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Developing a Movement-Based Group for High Schoolers with Anxiety During COVID-19

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Abstract

The COVID-19 pandemic has been associated with negative mental health outcomes, including increased rates of anxiety among adolescents. Adolescents with social-emotional disabilities experience additional challenges adapting to disruptions in routine and coping with feelings of anxiety caused by the pandemic. While effective treatments for reducing symptoms of anxiety exist, a large proportion of adolescents with clinical or sub-clinical levels of anxiety lack access to such treatment or do not seek out treatment on their own. Schools are seen as an ideal setting to implement programs that teach adolescents effective coping skills, however, the pandemic has drastically altered school settings and resulted in unprecedented challenges to providing students opportunities to practice positive coping skills in a safe and engaging manner. A highly adaptable therapeutic group, informed by both traditional and expressive therapies, may be uniquely suited to address symptoms of anxiety for adolescents amidst COVID-19. This thesis explored the development of a group that aimed to promote and practice movement-based coping strategies with anxious adolescents who attended a hybrid model, therapeutic school during the COVID-19 pandemic. Future research on the efficacy of movement-based coping skills in both virtual and physical school settings is recommended, along with additional considerations of trauma and cultural implications in the aftermath of COVID-19.

Developing a Movement-Based Group for High Schoolers with Anxiety During COVID-19

Since the beginning of the COVID-19 pandemic, reports of anxiety, depression, and suicidality among adolescents have surged, as demonstrated by significant increases in both parent- and self-reported mental health challenges (C.S. Mott Children's Hospital, 2021; Hill et al., 2020). In addition to fear of contracting serious illness, adolescents report that disruptions in normal routines, including school closures, cancelled activities, and limited face-to-face interaction with friends, have exacerbated negative mental health outcomes (C.S. Mott Children's Hopsital, 2021). Moreover, at an age traditionally defined by independence-seeking and exploration, adolescents have been confined to their homes, disconnected from social supports and missing out on opportunities that may help maintain a positive outlook and cope with feelings of isolation, despair, and anxiety in uncertain times. While the nature and number of disruptions to adolescent life is unprecedented, this thesis will focus on anxiety in school.

Given the amount of time adolescents spent in the physical school environment before COVID-19, it is important to note how drastically these settings have been impacted by the pandemic, and subsequently, how these changes have impacted students (Burgess & Sievertsen, 2020; Di Pietro et al., 2020). In the United States, due to legal mandates and public health concerns, in-person learning was abruptly halted in March 2020 and the consistency and stability provided by a traditional school day was uprooted (Gabrieli & Beaudoin, 2020; Reimers & Schleicher, 2020). Consequently, schools and students were faced with unprecedented challenges associated with navigating brand-new models of virtual learning while isolated at home. Immediate impacts on students' academic achievement, social interactions, physical health, and emotional well-being are evident (Gabrieli & Beaudoin, 2020; Walker, 2020), while long-term consequences are still unknown (Di Pietro et al., 2020; Reimers & Schleicher, 2020).

Adolescents with disabilities, whether cognitive or social-emotional in nature, experience significant challenges adapting to disruptions in routine, expectations, and environment, resulting in increased stress and maladaptive emotional and behavioral responses (Carthy et al., 2010; DiPietro et al., 2020). Thus, for adolescents in special education programs or therapeutic schools, disrupted routines and school closures that were triggered by the pandemic may have additional consequences for mental health, learning and skill development. Students who typically receive specialized services likely experienced disruptions in their services due to pandemic-related restrictions and school closures (Di Pietro et al., 2020; Reimers & Schleicher, 2020; Walker, 2020). Given the myriad stressors associated with the pandemic, it is imperative to acknowledge how it may have impacted adolescents with disabilities and their capacity to access supports.

While interning at a therapeutic high school that offered a hybrid model (half day in-person and half day virtual) for the 2020-21 school year, I joined staff in adapting academic and social-emotional programming in order to accommodate nebulous guidelines and ever-changing mandates that affected how students could experience learning and receive services amidst the pandemic. I witnessed students' responses to the continuing changes in their school environment; in particular, I noticed that the fluctuations in the delivery of services directly impacted students with anxiety – many of whose typical coping strategies to regulate emotions and behavior either looked different or were not accessible due to the nature of the hybrid model. For example, at school, students were unable to access alternative spaces outside their classroom to help deescalate behavior or regulate emotions and counseling staff had limited time to meet face-to-face with students in the first half of the day. In virtual classes, students were expected to participate in learning and socialization with minimal preparation and support. Many students kept their cameras off and muted, making it difficult to know if students were participating at all.

Due to the effects of the pandemic on programming and service delivery, students lacked sufficient opportunities to learn and practice effective coping skills for emotional regulation during the hybrid school day. Many students reported increases in anxiety and depression, and we observed an uptick in hospitalizations, echoing the climbing rates of anxiety, depression, and suicidality among adolescents worldwide since the start of the pandemic (Shamblaw et al., 2021). These trends underlined the importance of identifying effective coping strategies to help mitigate the negative mental health effects of COVID-19, while considering how to implement them safely in a therapeutic school setting given the complex consequences of the pandemic.

Drawing on both traditional and expressive therapeutic approaches to treating anxiety, I designed a weekly group session for students at a therapeutic high school who were receiving services related to primary social-emotional disabilities. In this group, I aimed to explore how movement-based coping strategies may help these students manage feelings of anxiety during COVID-19, with additional goals of creating a safe space, fostering trust and positive relationships among group members, and discovering new ways of relating to others (Ylonen & Cantell, 2009), particularly given the pandemic-related restrictions in place. After reviewing literature that informed the development of my group, I will describe how the sessions were implemented and what occurred in the group sessions. Finally, I will discuss what I learned from introducing a movement-based group in a hybrid model, therapeutic school setting with adolescents experiencing anxiety during COVID-19.

Anxiety in Adolescence

Anxiety disorders are among the most frequently diagnosed disorders for adolescents, and tend to be stable, chronic conditions that last into adulthood (Albano & Kendall, 2002; Pereira et al., 2018; Vallis et al., 2020; Walter et al., 2010). Between 10 and 20% of youth

experience an anxiety disorder by the age of 18, and up to 50% of cases include comorbid diagnoses, such as depression, substance-abuse, and bipolar disorders (Lorentzen et al., 2020; Walter et al., 2010; Werner-Seidler et al., 2017). Reported rates of anxiety among adolescents increased with the onset of the pandemic and its subsequent lockdowns (Shamblaw et al., 2021).

Anxiety involves physiological and psychological components: on the physiological level, when a threat is detected, the amygdala is activated which triggers the body's nervous system into "fight, flight, or freeze" mode, serving as the body's built-in warning system to protect against danger. At the psychological level, anxiety can be exacerbated or mitigated by conscious thought processes. While a moderate level of anxiety is considered to be a normal and adaptive part of life, anxiety can become problematic when it is consistently experienced at levels beyond what is necessary for a particular situation or expected for a given stage of development (Albano & Kendall, 2002). Different developmental stages are typically associated with the onset of distinct types of anxiety disorders; for example, separation anxiety tends to appear in early childhood, while social anxiety and generalized anxiety tend to appear in later childhood and adolescence (Walter et al., 2020).

Research suggests that treatment and prevention programs can help mitigate onset or delay symptoms of anxiety in youth, particularly if programs are introduced before detrimental response patterns (i.e., cognitions and behaviors) are solidified (Collins et al., 2014; Kearny et al., 2014; Werner-Seidler et al., 2017). Yet, while the prevalence of anxiety disorders in adolescents is high, less than half of those who need treatment receive care and many wait until adulthood to seek treatment, if at all (Kearny et al., 2014; Walter et al., 2020). Additionally, resources for providing effective treatment or prevention programs (e.g., trained clinicians,

behavioral specialists) are limited; and even more so amidst the pandemic, due to the high demand and resulting burnout of trained mental health professionals (Walter et al., 2020).

Left untreated, excessive levels of anxiety – clinically significant or not – can result in significant distress, hindered development, increased behavior problems, social isolation, impaired functioning in school, home, and other contexts, and increased likelihood of future psychopathology and suicidality (Albano & Kendall, 2002; Collins et al., 2014; Walter et al., 2010; Vallis et al., 2020). For adolescents, school avoidance is a common indicator of social or generalized anxiety, which can impair both academic learning and social skill development in the short term, with lasting impacts long-term (Knollmann et al., 2010). Further, avoiding school can deprive students of opportunities to practice managing anxiety in relevant, controlled situations.

Therapeutic Approaches to Treating Anxiety

The most widely established and articulated method of treatment for anxiety disorders is cognitive behavioral therapy (CBT), an intervention aimed at recognizing and altering cognitions and behaviors to improve mental health. While CBT was originally designed to treat depression, it has repeatedly demonstrated effectiveness in reducing anxiety symptoms and improving functioning among anxious adolescents (Albano & Kendall, 2002; Collins et al., 2014; Kearny et al., 2014; Kingery et al., 2006; Lorentzen et al., 2020; Vallis et al., 2020; Walter et al., 2020; Weitz & Opre, 2019; Werner-Seidler et al., 2017).

CBT is based in the belief that distorted cognitions (e.g., thoughts, beliefs, attitudes) and maladaptive behaviors play a role in both the development and maintenance of psychological disorders. CBT uses problem-focused and action-oriented strategies to interrupt automatic thought processes and employ positive coping skills that help decrease symptoms of a diagnosed mental disorder (Albano & Kendall, 2002; Werner-Seidler et al., 2017). CBT interventions

consist of psychoeducation regarding the nature of the disorder, techniques for recognizing and managing somatic reactions, cognitive restructuring (e.g., identifying and challenging disruptive thoughts), problem-solving, anticipating challenges, conrolled exposure to feared situations, and relapse prevention planning (Albano & Kendall, 2002; Wehry et al., 2015).

For individuals with anxiety disorders, CBT assists clients recognizing the signs of excessive anxiety and replacing maladaptive thoughts by employing coping strategies that help them successfully manage their anxious thoughts and feelings (Albano & Kendall, 2002). Coping strategies can include both cognitive (e.g., positive reframing) and behavioral (e.g., muscle relaxation) processes. Examples of successful coping strategies are effective problem solving and positive cognitive restructuring; avoidant strategies, such as distraction, are less effective in reducing symptoms of anxiety (Pereira et al., 2018; Shamblaw et al., 2021).

Mindfulness-Based Cognitive Behavioral Therapy

In recent decades, mindfulness has been employed in a wide range of clinical and non-clinical practices, promoting overall health and well-being in children, adolescents, and adults. Key components of mindfulness include presence, acceptance, and nonjudgement relating to one's thoughts, emotions, impulses and sensations (Wehry et al., 2015). Mindfulness-based cognitive behavioral therapy (MBCBT) follows CBT in the assumption that thoughts precede behavioral and emotional responses and applies mindfulness exercises, such as meditation, to traditional CBT skills (e.g., interrupting automatic thoughts). MBCBT encourages clients to focus on incoming thoughts and feelings, but not *attach* to them, emphasizing that the individual is separate and distinct from their emotions. By consciously attending to cognitions in the present moment, one can deliberately recognize triggers and interrupt or let go of unhelpful thoughts as

they arise. Combining mindfulness with CBT allows individuals to process and work through negative feelings in the moment, rather than avoiding and thus prolonging feelings of anxiety.

One potential limitation of both CBT and MBCBT is that they are considered "top-down" approaches: by focusing primarily on thought-based content, or minimizing cognitive distortions, one can work towards alleviating symptoms of anxiety as they manifest in behavior (Taylor, 2010). Top-down approaches like (MB)CBT, however, do not utilize the body as a primary source of information for how one experiences anxiety (e.g., shaking, aches, and pain) or apply this kind of somatic information as a valuable tool for psychological change. "Bottom-up," or body-based approaches (e.g., tapping, dance/movement therapy) on the other hand, recognize that the functioning of the mind is directly communicated and experienced through the body (Homann, 2010; Taylor, 2010). Thus, by engaging in somatic processes or integrating the body more fully in treatment, clients can use the body as a conduit for psychological change, learning to process and alter both somatic and thought-based content concurrently (Homann, 2010).

Dance/Movement Therapy

Dance/Movement Therapy (DMT) and (MB)CBT are separate and distinct treatment methods, but similar in that both approaches acknowledge the relationship between cognitions and their physical manifestations in the body (Kearny et al., 2014; Levy, 2005). However, while (MB)CBT focuses primarily on challenging cognitions as a means to altering behavior, DMT prioritizes the physical body as a fundamental source of information and experience. DMT is a psychotherapeutic modality that overtly employs movement as a tool to unite mind and body, integrate the physical and emotional aspects of an individual, and ultimately promote growth, healing, and positive wellbeing (Levy, 2005; Ritter & Low, 1996). DMT involves conscious and

unconscious movement, perceptible and imperceptible movement, and also emphasizes stillness; all forms of movement reflect, shape, and support a holistic understanding of the self.

Existing research suggests that DMT is an effective treatment tool for adults and adolescents with a range of symptoms; in particular, it has demonstrated effectiveness in treating anxiety disorders (Ritter & Low, 1996). In DMT, clients are encouraged to recognize the interdependent relationship between cognition (mind/psyche) and physical (body/soma) manifestations of emotion. Working through psycho-somatic experiences of anxiety allows clients to better understand how their anxiety manifests in the body and how to utilize somatic (behavioral) coping skills, such as deep diaphragmatic breathing and progressive muscle relaxation to manage their emotions.

By highlighting the significance of the mind-body connection and understanding how anxiety can manifest in multiple dimensions of the individual, DMT offers a more holistic approach than traditional methods in terms of working with and through anxiety. In an arts-based research study, Woodgate and colleagues (2020) captured adolescents' perspectives of their felt experiences living with anxiety and how they manage to cope. This study illustrated the distinct, though often overlooked, relationship between psyche and soma when considering how anxious adolescents function in their everyday lives. The participants clearly articulated how complex, subjective pain (e.g., mental, social, emotional) manifests as physical aches and pains in the body, which perpetuate a cyclical nature of further anxiety, fear, panic, and suffering. The multidimensional, holistic expression of these adolescents' experiences demonstrates that anxiety disorders should not be treated through the traditional lens of binary (i.e., psychological vs. physical, brain vs. body) models of pain and suffering (Woodgate et al., 2020).

Since anxiety disorders consist of both cognitive and physical components, it seems intuitive to gravitate toward an approach that targets both of these domains simultaneously. In fact, researchers are beginning to explore the potential of combining expressive, non-verbal approaches to therapy (e.g., DMT) with aspects of traditional methods (e.g., CBT), proposing that they may offer a unique and effective treatment for anxiety disorders (Taylor, 2010; Weitz & Opre, 2019). The nature of a combined approach to treatment may allow for greater flexibility in modifying methods to meet the needs of various populations across settings. Given the unparalleled circumstances of COVID-19, the malleability of a therapeutic intervention is key.

Treating Anxious Adolescents at School During COVID-19

Since many symptoms and impairments associated with anxiety in adolescents (e.g., stomachaches, social phobia, work refusal and avoidance) are often exhibited within the school setting (Kingery et al., 2006), school-based treatment programs may offer students an ideal setting to learn, practice, and apply coping skills and strategies in real-life situations, which can help reduce the risk of future anxiety (Collins et al., 2014; Werner-Seidler et al., 2017).

In general, there is widespread support for the implementation of school-based mental health programs, given that students are easily accessible during school hours and interventions can be delivered universally, regardless of students' risk for anxiety (Collins et al., 2014; Werner-Seidler et al., 2017). School-based programs also tend to be both time and cost-effective, since the school setting naturally does not include the same barriers to outside treatment, such as additional time, travel, and costs for adolescents (Werner-Seidler et al., 2017). Furthermore, studies show that teacher- or staff-led programs may be more effective than programs led by outside treatment teams, due to the nature of pre-established rapport and continued opportunities

to work with students throughout the school year whilst aware of individual strengths and other life stressors or pressures that may contribute to their anxiety (Collins et al., 2014).

However, while school may *typically* be an obvious and feasible setting to implement mental health programs for anxious adolescents, the COVID-19 pandemic has drastically changed how school settings look and function (Burgess & Sievertsen, 2020; Di Pietro et al., 2020; Gabrieli & Beaudoin, 2020). In-person learning was halted, leaving schools and students to navigate entirely new approaches to learning, including the virtual classroom (Gabrieli & Beaudoin, 2020; Reimers & Schleicher, 2020; Walker, 2020).

Research exploring the effectiveness of internet-based treatment programs for anxiety have demonstrated mixed results for children and adolescents (Ye et al., 2014). Unfortunately, the nature of the pandemic forced many mental health professionals to provide services over the internet or phone with little to no preparation or appropriate training. Since this thesis was written only one year after the pandemic began, little research to date has been completed regarding the impact of COVID-19 on the effectiveness of internet-based mental health services. Furthermore, the literature on internet-based delivery of a combined treatment approach (e.g., [MB]CBT and DMT) for anxiety is essentially untapped territory.

The Current Study

My field site – a public, therapeutic high school in Massachusetts – provided students the option to participate a hybrid (half in-person and half virtual) model for the 2020-21 academic year. The school serves students in grades 7-12 with various, comorbid diagnoses including Attention Deficit/Hyperactive Disorder (ADHD), Autism Spectrum Disorder (ASD), Generalized Anxiety Disorder (GAD), Major Depressive Disorder (MDD), Posttraumatic Stress Disorder (PTSD), etc., and whose baseline behavior was characterized by social-emotional

and/or behavioral difficulties that impacted their ability to be successful at their district's mainstream school. Based on evaluations of students' functioning, their Individualized Education Program (IEP) recommended services that our team of teachers and counselors could provide, supporting students' academic, social, emotional, and behavioral health and functioning.

While my site typically was able to provide student support and methods of instruction based on each students' learning styles and needs, the pandemic made it more challenging than ever to provide safe, effective, individualized accommodations for every student. For example, hybrid students could only socialize with the five or six students in their classroom cohort. We were unable to have students meet with other students outside of their cohort (face-to-face) to engage in effective problem solving and conflict resolution, even if the conflict begins outside of school, in the virtual classroom, or on social media. We were unable to provide alternative therapeutic spaces for students to de-escalate after an outburst and regulate their emotions and behavior before returning to the classroom. While in virtual classes, students lacked opportunities for in-person socialization entirely, whether that was with peers, teachers, or counselors, limiting their social skill building. The hybrid schedule also limited staff schedules, constricting the amount of time staff and counselors had to effectively lead psychoeducational groups or have 1:1 time with a student to check-in or work through appropriate coping strategies. Finally, the staff were unable to meet frequently as a full team, causing lapses in communication regarding students' needs, concerns, and sometimes plans for coping during the school day.

With pandemic-related stressors, screen/virtual fatigue, constantly changing mandates and restrictions, *and* the typical academic and social expectations associated with high school, many of the adolescents I worked with felt significant increases in their anxiety. They attributed their increased anxiety to the fact that they were aware their usual coping strategies were not in

place (e.g., no access to alternative therapeutic spaces, limited space for physical activities, less time to request check-ins with counselors). They were confined to the same seat, in the same classroom, with the same peer group, the entire time they were in school, meaning they were unable to access other social supports outside of their classroom cohort. Furthermore, the academic material had been modified for the option of remote instruction, meaning that there was a large amount of work assigned using their laptops. This online-based, independent learning model had two common consequences: a) students who finished their work early tended to sit quietly, ruminating on anxious thoughts in class, and b) students who struggled and had difficulty advocating for help fell behind, which caused more anxiety about the coursework they had to make up in the future. Drawing from my experience working with anxious adolescents in school during the pandemic, as well as the literature on traditional and expressive therapeutic modalities, I designed a weekly group session with high schoolers, exploring movement-based coping strategies that students could employ to help regulate their emotions and behaviors; specifically, to manage feelings of anxiety at school during the pandemic.

Method

Description of the Group

As part of the school's hybrid curriculum, students were required to attend two 45-minute, virtual "enrichment" classes in the afternoons from home, after four hours of in-person academic learning in the morning. My group consisted of four high school students who participated in a virtual, afternoon class called Positive Energy. Positive Energy was a weekly session held every Wednesday via Zoom from 2:15 to 3:00pm. Attendance varied between one and four students each week. The class was considered a "health and wellness" course for credit and was a requirement put in place by funding school districts.

While there were eight students assigned to the group, only four of the students actually attended and participated in the group more than once. All of the students who participated in the group were white females in the 10th grade, between the ages of 15 and 16 years old, and had documented diagnoses including GAD, MDD, PTSD, ASD, as well as history of eating disorders. All of the girls scored average or below average in tests of cognitive functioning. The primary concerns on their IEPs were social-emotional in nature, such as managing stressors and other personal concerns related to their diagnoses. I had been observing and working with these students in various capacities both individually and in groups since the start of the school year.

Plan for Group Sessions

For our virtual group sessions, my goals were to a) establish meaningful relationships with one another; b) foster healthy and supportive (non-judgmental) dialogue around mental health; c) use traditional (e.g., CBT-informed) and expressive (e.g., DMT-informed) therapeutic techniques to help teach and foster healthy coping skills; and d) practice useful coping skills to help with anxiety and other stressors that may have occurred beyond the group setting. The group structure each week consisted of a warm-up (10 minutes), psychoeducation and discussion (10 minutes), experiential/embodied activity (15 minutes), and reflection (10 minutes).

I began each session with a predictable group warm-up, which involved a game we called "Turn your camera on if…" The game asked everyone to begin with their cameras turned off. I presented everyone with a statement such as, "Turn your camera on if… you like to dance." The girls were encouraged to turn their cameras on if they agreed, keep them turned off if they did not agree, or even turn their camera on but cover it partway if they partially agreed. I started the game with simple, objective statements (e.g., if you have siblings) to get to know facts about each other, then we slowly progressed into more complex, subjective statements that sparked

discussion around mental health (e.g., if you think that your mental health is a priority; if you turn to people that you can trust will support you when you're going through a hard time).

After the warm-up game, we would transition into a psychoeducational segment. I would begin the group discussion by asking what the students already knew about the topic that week (e.g., biological origins of anxiety; deep breathing as a tool to manage anxiety, etc.), which would help guide our conversation further. We explored online articles and videos relating to the topic for that week and continued to engage in discussion about the content and how it may have related to any personal experiences that they felt comfortable speaking to.

Finally, we would engage in an embodied experiential activity, which involved me modeling and then practicing mindfulness- and movement-based coping skills altogether in the virtual space. I originally planned to explore a variety of activities (e.g., deep breathing exercises, yoga postures, meditations, mirroring and improvisational dance). However, as will be discussed in the results, the realities and circumstances of this virtual group made it challenging to explore such a wide range of movement-based activities. Therefore, I adapted my group's focus to learning and practicing different deep breathing exercises as one form of embodied coping for anxiety. I would explain and model the breathing exercises, including posture, hand placement and counting, and offer that they join me in whatever shape was comfortable for them for a few rounds. After our experiential practice, we would close our group with a discussion and reflection, allowing each group member to share their embodied experience with the movement-based activity, as well as if and how they might find it useful in other scenarios.

Results

Immediately after our group sessions, I would write down my observations of the group, including clinically relevant notes regarding students' physical and verbal expressions. I would

also reflect on my own embodied responses as the group facilitator. Handwriting my notes offered further opportunity for kinesthetic processing of my observations and attunement with my students throughout the sessions. Importantly, because these sessions were conducted through Zoom, it was often challenging to observe and attune to students' movement in the virtual space. Some days, students would keep their cameras turned off for almost the entirety of the session. If they kept their cameras turned on for the session, only a portion of their body (typically the head and sometimes upper body) would be visible to me.

Adjusting Plans for the Group Sessions

A critical component to the development of the group was my students' initial reluctance to try anything related to "dance" or "movement" as they understood the terms. For the very first session, the girls rejected participation and avoided the class entirely by not logging on at all. Before we had our second virtual session, I spoke with the girls in-person about their reluctance to participate in a movement-based group. Their preconceptions of the group involved activities that they reportedly were not willing to participate in voluntarily (e.g., dancing, yoga), especially in a group setting online. With that information in mind, I adjusted the language I used in the group, avoiding words like "dance," "movement," "yoga," "exercise," and similar terminology.

Upon learning that the girls did not want to participate in any movement-based class activity, I also adjusted my approach to engaging with them, while still keeping my goals in mind (e.g., learning and practicing embodied coping skills). In the first session the girls attended, I asked them why they were opposed to the idea of "movement" as they understood it, how they would prefer to spend time together, and would be most useful to them while we met together each week. Some of the girls subtly referenced unhealthy relationships with exercise, dance or yoga. All of the girls reported that they felt "too tired" to engage in movement or exercise after

already attending school in-person. They felt that by the time our virtual group started late in the afternoon, all they wanted was "peace and quiet", "time and space to themselves," and to "preferably not be on Zoom." These students – who already struggle with social and other forms of anxiety – had spent their mornings masked up in classrooms with peers and staff, rode crowded buses with other students, and spent almost an hour on virtual classes already; not to mention the regular school-related social and academic pressures, myriad pandemic-related stressors and "Zoom fatigue" that the general population had been experiencing for months.

Acknowledging these shared experiences around fatigue and anxiety, we began to explore what activities would potentially be engaging and useful to them, since they knew they still had to participate in the group to receive school credit, even if they did not *want* to. Keeping my initial group goals in mind while considering the concerns of my students, we examined the importance of managing anxiety they felt in school – both in-person and virtual. Then, we brainstormed a list of coping skills they wanted to learn more about, including deep breathing and meditation. From that first group session on, I refocused my language and planning around "mindfulness" and "coping skills," rather than "movement" or "yoga," as was originally planned.

Anxiety in the Virtual Classroom

Due to the nature of the hybrid model, I had the opportunity to observe and work with these students both in-person at school and virtually on Zoom. At school, I noticed that the students in my group were consistently applying positive coping skills in the physical classroom. For example, they were proficient in appropriately asking for walks or breaks with staff, listening to music while independently completing class assignments, and using fidgets during class lectures and discussions. Students also appropriately requested to check-in with counselors, where they successfully worked together to manage feelings of anxiety in the moment.

In contrast, I noticed that students had a difficult time logging on and participating in the virtual classes from home. Knowing that the school provided every student with a functional electronic device, and knowing how familiar these students are with technology, I knew that their absence online was not a matter of technical ineptitude in logging onto virtual classes. After speaking with students about their chronic absences or refusal to participate in virtual classes, I learned that most students experienced high levels of anxiety about attending class on Zoom. Particularly, students felt anxious about having their cameras on, their overall privacy, and the general lack of control over what other students might do or say in the virtual space.

Positive Energy: Warm-Up

Like many of the students who reported anxiety around attending Zoom classes, the girls in my group initially preferred to keep their cameras turned off during our group. This made it particularly challenging to consistently assess their movement behaviors in group. In response, I developed the "Turn your camera on if…" game before the first virtual session I led. I developed this game to help normalize the experience of anxiety and discomfort that many students felt about having their cameras turned on during virtual classes. Through this game, we also discussed the importance of visual cues in the virtual classroom, including facial expressions, head nods, and body language, which could help minimize disruptions and help one another see that others are listening, agreeing, or about to chime into a conversation.

An unintentional, additional benefit of this game was that it helped the girls form positive relationships within our group. Some of the students were in different physical classroom cohorts, meaning they were not able to interact during the in-person portion of the school day. Our game allowed everyone to quickly build rapport in the virtual space and get to know one another on both a factual level, as well as have deeper discussions around our own perspectives

and experiences relating to mental health and wellbeing. Once we got deeper into conversations, the girls tended to keep their cameras turned on for longer periods of time and engaged with each other in respectful conversation about the topics at hand. Over time, the warm-up game became less necessary, but it was something that they continued to look forward to each week.

When the girls did feel comfortable having their cameras on, I was able to observe the upper halves of their bodies, including eye contact, facial expressions, and general upper-body language. One of the students, E, actively and consistently participated in our game, turning her camera off and on when appropriate, eye contact focused on the screen, posture upright in her chair, gesturing as she spoke, and sharing extensively with the group in response to almost every prompt I offered. Another student, C, tended to keep her camera turned on the entire time, not engaging directly with the group when I asked everyone to turn their cameras off for each new prompt. She also kept her body and eye contact turned away from the camera as she focused her attention on another computer screen in her bedroom. C rarely participated verbally, but did respond when we called her by name, although she offered only short (e.g., one word) replies and did not look toward or face the camera. The other two students, I and M, participated in levels between that demonstrated by E and C; they turned her camera on and off when appropriate, engaged with the others and responded to prompts when called out by name.

Positive Energy: Psychoeducation

I originally intended for the psychoeducational segments of our virtual group to be well-structured and fairly didactic. For example, I planned to have a new video to share or an article to read with specific discussion questions to review together each week. However, I realized after our first session that these students were already quite familiar with the topics I had in mind: not only were they already experiencing anxiety *themselves,* in their own unique ways, but many of

the girls already had plenty of psychoeducational experience around anxiety and coping in other intensive treatment settings. Therefore, we used this time to engage in collaborative psychoeducation, where we would gather together information they already knew, research areas they were more curious about, and perhaps most importantly, discuss how each of them experienced anxiety in their own lives. This offered time for both self-reflection and deeper processing of their *own* experiences of anxiety, while also allowing plenty of opportunity to practice key interpersonal communication skills, including deep listening, perspective-taking, and understanding of others' experiences. This collaborative format helped guide the conversations in each session to be more student-focus and shifted the entire model of our group to a more collaborative, open-ended, and personal/experience-based psychoeducational structure.

The girls were able to share how they experienced anxiety on a physical level, including uncontrollable shaking, rocking, curling up into a ball, shrinking into the self, stomachaches and other physical symptoms. The girls were able to articulate how these physical manifestations of their anxiety directly impacted their social, emotional, and academic lives. For example, many of them had experienced such strong physical symptoms of anxiety that they refused to attend school in the past, causing them to fail and repeat a year's worth of academic work.

The girls were also able to articulate specific triggers of their anxiety. One student spoke about her strained relationships with her parents, which were exacerbated during the earliest phases of lockdown. Another student recalled her multiple hospitalizations for suicidal attempts and self-injury, and the uncertainty she felt about her seemingly endless cycle of depression. Another student pointed out that loud noises, particularly sirens, reminded her of how often her chronically ill mother would visit the hospital when she was younger, and always wondering if and when she would see her mother again. Another student pinpointed a string of recent events:

being abandoned in an emergency room at the start of the pandemic, spending months awaiting a psychiatric placement, only to end up moving into a group home which had suffered multiple COVID-19 outbreaks that kept her from attending school in-person for weeks at a time.

In most cases, the girls were able to directly correlate their physical manifestations of anxiety to specific triggers, demonstrating that they were already aware of the connection between the body and mind. Additionally, they were able to share examples of coping strategies they already knew and found useful in managing their thoughts and feelings of anxiety, including a few body-based coping skills. Some examples they shared were going for a walk or run, playing with fidgets, deep breathing exercises, meditations and mantras, listening to or playing music, watching TV, playing video games, reaching out to identified supports (e.g., friends, family, treatment team), and challenging negative thoughts and behaviors.

Positive Energy: Practicing Embodied Coping Skills

In the experiential portion of our group, we explored deep breathing exercises together as an embodied coping skill. As mentioned earlier, many of the girls already had a toolbox of coping skills, and some were already familiar with various deep breathing exercises that they learned in other treatment settings. After reviewing the physiological *and* psychological benefits to deep breathing, we chose different variations to learn and practice together. We began with a basic deep breathing technique, diaphragmatic breathing or belly breathing, where we practiced simple yet deep, full-body breaths. Then, each week, we explored a new variation, including "7-11 breathing" – in for a count of 7 and out for a count of 11, and "box breathing" – in for a count of four, holding for a count of four, out for a count of four, and holding for a count of four.

In each session, I would verbally introduce and briefly explain the exercise. Then, I would offer to demonstrate the exercise myself before leading the girls through it altogether. I

modeled the exercises with both supine and upright postures, including where I might put my hands on my body, and showed them how the belly rises or expands with an in-breath, and falls or contracts with an out-breath. When I asked them to join me in the exercise, I would offer alternate postures and placements, encouraging them to find a shape that felt comfortable to them and reminding them that they did not have to look exactly like me. I also offered for the girls to keep their cameras on or turn their cameras off, as I wanted them to feel as comfortable as possible and I recognized that they already experienced anxiety around having their cameras on. Once the girls were settled in their chosen postures, I counted out the breathing exercise for them. When the girls kept their cameras on, I see that they were following along, often closing their eyes, putting their hands on their chest and belly, and typically mirroring my posture. It was difficult to see the subtle movements of the breath over Zoom, so I would model exaggerated visual cues and sounds of my breathing while the girls engaged in the exercise with me.

After a few rounds of deep breathing, we would reflect together on the exercises, including how it made them feel, if they found it helpful, and in what situations they may use each technique. The girls reported feelings of lightness, floating, sleepiness, peace, and calm. In one session, a student verbally described how much calmer she felt after a round of 7-11 breathing, and I could hear how her tone of voice was lighter and softer than before we engaged in the exercise. Her body language was equally light and soft, as she demonstrated a feather-like motion with her hands in front of the camera and sunk softly back into her chair after she spoke. Another student shared that she had never thought about how the belly moves as we breathe; rather, she reported that she typically felt her breath move primarily in her chest and shoulders. She expressed a desire to focus more intently on the connection between her breath and her body's full range of expansion/contraction as she engaged in future deep breathing exercises.

The day after one of our sessions,, E noticed that the increasing energy and noise levels in her physical classroom were distracting everyone from successfully completing their class activity, and it was beginning to make her feel anxious. She raised her hand and asked her teacher and peers if everyone would join her in a deep breathing exercise in order to refocus the group on the reading. E was able to model the exercise for her class, and successfully lead them through a few rounds of 7-11 breathing together. Upon completing their last exhale together, the entire class was quiet and able to refocus and return to their reading activity as a group. In this example, E was able to apply this coping skill to a completely different setting outside of our virtual group: her physical classroom at school, with a number of other peers who also experience anxiety. Not only did she recognize that this skill could help regulate her own feelings of anxiety, but also to successfully deescalate the group as a whole.

The results demonstrate that while my group sessions did not pan out as I had originally intended, the students and I were able to collaboratively problem solve to develop a group format that was, in the end, sensitive to their needs in the moment, and ultimately beneficial to them in managing their feelings of anxiety during pandemic-era learning.

Discussion

Throughout my experience writing this thesis, I learned the importance of being flexible and willing to adjust expectations and goals for the group sessions I had originally planned. Fortunately, given the nature of the pandemic and its toll on my general sense of adaptability and predictability, I felt was well prepared for and honestly expected having to greatly alter my plans for leading a group that focused on movement-based coping skills amidst a global pandemic.

Firstly, I adapted my initial approach to the group upon learning that my students already had their own toolboxes of positive (some movement-based) coping skills they identified as

useful for them. Observing my students throughout the hybrid school day, I noticed that while they were using their coping skills consistently and successfully in the physical classroom, there was need for greater support in the virtual classroom. The students reported feeling greater feelings of anxiety around attending Zoom classes with other students (particularly ones they did not know well), turning their cameras on, speaking up with their microphones, and attending to class activities when they had other distractions in the home (e.g., video games, alternate internet tabs, cell phones and other screens/devices).

Additionally, my students were not afraid to be vocal about their *not* wanting to participate in gross-motor movement-based activities (e.g., yoga, dance) from the outset. Upon further reflection about their reluctance to participate in these types of exercises, it is important to consider that the girls I worked with had a history of eating disorders and struggled with body image; they reported feeling uncomfortable engaging in movement-based activities due to prior, unhealthy relationships with exercise, dance and yoga. One of the girls reported with awe that she had never thought about how her body expands and contracts with breath, suggesting that further exploration of the mind-body connection may be of further interest and useful to her. While DMT-informed techniques and coping skills may be beneficial for these students, it is imperative to ensure that movement- and body-based treatment methods are sensitive to and appropriate for individuals who have history of eating disorders or struggle with body image.

The process of listening to my students' voices and subsequently adapting to their challenges, preferences, and needs allowed me to practice a key therapeutic skill: "meeting clients where they are," including listening to and validating their opinions, wants, and needs. Even though adapting my plans for the virtual space meant I was not able to accomplish everything I set out to with this group, including more full-body movement exercises such as

yoga and improvisational dance, I believe that the deep breathing exercises we engaged in together began to pave the way for future body-based therapeutic work with these students.

Each week, by engaging in our warm-up game, participating in collaborative discussions, and modeling positive coping behaviors, we were able to create a safe and enjoyable space to explore how anxiety is experienced in both cognitive and physical realms. The girls reported feeling comfortable sharing openly and honestly about their own challenges with anxiety, and also felt safe and supported while practicing deep breathing exercises together as a group. The consistent structure of the sessions was ideal for students with anxiety, who benefit from predictability and stability, particularly throughout the pandemic, where constantly changing mandates directly impact students' routines and environment.

Additionally, the warm-up game ended up serving as a type of in-vivo exposure therapy: the girls recognized, voiced, and challenged their feelings of anxiety around having their camera on in Zoom. We were able to use the game as an enjoyable and engaging activity to start our afternoon and foster positive rapport, making the use of the camera a less anxiety-provoking situation than usual. The students were able to make new connections between having their videos turned on and engaging in a safe and enjoyable activity, rather than continuing to fear and avoid the use of their cameras to engage in the class. Within just one session, the girls reported feeling less anxious about having their cameras on within our virtual group setting.

I also found that it was helpful for me to be fully present in the sessions: having my camera turned on, focusing on the girls' videos (rather than my own, which can be distracting), observing and mirroring their physical presence, demonstrating and modeling behaviors, and joining them in our breathing exercises. Being mindful and present in each session offered more opportunity to engage in attunement, mirroring, and kinesthetic empathy, especially given the

challenges of accessing visual cues of others' full bodies within the virtual space. It also allowed me to model presence and other mindfulness-based techniques for the students.

Limitations

There are a number of limitations relating to this project. Firstly, the small number of students in my virtual group were all white females of the same age, in the same grade, with similar comorbid diagnoses. The girls all had experience with eating disorders and fraught relationships to their bodies and large-scale movement-based activites (e.g., sports, dance, yoga), which made it challenging from the outset to encourage certain types of movement-based coping strategies I had originally planned to implement. Furthermore, the girls regarded each of the others as friends, which made it easy to build rapport and foster strong, healthy relationships in our group setting. However, in working with more diverse populations or groups of students who do not know each other as well, it is important to spend more time building trust, rapport, and feelings of safety among all group members before diving into discussion around personal experiences with anxiety or other mental health challenges or practicing movement-based coping skills, such as deep breathing exercises or meditations, together in the virtual space.

Another significant limitation was the fact that this group took place entirely over Zoom. This, combined with the students' reluctance and anxiety around keeping their cameras on consistently, made it particularly challenging to observe, assess, and attune to their body movements in the virtual classroom. Because the students only turned their cameras for a fraction of our time together, and it was typically during an enjoyable activity in the group setting, my observations of body language, facial expressions, and other visual/physical cues were limited to those specific instances. Generally, these were non-anxiety-provoking scenarios

where students felt comfortable turning their cameras on, enjoyed each other's company and conversation, and/or were otherwise willing to have their physical presence visible on camera.

Lastly, as mentioned before, there was not a significant amount of buy-in on from the students to participate in movement-based activities during our virtual group. While this resulted in a significant shift of expectations and goals for my group, it continued to make it difficult to engage with and observe the girls in almost any capacity relating to movement or body-based activities throughout our entire time together. I therefore also had to abandon my second (adjusted) plan for the group, which was to eventually transition from deep breathing exercises into other movement practices such as progressive muscle relaxation and simple yoga postures.

Future Directions

Given the challenges and limitations I experienced in designing a movement-based coping skills group for adolescents during the COVID-19 pandemic, I will make a few suggestions for practitioners and educators who may wish to engage in similar work with other populations. First, it is imperative to draw upon trauma-informed theory and practice when developing an intervention for anxious individuals of any age – particularly those with multiple comorbid diagnoses and history of trauma. In particular, I found that my students with eating disorder experience had a difficult time engaging in movement-based activities due to previous strained relationships between their bodies and various forms of exercise, including dance and yoga. Thus, it is important to cultivate awareness around any potential movement- or body-based triggers that may be present for clients.

Another potential area for consideration is developing a complementary, in-person group that can be offered with appropriate safety considerations that adhere to pandemic-related restrictions and mandates. For example, a bi-weekly or monthly group, limited to a reasonable

number of people from the virtual group, may be offered in a large space (e.g., gym) or outdoor area. Participants may find that an in-person component may be helpful in order to more fully integrate the movement-based coping skills and increase body awareness. Similarly, the group facilitator may find in-person sessions helpful when it comes to establishing kinesthetic awareness, attunement, and empathy among group members. Finally, in-person sessions can also facilitate opportunity for further observation of the clients' movement-based coping skills and more accurate assessment of what clients may need on the physical/body level.

Finally, educators and practitioners should consider how to expand access to movement-based therapeutic programs in both the virtual and physical school setting. Particularly during the pandemic, when students found themselves constricted to either entirely virtual classrooms or in classrooms with limited opportunities to move out of their assigned seats, there was a dire need for students to be able to use physical movement as a means to cope with increasing feelings of anxiety. While some students may feel fatigued or reluctant to try gross motor activities (e.g., sports, yoga, dance), it may be useful to develop programs that teach a wide range of different movement-based or body-based coping skills and techniques with variations for students who may not be able to or feel comfortable moving in particular ways throughout their school day. Lastly, with the rise in demand for virtual-based programming, it is important to consider how to offer effective treatment programs in various online formats (e.g., telehealth, mobile app, etc.)

Conclusion

In this thesis, I learned more about whether movement-based strategies may be helpful for adolescent students experiencing anxiety at school, where they are experiencing a range of disruptions to their regular academic experience amidst the COVID-19 pandemic. These disruptions include being physically distanced from their friends and teachers during a crucial

time for academic and social-emotional skill development, being unable to use some of their previously learned coping strategies, having less time to meet with counselors, and having restricted space to move when their bodies express physical manifestations of anxiety. However, I learned that while students were able to adapt fairly well to pandemic-related restrictions in the physical school setting, students with anxiety particularly struggled with virtual classes, lacking appropriate support and opportunity to use effective coping strategies in the virtual space.

Research for my capstone reciprocally informed my in-service assignment, which included teaching and demonstrating movement-based activities for students and teachers to assist with regulation skills in both the in-person and virtual classroom. This could also inspire future research for designing a cost-effective, simple, movement-based intervention for dealing with student anxiety in both types of classrooms. This is particularly important when teachers' focus is often primarily on students' academic learning, but still need to address their anxious thoughts, feelings, and behaviors in order to refocus attention to their academic material. Having the additional support of parents and community members could deepen this learning for students and assist them in generalizing these skills to their homes and community.

A collaborative approach to intervention design could also help researchers, clinicians, and educators identify areas where we may consider breaking away from pre-existing expectations and structures tied to the traditional school setting that may no longer be working for students as we prepare to enter a post-pandemic and more technologically reliant world (Gabrieli & Beaudoin, 2020). It is also important to consider how academic and social-emotional expectations and goals for students may be altered, considering the drastic changes to both home and academic environment due to the pandemic, as well as the new and continually emerging skills and stressors students are exposed to with novel hybrid models and virtual learning.

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THESIS APPROVAL FORM

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

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