group was open to participants who were currently on the waitlist to receive individual services, as well as youth who were already assigned to a clinician, but who were considered by their clinician to likely benefit from group work. We then informed the organization that our group could consist of a maximum of 12 co-ed youth, with an ideal number of 8-10 recurring group members, allowing for the likelihood of participant attrition after the first session. Our final group consisted of 6 youth, 3 girls and 3 boys, between the ages of 12 and 14. The program ran from

May-June, 2015, at a time that CYMH offered few other groups addressing anxiety with this target demographic, allowing for the group to finish before commencing summer holidays from school.

Method

Participants were referred to the group by CYMH clinicians. Participants were selected based on their presenting problems, with a requisite that the youth be currently experiencing some form of anxiety based on self-reports, clinical diagnoses, and/or the assessments/opinions of clinicians. Furthermore, due to the creative nature of the program, we further stipulated that youth must be aware of the creative content, and comfortable with the prospect of drama techniques.

Assignments were collected via the referring clinicians, and group fit was determined based on clinician referrals that were conducted in-person, followed by discussion with the clinician.

We ran the group for eight consecutive weeks, with 90-minute sessions from 4:30-6:00pm. This allowed the youth time to get to the group location from the school. Once the youth arrived, we provided snacks and a “warm-up” exercise as a means to start the group and introduce the youth to the theme for the day. We also planned a closure activity to give time for the participants to debrief what was covered. Each session also included a 10-minute break at the mid-way point. This allowed the youth an opportunity to use the restroom and eat a snack, and also mitigated the risks of youth leaving during potentially challenging or sensitive disclosures. Youth were also reminded at the beginning of each session of the importance of safety and confidentiality in the group setting.

Response-based Drama Therapy Group Case Notes

introduction.

Throughout the run of the response-based drama therapy group, we kept detailed case notes that outline the goals of each session, and the material that was covered within each session. This enabled us to review the material from each week, and incorporate any missed material from previous weeks that was deemed necessary or fitting with client concerns. Furthermore, the case notes also demonstrate the importance of maintaining flexibility, as the activities employed often deviate from the outline, though only in instances when participants would form further discussion or participation in other activities. The following case notes are a reflection of the group process; however, they do not contain the individual case notes for each group participant. Our primary research goal was to create and launch a response-based drama therapy group in Child and Youth Mental Health; therefore, participant responses and assessments are not required to present the necessary information needed to understand or replicate our process.

session one: may 4, 2015.

This was the first session of the Response-based Drama Group. This session focused on a review of confidentiality and the limitations of confidentiality (a hard copy of the Child and Youth Mental Health statement of confidentiality was signed with participant’s individual clinician and kept in client file). This first session then reviewed each participant’s goals for the group. The group then created a working document that outlined what would help to support participants and ensure they feel safe to participate and engage in the group activities. This document was named “Party Rules” by the participants, ensuring the document remained reflective of their needs.

The first session then provided a response-based overview of psycho-education on anxiety. Rather than informing the youth what can happen in one’s body during a worried response, these

writers encouraged clients to consider what happens in their bodies when they feel worried, thus continuing to position clients as experts in their own experiences. Examples include sweating, racing heart, shallow breathing, worried thoughts, etc. We then encouraged participants to consider what occurred outside of their bodies, meaning contextual factors, which lead to feelings of worry. This prompted a drama based activity called “body talk” where participants explored various ways in which we show worry on our bodies and faces. This activity encouraged participants to walk in a way that reflected certain “mood” suggestions given by these writers. This then lead to a debrief discussion surrounding our own presentation in times of worry, and the creative ways in which participants demonstrate to others that they need space, or they need support.

Participants were encouraged to complete a mood diary that considers contextual factors contributing to a worried response and bring it in for the next group.

session two: may 11, 2015

The limits of confidentiality were reviewed again at the beginning of the group, as well as the working document surrounding participant safety created during the first group. These serve as helpful reminders for the group participants, as well as allow room for participants to add to the list of “Party Rules” if necessary.

This session focused the body’s responses to feelings of anxiety, and how social responses factor into this. This included a response-based discussion around how people experience anxiety in the body differently. The facilitators also engaged clients in a drama based activity called “Speed Gestures,” which consisted of one group member standing in the middle of the circle and acting out a gesture (ex. Waving hand “hello”) to another group member. That group member would then have the choice to respond with the same gesture or an opposite gesture, before trading places with the client in the circle. The facilitators then debriefed this activity, encouraging participants to explore what it is like to receive positive or negative responses from others, and how this relates to their experiences of anxiety. The facilitators also encouraged participants to consider the ways in which their own responses changed in relation to the positive or negative response they received from other group members.

Participants were again encouraged to complete a mood diary and practice “See, hear, feel.”

session three: may 25, 2015.

This session focused on acts of resistance and personal responses. This included a discussion surrounding anxiety as a response to external circumstances, and a consideration of what acts of resistance can often look like. For instance, some acts of resistance could be leaving the worrying situation, talking to a trusted friend or adult, talking back to the person involved in the worry provoking situation, etc. Furthermore, anxiety was also discussed in terms of an act of resistance, meaning that the anxious feeling itself could be considered an act of resistance to worrying contextual factors.

The group was then encouraged to create a tableaux of an anxious moment they have recently experienced, and a discussion around the event followed. This discussion took the form of the response-based “Three Houses and a Shed of Resistance” (Appendix C), to consider the dreams, good things, worries, and acts of resistance in the context of the group’s presented events.

Participants were again encouraged to complete a mood diary.

session four: june 1, 2015.

This session focused on social responses to anxiety. This included a discussion around how

others respond when the participant is experiencing anxiety, and how the participant then responds to those responses. This topic included a discussion surrounding how others behave and respond before, during, and after the participant experiences anxiety.

Participants were then encouraged to create a short scene of a time they experienced anxiety. Other group members were then encouraged to enter the scene and respond as characters within the scene. The goal of this activity is to create a dynamic, flexible improvisation, which allows room to discuss the various responses possible in any given situation. Furthermore, these scenes allowed youth to relate to each other's experience by participating in another participant's scene. A discussion surrounding which responses were helpful and unhelpful then followed. Participants were again encouraged to complete a mood diary.

session five: june 8, 2015.

This session focused on the idea that anxiety is an understandable response to stressful contexts, such as conflicts with others. This included a discussion encouraging group members to share stories describing a particular conflict they responded to by experiencing a high level of anxiety. The group then engaged in a drama therapy exercise called "Rainbow of Desire" (Diamond, 2007) in which the group chose one of the stories shared in discussion to reenact. The story was then explored from the protagonist's (story teller) and antagonist's (opposing force/person in conflict) point of views, looking at what each character may have desired and needed during that conflict. This activity helps to highlight the various tactics employed by the antagonist to resist acts of resistance, while also looking at the various ways the protagonist continued to resist the conflict. After this exercise, the group discussed the importance of considering context when reflecting upon our responses. Further, considerations were made as to the motivations of antagonists.

Participants were again encouraged to complete a mood diary.

session six: june 15, 2015.

This session focused on the concept of agency. This was then applied to drama therapy techniques to encourage participants to consider alternative choices and acts of agency in challenging circumstances that often result in client's experiencing anxiety.

The session began with a guided visualization/ progressive muscle relaxation. This led to a discussion on how to bring mindfulness practices such as this into daily life. The group was then given paper and encouraged to consider the "Drama Therapy Mandala" (Appendix F), which was posted on the wall. Participants were then given a chance to focus on their many skills, beliefs, vulnerabilities, and their guide, and artist. They then wrote these on the paper and taped it on the Mandala for discussion. Based on these reflections, youth were encouraged to create a scene that demonstrated their active responses to the scenario given, though considering at this time the ways in which they use the above Mandala traits. This led to a discussion of alternative responses and acts of agency within situations that may be anxiety provoking, and the idea of a "whole" person, created by a Mandala.

Important to note is that the vulnerabilities section of the Mandala is described as "what makes them human," and that vulnerabilities are not a bad aspect of a person. They are more considered "areas of development" rather than weaknesses.

Participants were again encouraged to complete a mood diary.

session seven: june 22, 2015.

This session focused on the idea of agency and preferred responses in relation to the experience

of anxiety. A creative activity and group discussion was held to explore this topic.

The group decorated two blank masks – one to represent the experience of anxiety and one to represent a preferred response. Throughout the activity, this writer engaged group members in a discussion about what anxiety means to them, how they would prefer to respond, and what agency they have to respond in preferred ways. Each of the ways in which the group members decorated the masks was explored in relation to their own interpretation of anxiety and their preferred responses.

session eight: june 29, 2015.

This session focused on a review of what participants learned throughout the group, and what aspects of the group were helpful for them. Participants were also encouraged to bring the masks they created last week to continue to explore agency within the context of what participants learned about their preferred responses to worries.

This session then employed a final role-play scenario in which youth were given the chance to enact their preferred responses to dramatic situations suggested by these writers. The situations chosen by these writers were common themes that emerged throughout the group; such as, tests in school, telling teachers about bullies, arguments with parents, or arguments with friends. Youth were then encouraged to demonstrate what stood out to them about preferred responses from throughout the group, and act them out in short scenes. The group then concluded with a pizza party and a scaling question check-in to give youth a chance to rate how they feel overall from 0-10 (10 being a high rating).

This was the final group session, and there was no follow up by these writers because we were not the primary clinicians for the participants at CYMH.

case notes conclusion.

As evidenced by the case notes, the original group outline was not rigidly adhered to. This is due to the variability in client participation, engagement in some activities over others, and the detail of the discussions. These writers found it important to ensure that the clients remained the experts throughout the group, and felt that maintaining flexibility in our overall daily goal was essential to ensuring that participants had the freedom to discuss and role play the moments that meant the most to them. Although we maintained this flexibility to the client's advantage, we did begin each session with a warm-up activity that framed an overall theme for the session. This helped to shape the discussion and encourage each participant to find relevance to their own contextual situations and responses. Therefore, the youth in these writers' group were best engaged when they are met where they were at, and allowed to explore situations most relevant to them at the time.

Ethical Considerations

After identifying the need for a response-based drama therapy group for adolescents experiencing anxiety at CYMH, we then sought to present the relevance of integrating creative arts groups in a community mental health setting to CYMH team leaders. To this end, we provided explanations and research to the CYMH teams on both response-based practice and drama therapy, and created a group outline to pitch to the team leaders, which targeted a demographic that did not have groups running concurrent to ours. Finally, we allowed clinicians flexibility in the referral process, and trusted their judgment on client fit for the group.

Because the group was conducted as a thesis project, ethical considerations were also made. For instance, because CYMH requires that each practicum student secure their own liability

insurance, we both registered as student members of the Canadian Counselling and Psychotherapy Association, which made us eligible for their group liability insurance. We also had to agree that participant information would not be included in the study. In addition, we were required to have supervision conducted by a CYMH clinician who was also a qualified clinical supervisor. Furthermore, as many of the youth had already completed the intake process through CYMH, they had already completed the necessary confidentiality agreements associated with involvement with the organization. To ensure this, we reviewed participants' files, and verbally shared the limits to confidentiality and consent at the time of the first group session.

Conclusion

This project outlines a response-based drama therapy approach in a group developed for youth ages 11-14 experiencing anxiety. The manualized group is also detailed, along with a thorough description of the ways in which we gained approval to conduct the group in an agency primarily focused on providing CBT groups to address anxiety concerns. Contextual factors are considered within the group to support youth in identifying their responses to anxiety provoking situations, while allowing youth to explore alternative ways of responding to anxiety that meet their individual needs and address context-specific situations.

The following section outlines our project manual, which details explanations and directions as to how this group was conducted.

Chapter Four: Project Manual

Week One: Psychoeducation on Anxiety

introduction (10 minutes).

Explanation of the group and expected outcomes.

activity: two truths and a lie.

Instructions:

- Have each person tell two truths about themselves and one lie.
- The group then has to try to guess which of the three statements is a lie.
- Allow any group member who wants to participate, the chance to participate.

confidentiality and group guidelines (10 minutes).

Directions for group guidelines ("Party Rules"):

- Write group suggestions on a piece of paper to be hung in the room during each group therapy session.
- Ask group members for feedback on what guidelines they would feel are appropriate for the group.
- Leave room for participants to rate their current level of anxiety.
- Explore what we could do as a group and as facilitators to provide support.

psycho-education: discuss anxiety as a response to contextual factors (20 minutes).

Directions: Engage the group in the following discussion.

"Anxiety means feeling worried, nervous, or fearful. We all experience anxiety at times and some anxiety can be helpful and helps us function well. For example, feeling anxiety before a test, interview, or public speaking can help you prepare for it.

When threatened or in actual danger, our body tends to provide an anxiety response, which can appear as fast heart rate, tightness in your throat or chest, sweaty palms, feeling hot/cold, short-

shallow breathes, etc. Our body will typically respond with an anxious response when we need to be aware of potential threats or harm. It acts as an alarm system to keep us from harm. We might also then notice that we feel frozen, or feel like running away, or feel like fighting (either physical or argumentative). We learn from past experiences when we should feel anxious, and so it makes sense that we could respond that way when we are in similar situation in the future. We also know that these responses help us to keep ourselves safe! So way to go! We found a way to ensure that we were safe when we didn't feel safe. However, we know that there are times when these types of responses, even if they have been helpful in the past, are not helpful; like on a test, meeting new people, going to school, etc. Therefore, it can be helpful to learn other ways to understand our anxious responses, learn when they are more likely to occur, and to also identify the many other skills we've learned to employ to get through those anxious feelings!

We can also experience anxiety in a lot of different situations, and we may feel this anxiety in different parts of our body or respond differently to these anxious situations, so we'll also look at mindfulness and guided visualization strategies to consider alternative responses to anxiety provoking situations!"

activity: "body talk" (20 minutes).

Directions:

- Have everyone walk around the room, silently.
- Instruct participants to begin embodying elements of different moments, including anxious moments, confident moments, brave moments, courageous moments, scared moments etc. These movements can be as small or as exaggerated as they would like to make them. Silliness is welcome!
- Invite participants to consider leading from different parts of the body (e.g., head, chest, hips, knees, feet etc.).
- Allow everyone to choose their 'moment' and which part of the body to lead from.
- Debrief.
- "How do these different movements make us feel different in our bodies?"
- "What do we notice about others when they walk in different ways?"
- Allow these answers to pave the way for a discussion on resistance in the shed of resistance. For example, "How can our body language be a way in which we attempt to have our needs met?"

activity: three houses and a shed (20 minutes) (appendix c).

Directions:

- Provide each participant with a copy of the three houses and shed assessment tool (Appendix C).
- Put the diagram on the board, and give each participant a sticky note to fill out how these aspects are relevant to them.
- Have a discussion about each house and ask for or give examples of what might fit under each house. Leave the shed of resistance for next step.

Example Questions:

- "What are some things that fit under your house of dreams? For example, one of my dreams is _____."
- "What are some of your hopes?"
- "What are some of your worries?"

- “What do you do to resist your worries?”
- Discuss the shed of resistance last, highlighting elements of resistance and tools to resist anxiety as a group.

homework and take-home resources (5 minutes).

Directions: Review the following resources with the group and answer any questions group members may have about the handouts.

- A Step-By-Step Guide to Responding to Anxious Moments (Appendix D)
- See-Hear-Feel / 5-4-3-2-1 (Appendix E)

Week Two: Physical Responses of Anxiety

check-in (5 minutes).

Directions: Review the limits to confidentiality and group guidelines. Engage the group in a discussion around how group members have been responding to anxiety over the last week and if they have noticed any changes since the previous group session.

response-based discussion: physical responses to anxiety (20 minutes).

Example questions:

- “What does your body do when you experience anxiety?”
- “How can you tell that you are feeling anxiety?”
- “How is it different than how you feel otherwise?”
- “What do you do in response to this feeling in your body?”

drama therapy activity: guided tour (20 minutes).

Directions: In partners, the participants begin to explore places that help to support the decrease of anxious responses (safe and comfortable places). Partner A closes their eyes while partner B moves through the space and describes, in detail, all of the pieces that help to calm the anxious feelings. They can actually move, and describe what helps to calm the various body responses they often feel. Repeat until both partners have had a chance to explore this.

drama therapy activity: speed gestures (20 minutes).

Directions: Standing in a circle, one person agrees to enter the circle. They then choose one person in the group and they make a gesture (any simple, repeatable gesture) towards a chosen participant. The person in the circle must then repeat the gesture given, and then respond with their own gesture that is fitting to the first (i.e. if someone gives them the cold shoulder, they could repeat that gesture, but then reach out to someone else in response to the first gesture). They then trade places in the circle with the other person entering, and choose a new person and new gesture. This continues until everyone has created and responded to a gesture.

closing (10 minutes).

Directions: Debrief the group with a discussion on the session’s focus and activities.

Week Three: Resistance and Personal Responses

check-in (5 minutes).

Directions: Engage the group in a discussion around how group members have been responding to anxiety over the last few days and if they have noticed any changes since the previous group session.

response-based discussion: resistance (10 minutes).

“We believe that anxiety can be an understandable response to challenging and stressful situations. It is an indicator that you don’t feel safe or are worried for a good reason. We also believe that we tend to resist, even silently or secretly, to such situations, and that anxiety might

actually be more accurately described as an act of resistance.

- “How is the experience of anxiety a form of resistance to the context you are in?”
- “What do you do when you experience feelings of anxiety?”
- “What do you do to resist experiencing anxiety?”

drama therapy activity: pushing-pulling (10 minutes).

Directions:

- Pushing: Take a partner. Stand facing each other and place your hands on each other’s shoulders and push. Use your muscles! One of you will be stronger than the other, so notice how your body is adjusting to meet the demands of the other person pushing. It’s not about winning and losing, but it is about finding the balance of strength and the ways in which you resist toppling over!
- Pulling: Switch partners. Face each other and take each other by the wrists. Lean out, taking on each other’s weight. Hold tightly and ensure that you are supporting your partner. Again, notice the ways in which you compensate with each other to not fall over, and notice how you adjust your weight or your pull based on what your partner needs!

response-based discussion: resistance (10 minutes).

Directions:

- Debrief the above activity.
- “What did you notice about how you met your partner’s demands?”
- “How did you resist being pushed over, or falling over?”
- “What connections do you notice between this type of resistance to your acts of resistance when you notice anxiety?”
- Review the Shed of Resistance from the previous week.
- “What do you usually think of when they think of the word ‘resistance?’”
- “What might you add?”
- Invite participants to reflect on moments of anxiety throughout the week.
- Highlight acts of resistance that group members express in this discussion.

drama therapy activity: tableaux (15 minutes).

Directions:

- Have everyone create an image of “Anxiety.” This is the “less-helpful” response to anxiety provoking situations. Have half the group unfreeze and explore the various tableaux created by the other students. On a sheet of paper placed in front of each person, have the unfrozen participants write any words that come to mind as they view the respective person’s tableaux. Invite them to think about what factors are at play when they are feeling anxiety. Then have the participants switch, allowing the other group the opportunity to view the other tableaux and write down words that come to mind in response to the tableaux image they are witnessing.
- Debrief this activity in a discussion.
- “What did you notice about other people’s responses?”
- Have everyone create an image of their own acts of resistance to anxiety. Repeat the previous directions with the new image.
- Debrief this activity in a discussion.
- “What differences did you notice?”

drama therapy activity: tableaux two (25 minutes).

Directions:

- In small groups, have group members think of a moment in time when they were dealing with anxiety. Have them consider this moment and all its parts. Have the each small groups choose one “Protagonist” (Story Teller) to represent them. Then have the protagonist “Sculpt” the group to create an image in a moment of this experience. Encourage facial expressions and include all participants. Have the protagonist tell each member what/ who their role is in the scene. Then have the groups show one another what they have each created. Allow them to come to an understanding of the image on their own. The story does not yet need to be attached.
- By looking at this image, have the other group fill out their 3 houses and a shed. (If there is only one person wanting to go, then include the whole group). Then review these houses on a big sheet of paper.

closing: (10 minutes).

Directions: Debrief the group with a discussion on the session’s focus and activities.

Week Four: Social Responses to Anxiety

check-in (5 minutes).

Directions: Engage the group in a discussion around how group members have been responding to anxiety over the last few days and if they have noticed any changes since the previous group session.

drama therapy activity: complete the image (15 minutes).

Directions:

- Discuss importance of not naming images.
- One person enters the circle and offers an image. Someone else then enters the circle and adds to the image. Then a third person and the first person in leaves the circle. Continue until everyone who has had a chance to go has gone.
- Debrief and discuss the images created. How do we respond to others responses? Can we know from our own responses how someone else might interpret that? Further discuss anxiety in connection to social responses.

response-based discussion: social responses (10 minutes).

Examples of questions:

- “How do social responses influence our world and experience of anxiety?”
- “What do you notice other people doing before you experience anxiety?”
- “What do people do when you experience anxiety?”
- “Who can tell when you’re feeling anxiety? How do they know? What do they say?”

drama therapy activity: role play (25 minutes).

Directions:

- Environment: Encourage someone to start a scene that expresses a time or place when they experienced anxiety. They don’t need to say anything at this point in the scene. Others enter the scene as they begin to get a sense of where the scene took place and add to the action, providing responses to the initial person’s actions and responses to the environment.
- Thought tracking: Freeze the scene as participants enter. Tap shoulders to reveal the character’s inner thoughts about the protagonist, or about their own experience as the character (potentially sorting through their own anxiety).

- Debrief and allow others to reflect on what this environment has meant for them, and what they could relate to from the scene.

drama therapy activity: if i was you ... (5 minutes).

Directions: Everyone lines up in two rows facing each other. The protagonist (s) (or any participant wanting this feedback) then walk between the two rows. Other participants provide external commentary and social responses that would be more helpful moving forward, and potentially encountering a similar scenario in the future. They may also provide helpful feedback in ways to sort through or recognize these social responses in the future.

closing (10 minutes).

Directions: Debrief the group with a discussion on the session's focus and activities.

Week Five: Context

check-in (5 minutes).

Directions: Engage the group in a discussion around how group members have been responding to anxiety over the last few days and if they have noticed any changes since the previous group session.

response-based discussion: context (10 minutes).

Example questions:

- “When does anxiety happen?”
- “Where are you?”
- “What are you doing?”
- “Who are you with?”
- “What are other people doing?”
- “How do you know anxiety is present?”
- “How do you feel differently than when anxiety is not present?”

drama therapy activity: defender (15 minutes).

Directions:

- Have everyone stand in a circle. Without saying a word, have participants choose another person to be the “defender” and one person to be the “antagonist”. Encourage participants to do this at random, and not base it on friendships etc.
- After you say “go”, participants will move their bodies to keep the defender between them and the antagonist as much as possible throughout the room.
- Debrief.
- “What did you notice during this exercise?”
- “What did you find interesting/challenging?”

drama therapy activity: surplus reality (40 minutes).

Directions:

- Encourage three participants to volunteer to share their stories, and allow them to share once three people have volunteered. The group then picks one story to work on. This is an opportunity for the group as a whole to choose one story that most reflects the context as it is for them.
- Everyone then has the opportunity to ask the protagonist questions, and share some of their own insights in connection with this story. This is the chance for everyone to get as clear a picture of the relationships and experiences as possible. The protagonist should share where the incident occurred, how they were feeling, what happened, what they

wanted, what they imagine the others in the story wanted, and the various acts of resistance (from anyone in the scene) that they can identify.

- Create the stage. The “other” in the scene can either be a real person, or externalized “Anxiety.”
- Create the character. Opportunity to flesh out both characters.
- The protagonist then improvises a scene with someone else that is reflective of the experience they described. The director then “Freezes” the action during moments of most complexity where the “conflict” arises.
- During this moment, the protagonist demonstrates one “desire” or “need” that they are looking to have met in this moment. They make the shape of this desire using as much of their body as possible. One person agrees to then enter the scene and take on the shape of the desire (if they feel they can understand the desire as presented by the protagonist). They can hear and speak, though they cannot move. They can now begin to explore ways in which they can attain this desire. It is a very specified moment in time.
- The protagonist then creates another desire to be portrayed by a new person.
- Now the protagonist creates a fear and someone represents that.
- Is there a fear or desire that has not been represented? The protagonist can then position them in relation to most - least near the antagonist in the scene.
- Now we have the protagonist's rainbow of fear and desire. One by one in order (as determined by the protagonist) the fears and desires enter the play space and work toward their fear or desire. The antagonist can then respond to these. The antagonist can walk, talk, and listen, though the fears and desires cannot move. (Goal: to explore how the characteristics of each fragment impacts responses).
- A secret thought can be integrated into this scene as well.
- Repeat the activity creating the antagonist's rainbow.
- Debrief the activity.
- “What did you notice as being different between the two scenes?”
- “What do you think this difference means?”
- “Can anyone else relate to the protagonist's/antagonist's experience?”
- Allow the protagonist to start their scene again. This time others can yell “Freeze” and enter the space providing more adequate responses that meet the protagonist's desires. They can respond in ways that support the protagonist.
- They can also freeze the scene and enter as the protagonist providing another tactic to get the protagonist's needs met.

closing: (10 minutes).

Directions: Debrief the group with a discussion on the session's focus and activities.

Week Six: Agency

check-in (5 minutes).

Directions: Engage the group in a discussion around how group members have been responding to anxiety over the last few days and if they have noticed any changes since the previous group session.

response-based conversation: agency (10 minutes).

Example Questions:

- “In what area of your life do you experience the most agency?”

- “How do you have the agency/control in how you respond?”
- “When/how have you been able to respond differently to contexts in which you usually experience anxiety?”

drama therapy activity: drama therapy mandala (15 minutes) (appendix f).

Directions:

- Review the 5 areas of the Mandala: Guide, Skills, Artiste, Vulnerability, and Belief.
- Give each participant a few pieces of paper.
- Draw the Mandala on a white board / Chart paper.
- Participants are encouraged to fill in the 5 areas of the Mandala, as it relates to them, and their own characteristics.
- Once everyone has put as many qualities as they would like on the board (anonymously, if they choose), the facilitators will verbally highlight some of the similarities to the group.
- Discussion questions:
 - “What does everyone notice about what others have put about themselves?”
 - “Did anyone find one category more challenging than others?”
 - “Less challenging than others?”
 - “How do these traits help in moments of worry?”
 - “How can these traits help you to respond differently in worried moments?”

drama therapy activity: role play (30 minutes).

Directions:

- Provide participants with scenarios relevant to situations they’ve provided in discussion.
- Allow participants to explore the traits discussed in the Mandala in the scenes provided.
- Repeat the same scene multiple times to encourage the use of multiple skills in the same scenario, also allowing other youth to share their suggestions in the same scene.
- Discussion:
 - “What stands out about the different skills used?”
 - “Which of these skills have you tried before? What worked? What didn’t?”
 - “What skills are you using to work toward your goal (guide) in these scenes?”

drama therapy activity: caption making (15 minutes).

- Encourage participants to consider creating a headline for their school newspaper.
- Give small groups a piece of paper to brainstorm on. They can create up to 3 headlines to share with the rest of the group.
- “If the school had a newspaper, how might the captions read if they were to report on the issues you’ve described above?”

3. Allow discussion surrounding the captions that emerge.

closing (10 minutes).

Directions: Debrief the group with a discussion on the session’s focus and activities.

Week Seven: Putting it All Together

check-in (5 minutes).

Directions: Engage the group in a discussion around how group members have been responding to anxiety over the last few days and if they have noticed any changes since the previous group session.

response-based conversation: changing the script (10-15 minutes).

Example Questions:

- “Now that we have the full story on anxiety in your life, what can we do to change the script?”
- “How would you prefer to respond? What would you rather do and feel?”
- “When have you been able to do this in the past? What was that like for you? How was it different?”
- “Who can you lean on for support in responding differently?”

drama therapy activity: mask painting (15 minutes).

Directions:

- Give participants two plain white masks.
- The first mask reflects participant’s dissatisfying responses to anxiety, and the second mask reflects the client’s preferred responses.
- Participants will then explore both masks through scenes suggested by the facilitator, but still in connection to topics the youth have previously suggested themselves. Example scenes:
- Scene 1: Writing a test.
- Scene 2: Argument with parent.
- Scene 3: Trying to tell a teacher about a bully.
- Discussion surrounding the dissatisfying response (with the first mask) and the preferred response (with the second mask).

drama therapy activity: role play (30 minutes).

Directions:

- Provide participants with scenarios relevant to situations they’ve provided in discussion.
- Allow participants to explore the traits discussed in the Mandala in the scenes provided.
- Repeat the same scene multiple times to encourage the use of multiple skills in the same scenario, also allowing other youth to share their suggestions in the same scene.
- Discussion:
- “What stands out about the different skills used?”
- “Which of these skills have you tried before? What worked? What didn’t?”
- “What skills are you using to work toward your goal (guide) in these scenes?”

closing: (10 minutes).

Directions: Debrief the group with a discussion on the session’s focus and activities.

Week Eight: Performance/Reflection

check-in (5 minutes).

Directions: Engage the group in a discussion around how group members have been responding to anxiety over the last few days and if they have noticed any changes since the previous group session or their time in group overall.

response-based conversation: review of everything covered (10 minutes).

Example questions:

- “What has been the biggest learning that you have had?”
- “How has your experience of anxiety changed? What is different?”
- “What is your biggest takeaway from this group?”

drama therapy activity: freeze (35 minutes).

Directions:

- Game begins with one scene (Example: dealing with a bully).
- Two participants volunteer to act out a very brief scene, trying to include as much physical movement as possible.
- Other group members can yell “freeze,” which prompts the two youth currently improvising to freeze.
- The youth who yelled freeze can then enter the improvisation space and “tap out” one of the youth currently in the scene.
- The youth who yelled freeze then takes on the shape the former youth was frozen in, and begins a new scene, demonstrating another preferred response to a different worry provoking situation.
- This is followed by a conversation that reviews what youth saw in each other’s improvisations, and what they find helpful/unhelpful.

closing: (15 minutes).

Directions: Debrief the group member’s time over the last eight sessions, exploring what they are taking away from their time in group.

Chapter Five: Discussion and Conclusion

When first contemplating the possibility of conducting a group within a government organization, such as CYMH, we had to consider the overall need, as there are multiple groups run through CYMH annually that appeal to a variety of age groups. However, as previously stated, CYMH primarily focuses on evidence-based, behavioural therapies, such as CBT and DBT, in their group design. Though both of these methods have empirical research to back their efficacy (Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008; Seligman & Ollendick, 2011; Rakfeldt, 2005), we were intrigued by the potential benefits of an alternative therapeutic practice in a group setting. Due to the extensive waitlists for clients to receive services through CYMH, there is often ample room to create a group that will enable multiple youth to move off the wait list or transition from their individual therapist into a group sooner (“Child and Youth Mental Health Plan,” 2003).

As the Ministry of Child and Family Development (MCFD) cites on their homepage, “Research shows that the average overall community prevalence rate for mental health disorders in children and youth is 15% (About Child and Youth Mental Health, n.d.). Despite these statistics, we wanted to challenge the notion of “mental health disorders” arising within children and youth, and to emphasize the contextual factors that contribute to youth experiencing distress. In other words, we were interested in providing programming for CYMH that celebrated the many ways in which children and youth resist challenging circumstances and oppression, and how engaging youth’s imagination, creativity, and humour may help to diminish suffering (Richardson & Bonnah, 2015). Our objective was to create a group that embraced creativity and worked “anti-oppressively” to highlight and understand the various forms of oppression that children and youth experience (Richardson & Bonnah, 2015). Because limited opportunity for such a group currently exists within the CYMH framework, we sought to create this group for youth to explore their own acts of resistance through theatrical means, as “theatre has had an historic role in society in providing a relatively safe way of talking back to power” (Prendergast & Saxton, 2009, p. 7).

Approval Process

Despite the benefits of pitching a response-based expressive arts group, there were some challenges in doing so with an organization that had primarily manualized, easily replicable youth anxiety groups at their disposal. For example, at the time we presented our concept to the organization, CYMH was already offering The Cool Kids Anxiety Program (“Cool Kids,” n.d.), which combined the use of psychoeducation, cognitive behavioural strategies, and the use of medication (when considered necessary by clinicians). This group was targeted towards youth between the ages of 8 and 12, with flexibility to move into the younger middle years. The second anxiety group was a CBT group for teens called Reducing Anxiety and Depression (RAD) (Saanich Child and Youth Mental Health Services, 2014). This manualized group was available to youth between the ages of 13 and 18, providing service to a large age range. Furthermore, each of these groups directs families toward the Anxiety BC website, which embraces a CBT approach to addressing anxiety (Anxiety BC, 2007). We recognized that our group design viewed anxiety through a different lens, not represented in CYMH groups at the time. We also realized the benefit of creating a manualized version of our group to increase the organization’s overall comfort in supporting the development of this group. Due to the incredibly limited research available on response-based or drama therapy treatment of adolescent anxiety, general research on both modalities was provided to CYMH team leaders, as well as our practicum supervisors during case consultations for one-on-one clients.

Limitations

Like all other therapeutic programs and interventions, this group had several limitations and constraints that held implications for its effectiveness. The group itself requires considerable facilitator flexibility, as the primary objective is to create a group space eligible to discuss, deconstruct, and explore contextual factors associated with youths’ responses to anxiety. This poses challenges when attempting to create a manualized group, as the nature of drama therapy is to remain open to the client’s own creative processes, whereas manualized groups are created in an attempt to be replicable with similarly measurable results each time (Strupp and Anderson, 1997). Furthermore, drama therapy requires a therapist to be comfortable with improvisation, as the group design indicates that each activity and debrief conversation is determined by the participants (Weber and Haen, 2005). Comparably, response-based practice rejects the “expert” stance of the therapist, and considers the youths’ agency within the context of their anxious responses (Yuen, 2007). Therefore, in conducting this group through additional community agencies, it may prove useful to include training or group discussion surrounding the facilitating therapist’s own therapeutic orientation, ensuring the integrity of the response-based discourse remains, as the language is paramount to facilitating the group as first proposed.

Additionally, the participant referral process also proved challenging. The youths’ current clinicians and the CYMH intake clinician conducted the screening for the group, and referred participants as they deemed appropriate. However, despite our efforts at providing clear screening guidelines and requesting the participants first complete the Beck Youth Inventory II, distinct variations in clinician screening took place. Although an “ideal” candidate for such a group does not necessarily exist, we first stipulated that referred youth have a basic understanding that the group would employ a host of dramatic techniques, and participants would vary in age from 11-14. It quickly became apparent that not all of the youth referred to the group were made aware of these guidelines, which impacted the overall attrition rate.

A final limitation of the group was the variations in our own supervision provided by our practicum supervisors. Though the supervisors themselves were in support of the group and made aware of the above criteria for referral, supervision rotated between three CYMH clinicians throughout the course of the group, leaving limited opportunity for the youth to become accustomed to and comfortable with the presence of each supervisor. Due to the weekly rotation of supervising therapist present during the group, it begs the question as to whether or not youth participation was inhibited due to this added variability, as inconsistency is a precursor of anxious responses (Grillon, 2002). Group structure, supervision, and participant consistency may have improved the participants' group experience and decreased their feelings of anxiety in connection with the unpredictability of the third therapist present, thus enabling further participation in the semi-structured dramatic activities and response-based discussion.

Future Implications

This group design has implications for a variety of professionals, such as community counsellors, youth and family counsellors, high school counsellors, and community mental health agencies, as it addresses the need for alternative approaches to supporting children and youth who experience anxiety. The group design and implementation was deemed successful by CYMH in its initial launch, as evidenced by our final group debrief session with our practicum supervisors who witnessed the progression of the group. Some final thoughts provided by the supervisors were related to individual client engagement and screening processes. For instance, as mentioned above, despite efforts to screen for appropriate client fit for the group, some youth chose not to participate in many of the activities. This appeared to inhibit the group's level of comfort with higher risk drama activities. Additionally, we noticed a correlation between youth referred by their own clinicians, versus those referred by the intake clinician. Youth referred by the intake clinician appeared to struggle to commit to the group's predetermined rules, as created by the youth themselves in the first session as guidelines for safety. Though this requires further investigation, it may be useful to ensure that each of the participants has access to individual therapy to ensure that the youth feel that they have enough space for follow up conversations in a one-on-one setting. A way to possibly mitigate the above concerns is to self-screen for participant fit.

It is also important to note that to our knowledge, a group of this design has yet to be offered in Child and Youth Mental Health clinics. Therefore, providing such programming could begin to integrate non-behaviourist therapies into group therapy settings. With that said, the efficacy of such a group still requires validation through the evaluation of pre- and post- assessment measures of each participant. Such findings could be useful in a government funded mental health organization when attempting to gain approval and funding to launch a manualized version throughout the province. Furthermore, such research would have increased implications for the field of response-based therapy and drama therapy, since very limited research has been conducted on the use of such modalities with youth experiencing anxiety.

Conclusion

Throughout the group design process, our overall goal was to provide alternative means of supporting youth experiencing anxiety within a community mental health setting, in which CBT continues to dominate therapeutic discourse. However, despite the widespread use of CBT in community mental health agencies, research shows the necessity to explore alternative means of providing therapy, due to recent evidence indicating that at least one third of anxious youth who

participate in CBT treatment do not have positive responses (Hudson et al., 2013; Miller, Short, Garland, & Clark, 2010; Podell et al., 2013). Although the prospective of launching a group through Saanich CYMH likely seemed alluring to clinicians due to the wait list and transition planning of current clients, attempting to launch a group utilizing response-based concepts did pose some challenges in convincing clinicians of the validity of our chosen approach. Fortunately, we were given the opportunity to present both response-based and drama therapy principles to Saanich CYMH clinicians, as a means of demonstrating the possible benefits of using response-based techniques within a drama therapy framework to the people who would be finding these principles useful in the future. Furthermore, the group design itself allows for multiple youth to receive service at the same time, thus freeing up clinicians who already have a full caseload to take on new clients from the waitlist. Finally, in creating a detailed manual, we made it possible for the Saanich CYMH team to continue to run the group without us available to facilitate. However, with that said, it would be beneficial for the manualized group to continue to be facilitated with flexibility, and by clinicians who are familiar with response-based processes. In moving forward, we hope to continue to provide response-based drama therapy group opportunities to community based organizations.

Appendix A: Response-based Drama Group Screening Items

If possible, meet with both parent/caregiver and youth together briefly for basic info giving, then youth alone. This meeting should take approximately one hour total.

- Explain content of group: 8 week long group, one session each week, running on Mondays from 4:30-6:00 p.m.
- Parent Involvement: Check with parents regarding their availability for the first session, and the final session. Although they won't be required to be present for the entirety of the first and last session, there will be brief opportunities for parental involvement at these times.
- Define drama therapy/ response-based practice: Group will begin with low-risk drama therapy activities to get everyone familiarized with each other and warmed-up. As we progress, there will be opportunity for improv and play devising. Response-based language will leave room to discuss how anxiety is a response to contextual factors.
- Assess motivation: How do you think you might benefit? What would happen if you don't do this group? How much do you want to be a part of this group? Any reasons for not wanting to do the group?
- Assess client goals: What do you hope to have happen from being a part of this group?
- Guidelines, expectations: Confidentiality, between session homework, importance of attending each session.
- Safety plan/ support for between sessions. Who in your life can help to support you with your between session tasks?
- Pre-and Post-assessment measures - the CBCL and Youth Self-Report.

Appendix B: Welcome Letter (Given to Participants)

Did you know that anxiety and worry are experiences that most (if not all) people experience?

We often hear messages that worrying is a problem, and that we would feel better if only we stopped. However, we believe that people worry when something does not feel right. For example, it makes sense to worry when we are in danger and we want to feel safe. That's why during the course of this group, we are going to take a closer look at what is happening when you feel worried. We are also interested in learning about what you do when you feel worried, and what you do to feel differently. We think it's likely that you have discovered really creative strategies of responding to worry, and we look forward to exploring these with you. We are also interested in learning about how other people respond to you when you experience worry. Our hope is that through this group, you will get the chance to explore other ways of responding to worry that are more to your liking.

We believe that you are doing the best that you can, and we are here to support you in feeling more capable in dealing with anxiety and challenging situations.

Appendix C: Three Houses & A Shed

Directions: Draw three houses and a shed under each title, and write/draw the words that fit the descriptions inside the house or shed.

House of Dreams:

House of Worries:

House of Good Things:

Shed of Resistance:

Appendix D: A Step-by-Step Guide to Responding to Anxious Moments (Given to Participants' Parents)

The following is a way of supporting your child when they experience anxious moments. It involves guidelines for ways to respond to your child and support them through their experience. This encourages a collaborative approach to responding to anxiety, and acknowledges that our different responses during these moments can influence the outcome, and encourages different responses in the future.

Here are 8 helpful steps to responding to anxious moments:

- Summarize what your child has said. Check how well you understand the problem and identify if you know what your child actually means. Communicate your empathy in a calm, compassionate tone.
- See if you can help your child identify the context in which this moment is occurring. Is there a pattern to their anxious response that you can help your child recognize?
- Discuss agency with your child. Acknowledge that they cannot change the responses of those around them, but they can acknowledge and understand their own responses with the context.
- Try to support your child to find ways to respond differently, rather than taking over the task. Help them strategize ways to navigate the situation, and identify aspects of the problem that they can control. Then allow them room to explore these aspects and see which strategies help. It can be helpful to respond by praising how creatively or intuitively they have generated these ideas, which can further encourage future comfort in these conversations.
- Respond to each strategy or idea your child has identified one by one, allowing time to really consider how helpful the new responses could be. It can be helpful to then ask what they think other responses to their responses could look like. For instance, “what would happen next if you did this?” Allow room for them to generate these possibilities and discuss them with you.
- Encourage your child to respond with the strategy that best fits for them, and that most likely prompts another positive response and outcome, while continuing to allow your child to have some agency in making these decisions. It can even be helpful to apply a rating scale (1-10) to the possible strategies, to leave room for the child to understand which responses seem the most probable to them.
- After encouraging these responses, provide space for your child to assess with you how helpful this response was. It can also be helpful to look at the responses of others around them as they responded to their own anxiety in this way.
- Evaluate how effective and supportive their own response was, while acknowledging the responses of others. This can also be helpful to include a rating scale for them to consider how helpful their own responses were, versus how others responded to them during this anxious moment.

You may find that you don't need to use all of these steps over time, or maybe you never require all of these steps! It can also be helpful to pick and choose which steps work for your family. By noticing the context in which the anxious moment occurs and establishing why your child is responding with anxiety, you may find that there are contextual factors that can be changed or responded to differently in the future!

Appendix E: “5-4-3-2-1” See Hear Feel Relaxation Technique

Sit or lie in a comfortable position, and begin to notice what you can see, hear and feel. Say to yourself gently: “I can see...*name any object in your field of vision*” and repeat for five different objects. For example: “I can see a picture”, “I can see a wall”, “I can see a lamp”, “I can see a book”, “I can see a chair”. Please note that if you do this exercise in complete darkness and you can't see anything, you can use imaginary pictures of everyday objects – just visualize them in your mind's eye, ideally choosing neutral images that don't have strong emotions associated with them, whether positive or negative. Then say to yourself: “I can hear... [name any sound you

can hear]” and repeat for five different sounds, for example: “I can hear the ticking of the clock”, “I can hear traffic outside”, “I can hear my breathing”, “I can hear a door closing”, “I can hear the wind”. Then say to yourself: “I can feel... [name any feeling or sensation you experience” and repeat for five different sensations, for example: “I can feel tension in my shoulders”, “I can feel the pillow under my head”, “I can feel the tongue in my mouth”, “I can feel my hair on my neck”, “I can feel my hand on my lap”. Repeat the sequence, this time naming only four things you can see, four things you can hear, and four things you can feel (the pictures/sounds/ sensations can be the same as last time, or different – it doesn’t matter). Repeat, naming three things you can see, three things you can hear, and three things you can feel. Repeat, naming two things you can see, two things you can hear, and two things you can feel. Repeat, naming one thing you can see, one thing you can hear, and one thing you can feel. By now, if you are not asleep yet, you should feel more relaxed and with much less “chatter” in your mind. If needed, you can repeat the procedure more than once.

*** Fill in the below headings in whatever way you most identify with!**

* Fill in the below headings in whatever way you most identify with!

Skills

(What are your skills?)

Skills

(What are your skills?)

Guide

(What motivates/ drives you?)

Guide

(What motivates/ drives you?)

Belief

(Who/ What do you believe in?)

Belief

(Who/ What do you believe in?)

Artiste

(In what ways are you creative? How do you use your creativity?)

Artiste

(In what ways are you creative? How do you use your creativity?)

Vulnerabilities

(What is difficult for you? What makes you human?)

Vulnerabilities

(What is difficult for you? What makes you human?)

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