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**“Hey! Whoa.”: Enhancing Dialectical Behavior Therapy with Drama Therapy for Patients
on a Short-Term Inpatient Unit and Trauma/Dissociative Inpatient Unit: Development of a**

Method

Capstone Thesis

Lesley University

May 3rd, 2022

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Graduate School of Clinical Mental Health Counseling: Drama Therapy

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Abstract

Dialectical behavior therapy (DBT) is a widely used treatment approach for many different populations across an array of clinical settings. There is ample supporting evidence on its effectiveness, however there is also emerging literature on the barriers and challenges when engaging with this treatment modality. Drama therapy is an embodied treatment approach that uses theatre processes and techniques to achieve therapeutic goals. The aim of this thesis was to combine drama therapy and DBT into a proposed method to explore the impact of this infusion with clients on two inpatient units: a short-term unit and a trauma/dissociative unit. This method was implemented through created drama therapy-DBT groups, on both units, that address the DBT skills of mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. The results of this process showed promising outcomes for anxiety management, enhanced confidence and self-acceptance, finding personal connection to the material, and relaxed defenses. This exploration suggests that the incorporation of drama therapy into DBT has the potential to have a positive impact on the noted DBT treatment barriers and challenges, thus making DBT more efficient and effective.

Keywords: Dialectical behavior therapy, drama therapy, barriers to treatment, short-term trauma inpatient unit, anxiety management

“Hey! Whoa.”: Enhancing Dialectical Behavior Therapy with Drama Therapy for Patients on a Short-Term Inpatient Unit and Trauma/Dissociative Inpatient Unit:

Development of a Method

“Hey! Whoa. Hey! Whoa. Take it! No.” These words are from a drama therapy theatre game. Drama therapy is an embodied psychotherapeutic approach that uses “drama and/or theater processes to achieve therapeutic goals” (North American Drama Therapy Association, n.d., para. 1). The above game is normally used in theatre as a warmup for the purpose of practicing focus, articulation, projection, eye contact, embodiment, presence, and group cohesion. Drama therapists use games like this to not only bring laughter and fun into the therapeutic space, but as distancing techniques for more heavy topics and feelings. This game has the potential to bring to the surface traumas related to interpersonal attachment but in a way that patients can safely play and interact with. Drama therapy calls this aesthetic distance, which is the concept of comfortably sitting between too close and too far emotionally activating material (Henson & Fitzpatrick, 2016). In addition, it creates the space to actively work on skills that are taught in dialectical behavior therapy (DBT).

Dialectical behavior therapy is an adapted form of cognitive behavioral therapy with the goal for individuals to better manage their stress induced behaviors, emotions, and thoughts that are causing misery and distress (Linehan, 2015). This is done by focusing on increasing skills in emotional regulation, mindfulness, distress tolerance, and interpersonal effectiveness (Linehan, 2015). Dialectical behavior therapy was originally created to eliminate or decrease suicidal thinking in clients diagnosed with borderline personality disorder (BPD) and “has become the treatment of choice for [BPD] and other complex clinical disorders in that its effectiveness is well-documented through empirically validated research” (Mercado & Hinojosa, 2017, p. 81).

However, clients who have engaged in DBT treatment have named initial interaction with skills, personalizing the skills, therapist-client relationship, intense emotions, and motivation to do skills and treatment as barriers for the treatment process and outcomes (Barnicot et al., 2015; Rogg et al., 2021; Schaich et al., 2021). These barriers lead to clients not completing treatment or getting the most out of treatment, in addition to exhausting resources (Barnicot et al., 2015; Rogg et al., 2021; Schaich et al., 2021). For example, a 12-month DBT program consists of weekly individual therapy, outside phone coaching, weekly group therapy, and therapist consultation time with other DBT therapists. This demands a substantial amount of time and resources from clients, clinical teams, and facilities. Even with the time and resources given, there are waitlists and average dropout rates of around 33% (Wieczorek et al., 2021).

At my clinical internship site, I started to notice how clients would respond to the DBT skills groups and how I felt observing them. I watched clients fall asleep, dissociate, verbally and physically express anxiety, and ask for handouts and specific exercises to better clarify the material. My attention during many of the DBT skills groups would drift, and there would be moments when I would have information overload. Noticing all of this, I became more curious about DBT's success rate and research related to client experience with the approach. As such, this thesis provides details on DBT's effectiveness and further discusses the common barriers to treatment for clients. Additionally, it expresses how drama therapy has the potential to enhance DBT and its treatment outcomes for clients by making it more embodied, personalized, and holistic. This is supported by addressing several drama therapy techniques and core processes which include: dramatic play, improvisation, aesthetic distance, role play, embodiment, dramatic projection, and metaphor. Each of these are explored in conjunction with current research on dialectical behavior therapy. In this thesis, I convey this exploration through a proposed method

applied with patients on a short-term inpatient unit and trauma/dissociative inpatient unit at my clinical internship site. I then discuss the findings related to this proposed method and share suggestions for future clinical considerations and research trajectories.

Review of Literature

Drama Therapy

Drama therapy has a framework based in psychoanalysis, behaviorism, and humanism (Emunah, 1994). These, integrated with the roots of drama therapy—dramatic play, theatre, role play, psychodrama, and ritual—create this framework (Emunah, 1994). Drama therapy is an action-based model that incorporates a holistic awareness with collaborative play which motivates participation and creates the space for therapeutic depth (Emunah & Ronning, 2021). The inherent aspects of theatre as therapy are the focus and importance on play; freedom given from acting; the necessity of a space to rehearse for imaginative or real life; the opportunity to engage, reexamine, newly navigate, and heal wounding and traumas in an embodied way; and the grounding and self-aligning awarded by dramatic ritual (Johnson & Emunah, 2021). Within drama therapy, there are specific key mechanisms of change. De Witte et al. (2021) noted that some of these changes are facilitated through active participation of a surplus reality, working at an aesthetic distance from the material, and the experience of felt awareness. Engaging in these three mechanisms of change allows for the possibility of transformation, which can be achieved through specific drama therapy core processes and techniques.

Drama Therapy Core Processes and Techniques

Dramatic Play

During the initial stages of drama therapy and often in the beginning of sessions, drama therapists incorporate play using lighthearted exercises and age-appropriate theatre games to

establish an environment that is playful and not intimidating (Emunah, 1994). This creates a protective and vital boundary during the beginning stages because of the natural distance generated within playing (Long, 2021). Creating this environment with dramatic play is important because utilizing inappropriate techniques at the beginning can lead to dropouts and vacillating attendance because of client reluctance and activated defense mechanisms (Emunah & Ronning, 2021). Additionally, incorporating play, especially in the beginning stages of treatment, builds the environment to cultivate self-esteem as well as confidence and trust in self, other group members, and the therapist (Emunah, 1994). This process of group and self-cohesion occurs naturally over time in therapy. However, utilizing play in the initial stages can speed-up and reinforce this process (Emunah, 1994).

It is proposed that play aids clients through emotional and psychological obstacles that impede personal growth and overall well-being (Long, 2021). By engaging in dramatic play with a client, a playful rapport and initial understanding of unseen issues and psychological obstacles are initiated (Emunah & Ronning, 2021). Therefore, a drama therapy play space has the ability to transform the macro world into a micro one for clients to explore and “create within the sessions a playful relationship with reality” (Jones, 2007, p. 93).

Improvisation

Emunah (1994) postulated that spontaneity is crucial in improvisation. When one responds spontaneously, they are reacting from their initial desires and impulses (Emunah, 1994). The spontaneous and improvised space can establish an awareness around habitual responses and patterns (Emunah, 1994). Consequently, these can be acknowledged, worked through, and altered, if desired, in this same space (Emunah, 1994). Drama therapists utilize improvisational games and exercises like “Hey! Whoa” to create this spontaneous and

improvised environment for clients to explore these aspects of themselves and their conditioning (Emunah, 1994). The change from the playful, imaginary space to the personal and intimate is initiated by the clients through their here-and-now reactions and connections to the present material or fictional world (Emunah & Ronning, 2021). The job of the drama therapist is to attune these shifts to discovery where the client holds meaning and challenges associated with past trauma or life experiences (Emunah & Ronning, 2021). As Emunah stated, “Without spontaneity, one cannot act in the present moment; one is tied to the past, held back by the future” (Emunah, 1994, p. 35).

Aesthetic Distance

Aesthetic distance is created through drama therapy techniques that are innately projective, such as role-play, object work, masks, puppets, figurines, and monologues (Henson & Fitzpatrick, 2016). Aesthetic distance, “also known as balance of distance” (Landy, 1997, p. 367), is the concept of being and fluctuating between over-and-under-distance, which facilitates the management of differing and complex emotional states for clients (Henson & Fitzpatrick, 2016). Under-distanced is when a client is emotionally too close or overwhelmed by material or the experience at present, and over-distanced is when they are not close enough to the present emotional material (Henson & Fitzpatrick, 2016). Finding aesthetic distance is different for every client, and it is suggested that those who are emotionally too close to material need to engage first with over-distancing techniques, while alternatively, when one is not close enough, they should explore through under-distancing techniques (Emunah, 1994). It is suggested that to build trust and comfort in the beginning sessions, one should use over-distancing exercises and activities because of the safe distance in which all can initially engage (Glass, 2006).

Role Play

Role play in drama therapy allows clients to connect with the real through the imaginative (Emunah & Ronning, 2021). Role playing is the action of playing a character, whether it is oneself, someone from one's life, or a fictional character (Jones, 2007). In drama therapy, this can appear as scene work and personification of external objects or material (Jones, 2007). Role playing and scene work, then, allow clients to explore the experience of another person or themselves within a created and dramatized representation of their life (Jones, 2007). This gives permission for clients to practice, transform, and see parts of their reality from differing perspectives and ideally an aesthetic distance (Jones, 2007). Role play can create opportunities for clients to experiment and engage with what they choose to avoid, consciously and unconsciously, in their lives (Jones, 2007).

Role play in a drama therapy space enables exploration of the notion of “rehearsal for life” (Emunah & Ronning, 2021, p. 49). This concept creates openings for clients to explore real life matters without repercussions and in a supportive space (Emunah & Ronning, 2021). Role plays enable the fictional space to meet reality and vice versa. This is noteworthy because it allows for therapeutic opportunities due to the role play being a representation of real-life experiences instead of factual life itself (Emunah & Ronning, 2021). At the beginning, the client has the control over how much fictional versus how much real that takes place in the scene work and role play (Emunah & Ronning, 2021). The drama therapist attunes to this shift, which indicates the client is ready and comfortable to engage with real-life challenges in the play space (Emunah & Ronning, 2021).

Dramatic Embodiment

Dramatic embodiment has been named as a therapeutic mechanism of change and something that deepens experiencing in therapy, which has been shown to make therapy more

effective (Armstrong et al., 2016; de Witte et al., 2021). Embodying or acting out material involves engaging and experiencing the body in the present, or here-and-now (Jones, 2007). Dramatic embodiment allows for the body and mind to be connected and engaged while they encounter and discover together in a therapeutic space (Jones, 2007). This leads to gained understanding through a more holistic approach where the knowledge obtained can be viewed and reflected more abstractly or concretely (Jones, 2007). By engaging the body in a dramatic play space, one can explore past traumas in the here-and-now in a safe, therapeutic space.

Dramatic Projection

In drama therapy, dramatic projection occurs when clients project parts of themselves on to characters, roles, monologues, puppets, or small objects like figurines (Jones, 2007). This is important in drama therapy because this process creates a distanced connection between one's emotional states and an external play object with which to explore these states (Jones, 2007). This externalized material and inner conflict can be explored and examined, which has the potential to create change due to the distanced perspective (Jones, 2007). A change can occur because once the internal is externalized, the client can explore a new relationship with the material and can then reintegrate with a new knowledge and perspective (Jones, 2007).

Metaphor

Finally, drama therapists utilize metaphor as a core process to facilitate aesthetic distance of overwhelming emotional material so clients can safely and comfortably explore internal issues (Jones, 2007). This distance gives clients the opportunity to address and connect with a conflict they would not feel comfortable directly engaging with in real-life (Jones, 2007). Metaphor is also used when a client is struggling with an impasse or to understand a problem (Jones, 2007).

This seems to operate and work under the idea that using metaphor gives an outlet to understand the unfamiliar by incorporating and introducing something that is familiar (Jones, 2007).

Dialectical Behavior Therapy

Dialectical behavior therapy was initially created for clients diagnosed with BPD and has become one of the most commonly used treatment modalities (Mercado & Hinojosa, 2017). This approach “has been proven to reduce suicide attempts, nonsuicidal self-injury, drug use, symptoms of eating disorders, and to improve psychosocial adjustment and treatment retention” (Landes et al., 2021, p. 66). Dialectical behavior therapy was created with biosocial theory in mind (Linehan, 2015). This theory is based on the idea that some individuals are born more sensitive to environmental emotional cues, perceived or not, and that there is a significant interaction with ineffective and invalidating environments. Therefore, some individuals need more guidance and a set series of personal skills to help regulate with small and large life experiences. The main modes of treatment for DBT are by way of skills worksheets that are taught in a discussion and instruction-based format (Landes et al., 2021), group and individual therapy sessions, and phone coaching with the focus being on learning the DBT core skills of mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance (Landes, 2021).

DBT Core Skills

The DBT manual provides an overview of several techniques that are outlined in four core skills sections, which each include corresponding worksheets. These core sections are reviewed next.

Mindfulness

The goal of mindfulness in DBT is to reduce tension and stress, gain awareness and control of one's mind, and accept reality as it is (Linehan, 2015). The DBT practice of mindfulness involves "intentionally living with awareness in the present moment...without judging or rejecting the moment...without attachment to the moment" (Linehan, 2015, para 1). Mindfulness is the first skill taught in DBT because it is vital for the acquisition of the other skills and general wellbeing (Zeifman et al., 2020). Additionally, research indicates that there is a positive link between mindfulness and improved clinical outcomes (Zeifman et al., 2020).

Interpersonal Effectiveness

The goal in the DBT interpersonal effectiveness skills is to learn how to set boundaries, fulfill one's needs, build healthy relationships and end damaging ones, validate one's experience, learn that balance and change are necessary for healthy relationships, build empathy for other perspectives, and end unwanted behaviors. This is a very skill-heavy section that involves many worksheets and homework assignments to track thoughts, behaviors, and progress (Linehan, 2015).

Emotional Regulation

Goals of emotional regulation are to understand and identify one's emotions, lessen the number of unpleasant emotions, increase knowledge of resiliency to cope with strong emotions, and reduce distress when experiencing painful emotions. In this section, clients learn where emotions come from and why they are important (Linehan, 2015). Biology and daily psychosocial stressors are discussed as contributing factors to managing emotions (Linehan, 2015). There are many correlating worksheets in this section as well.

Distress Tolerance

The distress tolerance skills involve the incorporation of the body by exposing it to muscle relaxation and sensory related techniques as well as the use of hot and cold temperatures (Linehan, 2015). These strategies immediately shock the nervous system when in high emotional distress. Goals of distress tolerance encourage radical acceptance of reality as it is, how to practice freedom from thoughts and urges, and how to survive highly distressful circumstances (Linehan, 2015).

Population and Setting

Dialectical Behavior Therapy is one of the therapeutic treatment approaches that has the most evidence-based literature on its effectiveness to decrease suicidal thoughts, self-harm, and emotional dysregulation for clients (Clarkin et al., 2007; Heard & Linehan, 1994; McMMain et al., 2009; van den Bosch et al., 2014; Verheul et al., 2003). Yet, there is evidence supporting lack of client engagement over an extended period, which naturally leads to an eventual resurgence of symptomology (van den Bosch et al., 2014). As stated, DBT was originally developed to treat those diagnosed with BPD and is now currently used in many clinical settings to treat multiple mental health diagnoses (Mercado & Hinojosa, 2017). There is limited research on DBT in short-term inpatient settings and more with outpatient, residential, and community programming (Clarkin et al., 2007; Heard & Linehan, 1994; McMMain et al., 2009; van den Bosch et al., 2014; Verheul et al., 2003). This approach was developed with a Western, affluent, and educated population context (Haft, 2022), however there have been adaptations to experiment with how transferable it is to other diverse groups (Haft et al., 2022; Keng et al., 2021; Mercado & Hinojosa, 2017). Additionally, DBT treatment programs are traditionally long, expensive, and resource depleting, which contribute to the challenges of accessibility and sustainability (Popowich et al., 2020; van den Bosch et al., 2014; Wiczorek et al., 2021). Therefore, there

have been efforts to adapt the DBT model by experimenting with condensing it into less weeks (van den Bosch et al., 2014; Wieczorek et al., 2021). This has been done in many ways such as distilling the DBT skills groups into a 12 to 20-week process (Wieczorek et al., 2021).

Barriers in DBT treatment

Most research done on DBT is quantitative and does not focus on the qualitative aspects of engaging in DBT treatment (Little et al., 2018; Rogg et al., 2021). Rogg et al. (2021) and Little et al. (2021), who have engaged in some of this qualitative, client-perspective work, suggest more involvement in this realm as further evidence emerges about the challenges in participating in DBT treatment (Barnicot et al., 2015; Little et al., 2018; Rogg et al., 2021; Schaich et al., 2021). These challenges, as expressed by clients, include specific barriers to treatment: initial interaction with skills, personalizing the skills, therapist-client relationship, intense emotions, and motivation to do skills (Barnicot et al., 2015; Little et al., 2018; Rogg et al., 2021; Schaich et al., 2021). If clients are not able to properly learn, internalize, or find motivation to do the skills, then that directly and indirectly impacts the rest of their treatment and opinions on the DBT skills utility (Rogg et al., 2021). For example, if a client struggles or fails to integrate a mindfulness or emotion regulation skill, then it can directly impact their ability to regulate when learning other skills and in life. Each barrier is discussed in more detail below.

The First Barrier: Initial Interaction with the Skills

Qualitative literature states that interpersonal anxiety in group sessions, pace, manualized language, and mode of learning the skills directly impacts absorption and receptiveness to DBT material (Barnicot et al., 2015; Little et al., 2018; Schaich et al., 2021). Clients shared their anxiety about being in groups with others as a component that hindered their treatment in the beginning and expressed making skills learning more enjoyable, participatory, and collective

with the whole group (Barnicot et al., 2015) as a suggestion to lessen anxiety. Additionally, the challenging initial interactions with the language and vernacular used in DBT “has the potential to alienate individuals and hinder the use of skills and techniques” (Little et al., 2018, p. 296).

The Second Barrier: Intense Emotions

Clients expressed in moments where emotions were too much that they were not able to, or struggled to, engage in DBT skills (Barnicot et al., 2015; Schaich et al., 2021). They shared that they were lost due to emotional overload (Barnicot et al., 2015; Schaich et al., 2021). Over time, some were able to integrate the skills more effectively because of the regular and consistent use of them and practicing them during less emotional highs (Barnicot et al., 2015; Schaich et al., 2021). There was also a qualitative finding that using the opposite action (OA) DBT skill created challenging feelings and emotions (Rogg et al., 2021) because of the exhaustion that sometimes followed the utilization of it. This correlates to similar findings from Barnicot et al., (2015) and Schaich et al. (2021).

The Third Barrier: Motivation to Engage and Continue Treatment

This was expressed as a barrier that is multifaceted in that motivation is individual to the client and their own processes (Barnicot et al., 2015; Rogg et al., 2021; Schaich et al., 2021). Clients conveyed that engaging with the OA skill was demanding and exhausting, so they shared that the practice of envisioning goals was helpful when not feeling motivated to utilize skills (Rogg et al., 2021, p. 55). Clients also expressed that repetition and physical practice of skill work would build an innate internalization of the skills (Rogg et al., 2021).

The Fourth Barrier: Therapist-Client Relationship

Clients expressed the importance of therapist interactions, communication approach, and therapist support (Barnicot et al., 2015; Schaich et al., 2021). If therapists were not personable,

too fast with delivery of material, and not transparent enough, this aided in clients not successfully absorbing the DBT material or enjoying the treatment process (Barnicot et al., 2015; Rogg et al., 2021; Schaich et al., 2021). Clients appreciated when therapists were more involved in the collective process and disclosed their personal connections to the skill work (Barnicot et al., 2015). Clients also enjoyed when therapists regularly checked in with the group as well as teaching the skills in a light way through a variety of different formats (Barnicot et al., 2015). Additionally, burnout of DBT therapists due to lack of resources and normal length of DBT programs is normal in the field (Landes et al., 2021; Popowich et al., 2020). This can lead to therapists not being as available for the important DBT element of phone coaching and or who cannot fully attend to their clients (Landes et al., 2021; Popowich et al., 2020).

The Fifth barrier: Personalization of the Skills

It took clients trial and error to discover which skills and what aspects of those skills worked for them (Barnicot et al., 2015; Rogg et al., 2021; Schaich et al., 2021). What helped this process was learning from other group members and hearing about their experiences (Barnicot et al., 2015; Rogg et al., 2021; Schaich et al., 2021). Additionally, to improve the teaching of skills and make it more personalized, clients proposed giving more examples related to real life as well as an evaluation of their personal behaviors as connected to the skills work (Rogg et al., 2021).

Inpatient Units

The environment of an inpatient unit is set up to stabilize admitted patients. Each patient is assigned a treatment team that often consists of a psychiatrist, social worker, and head nurse (McLean Hospital Guide to Inpatient Care, n.d.). The external treatment team can consist of group therapists, mental health workers to check in with, additional nurses, and pharmacists (McLean Hospital Guide to Inpatient Care, n.d.). The patients and their treatment teams

collaborate to create a treatment plan that aligns with values and goals for the client (Seton, n.d.). This could include medication changes and connections to outside resources such as outpatient therapists and other mental health facilities for continuation of treatment for one's specific diagnosis (Seton, n.d.). The setting also comprises groups occurring throughout the day which include therapeutic and fresh air groups (McLean Hospital Guide to Inpatient Care, n.d.; Seton, n.d.). The average stay is about a week or two with instances of longer stays that could add up to a few months. This depends on if the client is safe from self-harm and stable enough to continue treatment outside of the hospital (Seton, n.d.).

Methods

For this method, I sought to learn what would occur if DBT skills were taught in conjunction with drama therapy. The method attempts to address the barriers discussed above as well as teach DBT with the goal for clients to internalize the skills more quickly and effectively, while keeping it emotionally manageable and playful rather than overwhelming, distressful, and confusing (Barnicot et al., Little et al., 2018; 2015; Rogg et al., 2021; Schaich et al., 2021). To determine the feasibility of integrating DBT and drama therapy, I created four separate group plans to execute at my clinical internship site. Each designed plan addressed one of the four pillars taught in DBT: mindfulness, interpersonal effectiveness, emotional regulation, and distress tolerance. Two of these skills groups, mindfulness and interpersonal effectiveness, were conducted twice, while emotional regulation and distress tolerance were implemented once. This was due to what was needed on the units during the thesis' specific time frame. The structure of the mindfulness group was not changed for the second facilitation. At this time, no changes felt necessary because of the success of the first attempt. Additionally, the activities utilized for all the groups went through a trial-and-error phase. This was done by personal observations of

activities that had been received positively in groups on both units over multiple months. However, there was a change in method delivery for the second group of interpersonal effectiveness because of group member size.

Setting

I worked with adult patients from two different units in a large psychiatric hospital in the Northeastern region of the United States: a short-term inpatient unit and a trauma and dissociative disorders inpatient unit. I utilized the units' main group rooms where most groups were held. These rooms are located directly on the units. The trauma/dissociative disorders unit room is a large space with chairs lined up around the wall of the room. The short-term unit spaces are medium in size and have a small coffee-like table in the center of the room. The DBT skills groups were in the late mornings or early afternoons and the expressive therapy groups most often were in the late afternoons. Clients were not obligated to go to groups, but they were encouraged by their treatment teams to attend.

Population

Patients on both units range from 18-65+ years old with a variety of psychiatric disorders including major depressive disorder, generalized anxiety disorder, bipolar disorder, posttraumatic stress disorder, and personality disorders, with the most common being borderline personality disorder. Both units are considered short-term, inpatient units admitting those who have suicidal ideation, attempted suicide, or manic and/or depressive episodes. Interventions used to assist stabilization of patients are medications, development of new coping strategies, and psychoeducation. An array of skills, medication management, and expressive arts therapy groups were offered throughout the week on both units. Group attendance was not mandatory but heavily encouraged with groups ranging anywhere from 2-13 members.

Due to the nature of both units, the Covid-19 pandemic, and differing paths of recovery, patients' treatment timeframes typically range from as little as a week to a few months. At the time that the method for this thesis was implemented, the short-term unit had longer admissions than the trauma and dissociative unit. In addition, the short-term unit had two separate sides, North and South, both offering the same care but with different staff on treatment teams. For this unit, most of the time, the expressive arts therapists are the only team members that float between the two sides. I mention these details to comment on attendance and engagement or double engagement from patients. Regarding this thesis, no client attended the groups connected with the method twice due to my chosen spacing.

The skills groups mainly focused on learning DBT core skills; and the expressive arts therapy groups included visual arts, drama, and music therapies. There was a skills and expressive arts therapy group offered every day, Monday through Friday. I took advantage of this by implementing my method in many ways, based on the day and what was needed on the unit for the patients. I either weaved drama therapy and a DBT skill together for a skills group or led a skills-themed drama therapy group following a DBT skills group taught by a social worker trained in dialectical behavior therapy.

In the following sections, I will present group agendas that were created for the proposed method. The goal was to create individualized agendas for every DBT skill. Below are the summaries of the plans that were used in the therapy groups. For the full plans used, see Appendices A, B, C, and D.

Mindfulness: Mindfulness in Action (Appendix A)

The opening of the mindfulness group consisted of starting with the DBT mindfulness handout 1A (see Appendix A1) detailing what is mindfulness. The core section included mental

and physical activities to practice mindfulness: theatre game Zip-Zap-Zop, yoga poses/stretchers, group story, daily mindfulness cards. The closing included group members to go around and name one mindfulness activity that they would like to try and incorporate into their life.

Interpersonal Effectiveness: Hey! Whoa. (Appendix B)

The opening of the interpersonal effectiveness group involved playing the theatre game “Hey! Whoa.” This is a circle game where group members need to engage with all group members. The core activity incorporated the card deck *Boundaries* (Harper, 2021). Each card has a “What would you do?” scenario written on it. The group was divided into pairs and the pairs had to pick a card to create two separate scenes from it: One scene represents a more impulsive response to the scenario and the second scene is a reflective, less impulsive response. Each pair had to present their scenes. Closing consisted of stating one thing you will take from group and one thing you will leave behind.

Emotional Regulation: Opposite Action Monologues (Appendix C)

The opening of the emotional regulation group had group members communicate how they were feeling but using their bodies to show this. The group physically mirrored each feeling shared. The core activity involved reading through as a group the DBT emotion regulation handout 3: What Emotions Do for You (see Appendix C1). Then it moved on to using the DBT emotion regulation handout 10: Opposite Action (see Appendix C2) where group members were instructed to look at first box. Out of the four emotions, members chose one to focus on. Group members were then instructed to write a monologue in the voice of their chosen unpleasant emotion. Once complete, group members read a line or two out loud to the group. Next was looking at the emotion wheel handout (see Appendix C3) where members were instructed to identify a more pleasant emotion that could help or guide the first emotion they chose. Group

members then had to write in the voice of this more pleasant emotion and think of an accompanying gesture. All then presented their guiding emotion monologue with correlating embodied gesture. Closing for this group entailed standing in a circle and having each group member embody their guiding emotion with all others mirrored.

Distress Tolerance: In Challenging Moments (Appendix D)

The distress tolerance group began with a drama therapy activity of sculpting scenes for specific locations. Participants joined the sculpt of a specific place, acting as a person, item, or aspect of that place. Three of these scenes were completed. The core activity started with passing out the DBT distress tolerance handout 4: STOP skill (see Appendix D1), correlating four-boxed handout (see Appendix D2), and emotion wheel handout (see Appendix C3). Once we read through appendix D1 as a group, each member filled in all four boxes of Appendix D2. Once these were completed, members were instructed to create a physical sculpt or gesture for each box. The goal was to do these gestures in a row like a moving story. Each group member showed their moving story and we discussed as a group. The closing consisted of group members embodying or “sculpting” their last box, “Proceed mindfully.” This was done in a circle and the group mirrored everyone.¹

The groups’ results were recorded through my own personal reflective journal entries after every group. These reflections consisted of thoughts, feelings, and observations during sessions based on interactions between group members, what was shared by individuals in and after groups, and the general feeling of what was taking place in the group room. The journal entries were purposely written in a free-write format accompanied later by supplemental

¹ The Distress Tolerance core exercise with worksheet (Appendix D2) was an adaptation inspired from an activity created by a cohort friend and peer, Travis Ciempa.

technical notes on group structure and implementation for future review and use. The emotional regulation group had additional notes from a drama therapy peer and colleague who observed this particular group. Sharing the results through themes was intentional to show direct interconnection with the DBT goals and drama therapy themes discussed in the literature review. Most of the details presented below come directly from my reflection journals and correlating notes.

Results

From the combination of reflections and notes, main themes emerged: anxiety management, enhanced confidence and self-acceptance, finding personal connection, and relaxed defenses.

Anxiety Management

In all six groups, there was a felt sense of reduced and managed anxiety after engaging the body. This was supported by more loose and open body language as well as laughter. In my observation, it did not seem to be attributed to anxious laughter because it occurred during the opening game activities. During the mindfulness group's opening activity, two clients spoke about their social anxiety because the activity consisted of playing a game in a circle which involves making eye contact. Both clients made it through this activity and presented with more open body language after the activity's conclusion. Later, during the group story activity, this same group did not think about their anxiety until I asked the following questions at the end of this activity: "what was is like not being able to prepare for what to say next? Did anyone have some anxiety or want to plan?" One client shared not being impacted, while another stated not thinking about it until that moment, since I mentioned it. This same client shared there was little anxiety, but it was hard to notice for them and that they were not overtaken by it. In the other

mindfulness group on the trauma/dissociative unit, during this same activity, there were some echoes of anxiety around not being able to think ahead of what to say; however, each person managed anxiety and contributed to the group story each time.

On the same unit during the interpersonal effectiveness skills group, I guided a client through a scene based in a restaurant where someone's child was running around disturbing dinner for guests. This client had destabilizing anxiety because they did not know how to proceed in the scene other than angrily express feelings or walk away entirely, and not address wants or needs, which was displayed in the first scene. The goal for the second scene was to act it out in a less impulsive and more reflective response in accordance with values. This client became anxious when asked to do this alternative scene. The client paused during the scene and said they did not know what to do and named they were shaking and anxious. Also, the client expressed that the situation reminded them of past experiences in their life. In that moment, we as a group spoke about and worked through alternatives. After discussing, the client settled on kindly asking the mom in the scene to control their child first. Then when that did not work, the client asked the wait staff to help. The client was able to accomplish the scene from start to finish while managing their anxiety.

During the emotional regulation skills group, one client mentioned this was the first group on the unit for which they were able to fully sit through and participate in a long time. This was because of how severe their anxiety had been, which limited their engagement and attendance in groups. They commented on feeling comfortable and less consumed by fear, which was the emotion they chose to focus on for the activity. The distress tolerance skills group had a felt sense of ease after the opening activity, which continued through the activity's remainder

and closing. This observation was confirmed by looser body language and the desire to share their thoughts and feelings in relation to the core activity when the time came.

Enhanced Confidence and Self-Acceptance

For the mindfulness group on the trauma/dissociative unit, clients expressed feeling nervous to do the yoga poses. They shared they were fearful of embarrassing themselves and that their inner critics were loud in saying they will do the activity wrong. Clients spoke of pushing through the voices and some fully embraced this activity by coming into the center of the room to teach their pose. It is important to note this activity took place after the opening theatre game activity, which seemed to establish an ease and lightness within the group. This was represented as laughter and fluidly open body language.

Enhanced confidence and self-acceptance were present in the interpersonal effectiveness group, as well. On the same unit, clients explored the use of saying “no” during the “Hey! Whoa” activity at the top of group. I mentioned noticing and naming how it feels to say no during this game and if any thoughts or feelings arose. Most raised their hands and agreed that saying “no” in general was hard. Even during the game, all stated that similar thoughts and feelings cropped up while playing, but that they were able to stay present and say “no” because they were having fun. One client mentioned having a lack of boundaries and always putting others before themselves and found it hard to self-advocate and express emotion. This client thoroughly enjoyed saying and practicing “no” in this activity which was shown through their engagement and interest during that level of the game. Other group members had fun with it and noted the connection to real life. The next day, per supervisor report, the same client who struggled with boundaries expressed really enjoying and finding the activity helpful for practicing “no” and now felt more confident and competent to practice and do it in life.

During the emotional regulation group on the short-term unit, the core activity involved group members first choosing a more negative emotion displayed on the DBT handout and writing a speech or monologue in the voice of this emotion. Then, they thought of a correlating positive emotion to guide and help the negative emotion. Clients needed to create a physical gesture that embodied this positive emotion in addition to a monologue from this emotion. The most common negative emotion chosen was fear, with six participants, and one chose anger and sadness. One client chose confidence as the emotion to help them overcome their fear and be fearless. Clients seemed to enjoy and find confidence when sharing their gesture with the group. Many stood to proudly show the group their gesture while saying affirming words from the written correlated monologue.

Enhanced confidence and self-acceptance were present during the distress tolerance group when a client was able to gain closure in their own decisions and feel secure in them. The activity involved choosing a challenging moment that one has struggled with and examining it in the context of the DBT distress tolerance worksheet STOP (see Appendix D1) with my method's connected worksheet (see Appendix D2) and instructions to create a moving sculpt. This client initially needed help with the activity and questioned if they did it right. They were reassured and we walked through what they wrote down together. After this, there seemed to be more clarity around their decision and closure. This client shared they struggled with caring too much about what others thought. Working through this activity, they reported it made them feel they made the right decisions for their needs.

Finding Personal Connections

This theme was present in both interpersonal effectiveness groups. The client who enjoyed saying "no" in the "Hey! Whoa" game found connection in their life related to self-

advocacy. They expressed feeling more competent in saying “no” in their day-to-day. For the interpersonal effectiveness group on the short-term unit, a client made the connection between the adapted group for my method and dialectical behavior therapy. During this group, I did not mention anything about dialectical behavior therapy. Both clients present had attended at least one of the DBT groups on interpersonal effectiveness led by a social worker on the unit. One client stated that what they found helpful about my interpersonal effectiveness group is that it put the DBT skills learned in previous groups into action. They went on to talk about getting the skills more into the body and that is what they enjoyed.

For the emotion regulation group, six participants chose fear from the DBT list on Handout 10 in the manual (see Appendix C2), as an emotion they experience regularly. The majority chose fear, but each identified a different positive emotion to assist their individualized fear. Which then created personalized gestures from each member. Additionally, this theme is internally present for the distress tolerance group because it was tailored to be personalized. Since it is based in identifying one’s own challenging moment, each client had an individual moving sculpt to express and share.

Relaxed Defenses

All six groups allowed for most individuals to relax their defense mechanisms. This observation was supported by active engagement and sharing throughout the groups, even though at the start of groups, members physically and vocally expressed reservation and anxiety. For example, in one group, we opened with the prompt: how are you feeling? Then asking each member to communicate this with their body. There was some protection and reservation represented through crossed and wrapped arms over the top half of body for most group members. Nerves were also present, which was conveyed by tense shoulders and

acknowledgment of fidgeting. By the end of this group, all clients had actively and openly fully participated. In addition, there was laughter throughout, and towards the end, the group felt light, warm, and relaxed. This seemed to be a pattern for most of the groups.

During one of the mindfulness groups, there was a client who started at the beginning with their feet curled up onto the chair, which presented as protective body language. By the end of the opening activity, this client had uncurled their legs and engaged full body in the next activity. In this same group, there was resistance from another client at the beginning who presented with challenging back statements about mindfulness. This particular client was known for attempting to derail facilitators. They were stating there is no difference between mindfulness and active dissociation or autopilot. This client became more open and softer throughout and towards the end of group. Only one client out of the six groups which were facilitated with around 35 participants in total, exited early due to verbally expressed severe social anxiety.

Discussion

This method aimed to explore the infusion of drama therapy into dialectical behavior therapy. The intervention goal was to enhance the transmission and integration of DBT with drama therapy for patients on two separate inpatient units. There is an abundance of literature examining the popularity and efficacy of DBT treatment for many different mental health settings (e.g., Barnicot et al., 2015; Rogg et al., 2021; Schaich et al., 2021; Wieczorek et al., 2021). Researchers have tried to discover and suggest different ways to improve this treatment approach and make it less resource exhausting (Barnicot et al., 2015; Little et al., 2018; Rogg et al., 2021; Schaich et al., 2021; Wieczorek et al., 2021). However, there is almost no literature discussing the combination of DBT and drama therapy. Roohan and Trottier (2021), have started this exploration through their research on Wise Mind and created model: action-based dialectical

behavior therapy. This model also focuses on addressing the barriers when engaging with DBT treatment and motivations to make it embodied, or “action-based.” For their case study, the attention was on a specific technique clients learn during the mindfulness skill section of the DBT manual, called Wise Mind. This thesis aimed to add a broader examination of the infusion of drama therapy into DBT by focusing on the overlap of DBT core goals and barriers with drama therapy effectiveness research.

In addition, there is limited research on the effectiveness of DBT for adults in an inpatient setting. I wanted to explore this fusion because literature that includes suggestions on how to advance DBT treatment, overlaps with common outcomes and components of drama therapy. I was also curious how other aspects of drama therapy not included in this overlap could benefit the DBT method. In conjunction with reviewing the literature, I created my proposed method with these gaps and overlaps in mind to target them with drama therapy core processes and techniques. This section further discusses the results of this method by focusing on the techniques and core processes that seemed to address the DBT barriers more consistently and then turns to limitations and recommendations for future research.

Beginning with Play and Embodiment

Important for all group members was an opening activity that involved play with the incorporation of body. Whether it was the use of a theatre game, communicating how one is feeling using the body, or contributing to a group scene, play with embodiment seemed to establish and positively influence how the remainder of groups continued and finished. At the start of all groups, there was natural resistance and closed body language. After the utilization of an opening that included play and embodiment, this opposition and hesitation appeared to melt away. Warming the groups up in a playful and embodied way observably had a positive impact

on how the clients perceived and responded to the rest of the group activities and goals. An example of this was the ease and lightness that was felt after the opening game of one of the mindfulness groups. This overall feeling allowed clients to transition into the next activity with the comfort and confidence to silence discouraging inner critic voices activated by this second activity. Having playful and embodied openings, built group trust and cohesion which created the space for more vulnerable sharing and experiencing. Components in the openings that seemed to aid in the creation of this environment were laughter, client choice within the activities, and the ability to make mistakes with no judgement from others, specifically in the opening games. The establishment of this safe and light environment at the top of groups seemed to create the space for clients to be more open and embrace group materials and activities. In addition, this discovery addresses three out of the five barriers discussed in the literature review: initial interaction with skills, therapist-client relationship, and motivation to do skills and treatment (Barnicot et al., 2015; Rogg et al., 2021; Schaich et al., 2021). Starting with something playful and embodied made interacting with the skills work easier and more interesting while setting up the space for clients to have a good alliance with me and the rest of the group members. Important factors in drama therapy are the establishment of “a safe environment and the value of a positive therapeutic alliance” (de Witte et al., 2021, p. 15).

Importance of Aesthetic Distance

The use of distance is important when working with this population because the treatment goal for the units is stabilization. Aesthetic distance was present in at least three clear areas: theatre games, scene work, and metaphor. I believe aesthetic distance was important for the process and internalization of the material because it allowed the clients to experience and practice real life challenges in a contained drama therapy space. This observation addresses all

five barriers: initial interaction with skills by creating a safe enough distance to interact and engage with material; intense emotions by playing in the here-and-now and externalizing and personifying the emotions to create more distance, motivation to do skills and treatment by incorporating active games and exercises that felt manageable to do and externally adapt for self; therapist-client relationship by creating a safe enough distance through lighthearted activities to build an alliance; and personalizing the skills through utilizing activities that create a comfortable and personalized experience.

Theatre Games

Incorporating the theatre game “Hey! Whoa” made space for engagement with attachment and boundary work. This is a game where those playing have the choice to receive and pass commands. It brings to the surface personal experiences with attachment and boundaries, but in a space that both can be played with. The playing of the game mixed with the inter and intrapersonal triggers creates the aesthetic distance. Clients have an awareness of their interpersonal triggers but can practice exercising choice and options while playing the game. This gives the potential opportunity to internalize interpersonal effectiveness skills more quickly. This is supported by Schaich et al.’s (2021) recommendation on the use of practical exercises for each taught skill to aid in the learning of the skills. The barriers that have the potential to be addressed with this technique are: initial interaction with skills by creating an environment that is initially light and fun; motivation to do skills and treatment because of the lightness and play attached to the skills learning; and therapist-client relationship because of the natural alliance that can be built when interacting through playing or theatre games.

Scene Work

Knowing the scenes are not real, clients were able to work through real life experiences and emotions in a contained play space. It is connected to the idea “that acting gives permission to experiment with and practice alternative ways of being, behaving, and feeling” (Johnson & Emunah, 2021, p. 46). The distance is knowing that it is not real, but real emotions are evoked in the process of the scene work. It is a distanced and embodied way to internalize distress tolerance, emotion regulation, and interpersonal effectiveness skills. This specific drama therapy technique for this thesis clearly addressed distress tolerance and emotional regulation more than interpersonal effectiveness skills. Clients had the opportunity to actively engage with regulating their distress and emotions during the scene work. This discovery aligns with clients’ suggestion on having a more practice-oriented teaching approach (Rogg et al., 2021). Naturally, there was interpersonal work taking place, however there was no clear indication of growth or challenge in this area. The barriers addressed with this element are: initial interaction with skills because of the low-stakes environment scene work creates when working with real-life material; intense emotions because of the opportunity to interact with challenging and intense emotions in a contained playspace; therapist-client relationship because of the alliance built when working through scenes with clients, and personalizing the skills because the natural personal projections meanings clients attach to the characters and scenes with which they are engaging.

Metaphor

Metaphor was present in the emotion regulation skills group for this method. Clients needed to personify a negative and positive emotion. Doing so distances emotions clients name as challenging. It is easier to interact with an emotion when you are no longer addressing it as part of you, but instead outside of you because you are engaging with a created metaphoric reality (Henson & Fitzpatrick, 2016; Jones, 2007; Landy, 1983). Clients could engage with a

negative emotion they identified because it was aesthetically distanced. This allowed space for empathy and better understanding when the positive emotion was introduced with its own voice and monologue. This specific technique creates the space to engage safely and effectively with emotions and emotion regulation skills. The barriers addressed with this element are: initial interaction with skills because of the distance metaphor creates with initial complex feelings about learning new skills and treatment; intense emotions by personifying or working with these emotions to gain a different perspective around them; and personalizing the skills because of the natural personal projections and meaning making that occurs with using metaphor.

Playful Spontaneity and Anxiety Management

The spontaneity needed in playing the games and the creation of the group story was successful in one activity more than the other. The continue the story activity did not evoke as much spontaneity as was intended. This activity seemed to bore the clients, an observation which was supported by a noticeable decrease in energy; there was the sense of it being too easy or rudimentary. However, in the theatre games “Hey! Whoa” and “Zip Zap Zop,” playful spontaneity was accomplished which led to success in managing anxiety. The nature of playing games was helpful in balancing anxiety for group members. Therefore, when the need to be spontaneous during the game triggered anxiety, the playfulness aspect of the game aided in managing anxiety. This space allowed clients to practice the skill of managing anxiety and make choices that are in line with what they want. Drama therapy is unique in that it relies less on reading and writing abilities and instead gives the opportunity for clients to physically engage with newly learned skills (Blacker et al., 2008). This discovery has the potential to address the barriers: initial interaction with skills because utilizing theatre games showed success in managing anxiety, which was the key feeling voiced when initially interacting with skills work;

and intense emotions by creating an aesthetic distance with challenging feelings and thoughts that may arise during the session, which can create an opening to view these feelings and thoughts from a different or further perspective.

Limitations

There are a few limitations attached to the delivery of this method. A key one is that I am not a certified DBT therapist. Therefore, my knowledge on DBT involves only reading the DBT skill training manual and attending the DBT groups, led by certified DBT social workers, at my clinical internship site. I was only able to run emotional regulation and distress tolerance groups once each in the timeframe of this thesis. If these could have been facilitated again, there could have been more information to gather. Clients at this site are majority White with some Black and People of Color which speaks to the lack of cultural diversity present within this exploration. Many clients resided in the Northeast, however, there are others who came from other parts of the country, and occasionally the world. These are limitations because the lack of diversity in race and regional location leaves holes and gaps in the exploration that took place. The groups for this thesis were predominantly White with some Black and Latin American participants. There is also the component of this author being a White, cis-gendered female who was educated and raised in Western, United States culture. This can influence perceptions, foci, and scope during the creation and implementation of the method, in addition to gathering and reviewing results thereafter (Sternberg, 2006). Additionally, there are many variables worth mentioning that could contribute to the moods and impulses of clients on the unit. Most clients received medications and interacted with other treatment interventions. These have the potential to influence how people exist and cooperate in groups. The stabilization goal of each unit impacts the amount of time spent with clients, so no true measurement can be taken. This is the case

because there is inconsistency in how often we see clients and how long their admission is, therefore, it was not possible to truly track their progress. Additionally, with varying times on admissions, there was the potential to build stronger client-therapist alliances with some clients over others, which had the potential to impact feelings about and participation in groups.

Future Clinical Considerations and Research

Seeing this method used more long term would generate more information that could be utilized, mainly in the areas of internalizing the skills. It was not clear how much DBT language was remembered by group members. Finding a way to measure this would be helpful as related to the proposed method. I am also curious around the balance of DBT with drama therapy. Experimenting with more DBT vernacular and skills worksheets with less drama therapy and vice versa. I believe some dialectical language is important to learn from the DBT manual, however I am curious how much drama therapy can be infused into the manual. For example, I believe infusing more role play and scene work into the interpersonal effectiveness techniques can expedite learning these skills in the manual. This was an area many clients shared in group, noting it would be helpful to explore in action. I would also like to explore more with dramatic embodiment and projection inside the distress tolerance procedures. I think incorporating these drama therapy techniques could expand and enhance how to internalize this area of the manual. Additionally, I would want to have dramatic play be a component at the beginning of every session.

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Appendix A

Mindfulness in Action

Opening: What comes to mind for you or what associations do you have when you hear Mindfulness?

Pass out DBT Mindfulness Handout 1A (Appendix A1) detailing what is mindfulness. Go around and have group members read the handout and reflect on what they are reading/hearing. Remind and emphasize throughout the session components of no judgments, no attachments, and bringing self back to present.

Activity: Share with group we will be practicing Mindfulness through different activities. Express that if *“you start to get pulled away or have judgments, without shame, come back and focus on the present. Notice what thoughts and sensations come up when doing these activities and practicing Mindfulness.”*

Activities:

- **Theatre game Zip-Zap-Zop:** First activity is a theatre game meant to start lightly. The directions of the game is to pass Zip Zap Zop around the group. Leader starts passing Zip to another group member, person who receives Zip passes Zap to another group member, person who receives Zap passes Zop to another and then that person passes Zip to another, and the cycle starts again passing Zip Zap Zop around the room. Goal is to maintain eye contact with who you are passing to and who is passing to you as well as a gesture of hands together forming an “arrow” to who you are passing to. Another goal is to keep up with the established beat of “Zip, Zap, Zop.” This can be at any beat leader establishes and can increase speed if group wants/is ready. Teach game and practice a few times until everyone has it mostly down, taking 1-2 group breaths between practice rounds. The breaths help regulate any nerves and anxiety that may arise when learning or participating. Slip in components of Mindfulness to help as reminder: no judgments, no attachments to thoughts, and stay in present by coming back to the game. Play the game as many rounds that feels appropriate. You can speed up or slow down to adjust to the group needs. Take 1-2 group breaths after every round.
- **Yoga Poses/Stretches:** Leader has cards or examples of specific yoga stretches (if you don’t have yoga poses cards, or don’t have time to put a list together, group members can teach their favorite stretch to the group). Goal of this activity is to name what stretch/yoga pose you will be teaching the group and then teaching it to the group. Go around the circle and have each group member teach their stretch to the rest of the group. The rest of the group then does the stretch all together, each group member adjusting to their needs and current ability (some might need to sit or not overextend themselves). At the top remind group to practice Mindfulness. Tell group to *“notice what happens when you teach your stretch. What thoughts are you having? Check in to see what is occurring in your body. When you notice you have drifted away from the exercise, come back without shame.”* Remind the group throughout to practice goals of no judgment, no attachment, and try to stay/come back to the present. After every group member has gone, ask the group how it was for them. *“What thoughts were coming up? What physical sensations? Were you able to practice the goals of mindfulness?”* Hear and validate their experiences.
- **Group Story:** Leader instructs the group that they will be creating a group story together. Each person will contribute one word to the story every time it is their turn. Someone will start with one word then the next person will add a word that contributes to the story. Going around the circle, each group member will add a word until the story is complete. Discuss what thoughts came up while doing the exercise. Ask group: *“What was it like to not be able to plan the word ahead of time?”* *How was practicing mindfulness?”*
- **Daily Mindfulness Cards:** Leader can have daily mindful activities in card form or in list form (reading a book, having a morning routine, tea break, hot/cold shower, etc.). Give each group member a card or something from the list to read. Have each person read their given activity to the group. Each person can take this with them for their toolbox or not. Someone might resonate with what someone else reads. Group members can comment on if the daily activity they have would work for them.

Closing: Ask group for any final thoughts or comments they would like to share. Go around and have members name one mindful activity they heard or tried that they would like to try and bring with them/incorporate for their life.

Appendix A1

MINDFULNESS HANDOUT 1A

Mindfulness Definitions

WHAT IS MINDFULNESS?

- **Intentionally living with awareness in the present moment.**
(Waking up from automatic or rote behaviors to participate and be present to our own lives.)
- **Without judging or rejecting the moment.**
(Noticing consequences, discerning helpfulness and harmfulness—but letting go of evaluating, avoiding, suppressing, or blocking the present moment.)
- **Without attachment to the moment.**
(Attending to the experience of each new moment, rather than ignoring the present by clinging to the past or grabbing for the future.)

WHAT ARE MINDFULNESS SKILLS?

- Mindfulness skills are the specific behaviors to practice that, when put together, make up mindfulness.

WHAT IS MINDFULNESS PRACTICE?

- **Mindfulness and mindfulness skills** can be practiced at any time, anywhere, while doing anything. Intentionally paying attention to the moment, without judging it or holding on to it, is all that is needed.
- **Meditation** is practicing mindfulness and mindfulness skills while sitting, standing, or lying quietly for a predetermined period of time. When meditating, we *focus* the mind (for example, we *focus* on body sensations, emotions, thoughts, or our breath), or we *open* the mind (paying attention to whatever comes into our awareness). There are many forms of meditation that differ mostly by whether we are opening the mind or focusing the mind—and, if focusing, depending on what is the focus of our attention.
- **Contemplative prayer** (such as Christian centering prayer, the rosary, Jewish Shema, Islamic Sufi practice, or Hindu raja yoga) is a spiritual mindfulness practice.
- **Mindfulness movement** also has many forms. Examples include yoga, martial arts (such as Qigong, tai chi, akido, and karate), and spiritual dancing. Hiking, horseback riding, and walking can also be ways to practice mindfulness.

Appendix B

Hey! Whoa.

- DBT skill goal: Interpersonal Effectiveness
- Drama therapy theme goals: social skills, social interactions, self-confidence, sense of identity and self, self-expression, emotional regulation, empathy, bodily awareness, empowerment, and spontaneity.

Opening

Play “Hey! Whoa” in a circle to start. Build up with first four levels: “Hey”, “Whoa”, “Take it”, “No.” Have group members practice with saying “no” and not saying it. Afterwards, discuss what thoughts came up while playing.

Activity

Divide group into pairs. Have each pair pick a card from the *Boundaries* deck (Harper, 2021). Each card has a “What would you do?” scenario written on it. The scenarios are conflicts or confrontations in which one might be placed in real life. Instruct pairs to create two separate scenes: One scene represents a more impulsive response to the scenario and the second scene is a reflective, less impulsive response. Present the final scenes to the group. Discuss as a group afterwards what it was like witnessing, presenting, and working on the scenes.

Closing

What is one thing you will take from group and what is one thing you will leave behind?

Appendix C

Opposite Action Monologues

- DBT skill goal: Emotional Regulation
- Drama therapy theme goals: self-confidence, self-esteem, sense of identity and self, self-expression, wellbeing, emotional regulation, bodily awareness, empowerment.

Opening

Use your body to communicate how you are feeling. Members will mirror each person's gestured feeling. Ask the group what is present today based on gestures.

Activity

1. Pass out DBT Emotion Regulation Handout 3: What Emotions Do for You (Appendix C1). Read through as group and discuss what popped out for people.
2. Pass out DBT Emotion Regulation Handout 10: Opposite Action (Appendix C2) and instruct group members to look at first box. Out of the four emotions present, have them choose one to focus on. Instruct group members to write a monologue or speech in the voice of this negative emotion. What would this emotion say if it could talk? Have them read a line or two out loud to the group.
3. Opposite Guiding Monologue: Pass out emotion wheel handout (Appendix C3) and instruct group members to identify a positive emotion that could help or guide the first emotion they chose. Write in the voice of this positive emotion. What would this emotion say if it could talk? Then instruct members to think of a gesture for this positive emotion. How would you embody this emotion?
4. Present: have group members "act out" their positive, guiding emotion monologue with correlating embodied gesture.
5. Discuss what came up.

Closing

In a standing circle, have each group member close out embodying their positive, guiding emotion and naming one self-care strategy they will utilize that evening.

Appendix C1

EMOTION REGULATION HANDOUT 3 (Emotion Regulation Worksheets 2, 2a–c)**What Emotions Do for You****EMOTIONS MOTIVATE (AND ORGANIZE) US FOR ACTION**

- Emotions motivate our behavior. Emotions prepare us for action. The action urge of specific emotions is often “hard-wired” in biology.
- Emotions save time in getting us to act in important situations. Emotions can be especially important when we don't have time to think things through.
- Strong emotions help us overcome obstacles—in our minds and in the environment.

EMOTIONS COMMUNICATE TO (AND INFLUENCE) OTHERS

- Facial expressions are hard-wired aspects of emotions. Facial expressions communicate faster than words.
- Our body language and voice tone can also be hard-wired. Like it or not, they also communicate our emotions to others.
- When it is important to communicate to others, or send them a message, it can be very hard to change our emotions.
- Whether we intend it or not, our communication of emotions influences others.

EMOTIONS COMMUNICATE TO OURSELVES

- Emotional reactions can give us important information about a situation. Emotions can be signals or alarms that something is happening.
- Gut feelings can be like intuition—a response to something important about the situation. This can be helpful if our emotions get us to check out the facts.
- **Caution:** Sometimes we treat emotions as if they are facts about the world: The stronger the emotion, the stronger our belief that the emotion is based on fact. (Examples: “If I feel unsure, I am incompetent,” “If I get lonely when left alone, I shouldn't be left alone,” “If I feel confident about something, it is right,” “If I'm afraid, there must be danger,” “I love him, so he must be OK.”)
- If we assume that our emotions represent facts about the world, we may use them to justify our thoughts or our actions. This can be trouble if our emotions get us to ignore the facts.

Appendix C2

EMOTION REGULATION HANDOUT 10 (Emotion Regulation Worksheet 7)



Opposite Action

Use opposite action when your emotions do NOT fit the facts or when acting on your emotions is NOT effective.

EVERY EMOTION HAS AN ACTION URGE.

CHANGE THE EMOTION BY ACTING OPPOSITE TO ITS ACTION URGE.

Consider these examples:

<u>EMOTION</u>	<u>ACTION URGE</u>	<u>OPPOSITE ACTION</u>
Fear	Run away/avoid	Approach/don't avoid
Anger	Attack	Gently avoid/be a little nice
Sadness	Withdraw/isolate	Get active
Shame	Hide/avoid	Tell the secret to people who will accept it

HOW TO DO OPPOSITE ACTION, STEP BY STEP

- Step 1. IDENTIFY AND NAME THE EMOTION** you want to change.
- Step 2. CHECK THE FACTS** to see if your emotion is justified by the facts.
Check also whether the intensity and duration of the emotion fit the facts.
(Example: "Imitation" fits the facts when your car is cut in front of; "road rage" does not.)
An emotion is justified when your emotion fits the facts.
- Step 3. IDENTIFY AND DESCRIBE YOUR ACTION URGES.**
- Step 4. ASK WISE MIND:** Is expression or acting on this emotion effective in this situation?
If your emotion does not fit the facts or if acting on your emotion is not effective:
- Step 5. IDENTIFY OPPOSITE ACTIONS** to your action urges.
- Step 6. ACT OPPOSITE ALL THE WAY** to your action urges.
- Step 7. REPEAT ACTING OPPOSITE** to your action urges until your emotion changes.

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Appendix D

In Challenging Moments

Opening: After introducing names and pronouns, the group begins drama therapy “sculpt this scene” at a specific location. One by one, participants join the sculpt of a specific place, acting as a person, item, or aspect of that place. Once everyone is in their frozen sculpture or moving sculpt, the facilitator points to each person to say what they are representing. Complete group/scene sculpts in 3-4 different places based on time. Potential places include: grocery store, birthday party, park, theme park, spaceship.

Activity:

1. Pass out DBT Distress Tolerance Handout 4: STOP skill, correlating four-boxed handout, and emotion wheel handout (attached to this plan). Facilitator briefly goes over the DBT skill handout by having group members read it. Facilitator then directs group members to look at the correlating four-boxed handout saying, “we will go through these boxes one by one.”
2. Facilitator says “Let’s focus on the first box. Think of a challenging moment you have encountered that is not too activating. Write down or draw that moment in the first box under *The Challenging Moment—Stop.*” Facilitator gives an example of sitting in traffic going to an appointment.
3. “Let’s go to the second box. Write down what your pause would be or ‘Take a step back’ would be. Going to the example, the pause would be breathing in and checking in with self. Emotions are heightened and I need to check in to see what I am feeling. This is where mindfulness comes in. Pausing, taking a step back and checking in.”
4. “Now let’s go to the third box, ‘Observe.’ This is connected to the pause, taking a step back, and the check in with self. What are the feelings of why you are overwhelmed? In terms of the example, I am frustrated because I don’t want to be late. I am worried and anxious because I don’t want to lose my appointment, etc. Write or draw those. There can be few or a lot of feelings and emotions. Whatever makes sense in the moment. If you struggle with identifying emotions or are currently struggling to identify, use the emotion wheel handout.”
5. “Let’s focus on the final box, ‘Proceed mindfully.’ What is a positive coping skill you use or a skill you use to help find calmness? Write or draw the coping skill you think would be good for this challenging moment. Once calmer, proceed with action based on values and what will make this moment better. Example would be listening to music and calling the place where I have the appointment to tell them I will be late because of traffic.”
6. Once everyone has completed, the facilitator will instruct participants to think about if they were to create a sculpt or picture for each box. Facilitator references the opening activity as the example. “What would each box look like?” Facilitator gives time for group members to think of sculpts for each box. Next, the facilitator will instruct the group that as a group we will go through our sculpts all together at once. If needed, take time to figure out a sculpt for each box by going through each box as a group so members can create sculpt. Goal is for each member to have their own sculpts for their boxes 1-4. Goal is to do these sculpts in a row as a group like a moving story.
7. Facilitator asks if 1-3 people would like to share their sculpts/moving story.
8. Leave room for some reflections

Closing: In a circle group members will go around and embody or “sculpt” their last box, Proceed mindfully. The group will mirror everyone. Goal is to end on a calm note.

Appendix D1

DISTRESS TOLERANCE HANDOUT 4 (Distress Tolerance Worksheets 2, 2a)



STOP Skill



- S**_{top} Do not just react. Stop! Freeze! Do not move a muscle! Your emotions may try to make you act without thinking. Stay in control!
- T**_{ake a step back} Take a step back from the situation. Take a break. Let go. Take a deep breath. Do not let your feelings make you act impulsively.
- O**_{bserve} Notice what is going on inside and outside you. What is the situation? What are your thoughts and feelings? What are others saying or doing?
- P**_{roceed mindfully} Act with awareness. In deciding what to do, consider your thoughts and feelings, the situation, and other people's thoughts and feelings. Think about your goals. Ask Wise Mind: Which actions will make it better or worse?

Note. Adapted from an unpublished worksheet by Francheska Perepletchikova and Seth Axelrod, with their permission.

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Appendix D2

<p><u>The Challenging Moment-Stop</u></p>	<p><u>Take a step back</u></p>
<p><u>Observe</u></p>	<p><u>Proceed mindfully</u></p>

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