Babeş-Bolyai University, Cluj-Napoca
Școala Doctorală Psihologie Cognitivă Aplicată
Faculty of Psychology and Educational Sciences
Department of Psychology

Therapists' Attitudes towards the Combined Effect of Dance-Movement Therapy with Cognitive-Behavioral Therapy on Treatment of Children with Anxiety Disorders

Doctoral Thesis

PhD Coordinator

PROF. DR. Adrian Opre

Doctoral student

Naomi Weitz

CLUJ-NAPOCA, 2020

TABLE OF CONTENTS

Keywords: DMT, CBT, anxiety disorders, children, attitudes and perceptions

CHAPTER 1. CONCEPTUAL AND EMPIRICAL FOUNDATIONS

This research examined therapists' attitudes towards the combined effect of Dance-Movement Therapy (DMT) with Cognitive-Behavioral Therapy (CBT) on the treatment of children with anxiety disorders (ADs). ADs (APA, 2013) are among the most common psychiatric disorders and they may appear even as soon as in childhood (Costello, Egger, & Angold, 2004; Higa-McMillan, Francis, Rith-Najarian, & Chorpita, 2016). Although often they may be adaptive and related to the child's development (Gullone, 2000), in some cases they may reach high levels of severity baring negative impacts on many aspects of the children's functioning and lives. In addition, physical symptoms and complaints also characterize ADs (Egger, Costello, Erkanli, & Angold, 1999; Hofflich, Hughes, & Kendall, 2006; Ramsawh, Chavira, & Stein, 2010). About 5% of children and youth in the Western World meet the criteria for ADs (Rapee, Schniering, & Hudson, 2009; Robichaud, Koerner, & Dugas, 2019). Despite their high prevalence, ADs in childhood are under-diagnosed and therefore, often are not treated properly (Chavira, Stein, Bailey, & Stein, 2004). In Israel, about a fifth of the children and adolescents suffer to some extent from various types of ADs (Regev & Snir, 2016).

The current study focuses on two treatments for (ADs): Cognitive Behavioral Therapy (CBT) as the most effective treatments of ADs cited in the literature (Higa-McMillan et al., 2016 Banneyer, Bonin, Price, Goodman, & Storch, 2018), And Dance Movement Therapy (DMT) (Payne, 2003; Tortora, 2016).

CBT is an evidence-based therapy focused and goal oriented. It represents a combination of cognitive, behavioral, emotional and social strategies for change, based on the theories of Ellis (1962) and Beck (1976). CBT is the first-line intervention for childhood anxiety disorders and have been proven highly effective when treating both adults and children (Banneyer, Bonin, Price, Goodman, & Storch, 2018; Beck, 2011; Butler et al., 2006; Farrell, Ollendick, & Muris, 2019; Hofmann et al., 2012; James, James, Cowdrey, Soler, & Choke, 2013; Walczak, Breinholst, Ollendick, & Esbjørn, 2019). The interventions offer an organized structure of treatment activities, which challenge the way the child thinks, acts, and feels. CBT among children with ADs is focused on behaviors and relationships in the external reality (Kendall, 2012) including Case formulation (Sim & Gwee, 2005), cognitive and behavioral interventions, especially: psycho-education, thoughts' and emotions' identification, cognitive structuring, relaxation, gradual exposure, rewards and additional home assignments. Usually, in CBT, training and skills sessions relate to: awareness of physical and emotional reactions and to

specific physical symptoms of anxiety; identifying and evaluating anxious “self-talk”; skills of problem solving, such as the ability to introduce changes in the anxious self-talk together with developing self-esteem sense of self-efficacy and coping methods (Kendall & Hedtke, 2006). There are evidence toward empirically supported innovative interventions and modes of treatment using CBT for children with anxiety disorders. Novel treatment approaches (such as technological advances and self-help modalities of CBT) are constantly developed (Farrell, Ollendick, & Muris, 2019).

DMT is included amongst the Expressive Arts Therapies, which are based on practices and theories that connect between arts, creativity, and therapy .It is a psychotherapeutic use of dance and movement, based on the connection between body and mind, and the healing power of dance (Wengrower, 2016). DMT merges body psychotherapy and expressive arts, and traditionally lean on psychodynamics theories. It is used therapeutically to strengthen the emotional, cognitive, physical, social and spiritual integration of the individual (ADTA, 2019; EADMT, 2019). Many Dance-Movement therapists have tried to find and establish a theoretical basis for their work, while employing different therapeutic approaches (Bernstein, 1979; Gross, 2005). In DMT, the body is the primary tool to encourage children to express themselves. The therapist and the parent (if present) use their bodies as well to reflect and adjust themselves spontaneously to the child. DMT therapeutic environment is appropriate for children (rich with sensory stimuli, music, and rhythm, use of space, relaxation, imagination, and practice with organized and spontaneous movement, play, and dance). As such, it provides the child with a secure feeling, contributes to understanding the role of initial relations, and the understanding of the meaningful role of the nonverbal interventions as the primary means of communication and relationships development (Tortora, 2016). Although dance is one of the most ancient forms of healing, DMT established as a profession in Western countries in the 1940s, and spread in Eastern countries and worldwide beginning in the 1990s. Research on DMT has been mostly qualitative, but in recent years, quantitative research is conducted as well and continuing to develop (Koch, Riege, Tisborn, & Biondo, 2019). DMT was found effective in decreasing anxiety and depression (Koch et al., 2014, 2019; Ritter & Low, 1996). Thus, more research is needed to deepen and sharpen the knowledge on the therapeutic mechanism of DMT and dance interventions, especially those that combine other types of therapies such as CBT.

However, DMT and CBT, two treatment approaches for ADs, are based on distinct theoretical assumptions and therefore are inherently different. Nonetheless, in the last decade, combining these approaches is becoming more common.

The use of combined therapies in treatment of anxiety disorders (ADs) is becoming more and more frequent and common. In recent years, integrative psychotherapy has moved from the margins of psychotherapeutic activity to a much more central and dominant stream. Four main types of integrative approaches are mentioned in the literature: Technical eclecticism, common factors, assimilative integration, and theoretical integration (Stricker, 2010; Wampold, 2015).

Several attempts were made to integrate therapies combining components of CBT with components of psychodynamic therapy (the basic psychological theory of DMT). For example, Wachtel (1977, 2014) suggested expanding the dynamic approach along three axes relating to the connection between our inner world and behaviors in the external reality; Ryle (Ryle & Kerr, 2002) developed Cognitive Analytic Therapy (CAT); Similarly, Fonagy and Bateman (2006) developed the Mentalistic approach based on Theory of Mind; Perry (2008) specifically referred to 'a sequential combination' of psychodynamic therapy and CBT.

An additional contemporary model is Process-Based CBT (PB-CBT; Hayes & Hofmann, 2018), which represents an important advancement in the field of CBT. It describes how to target relevant and largely transdiagnostic processes that can combine or bridge different treatment orientations, definitions, and even cultures.

The professional research literature includes various references to integration between CBT and Expressive Arts Therapies (Czamanski-Cohen, 2012; Beardall & Surrey, 2013; Malchiodi & Rozum, 2012; Sharon, 2018; Treadwell, Dartnell, Travaglini, Statts, & Devinney, 2016). According to Shelby and Berk (2009), the integration of CBT with play and creativity helps children feel more comfortable with the treatment, and thus make it more effective.

Forms of integrative approaches that combine principles from DMT and CBT from the Third Generation of cognitive-behavioral approaches, combine elements that focus on experience and body-mind intervention techniques, such as Mindfulness (Weiss, 2009), Dialectical Behavior Therapy (DBT) (Linehan, 2018) and Schema Therapy approach (Young, Klosko, & Weishaar, 2003), that use experiential imagery, dialogue work as well as cognitive behavioral interventions. Another example is the integrative model, "See Far CBT", that combines Fantastic Reality (FR) with CBT and Somatic Experiencing (SE) (Lahad, Farhi, Leykin, & Kaplansky, 2010); this treatment model for ADs and trauma intended to provide a quick and stable response to the need to cope immediately with the symptoms of stress and anxiety and to diminish as soon as possible their mal effects on functioning.

The specific combination between DMT and CBT has not yet been investigated in general, and amongst children with ADs in particular. In the research literature, this combination of

treatments appears only indirectly, such as in the combination between mindfulness and DMT (Beardall & Surrey, 2013), in a new "meta approach" (Parsons et al., 2019), Body-based strategies for emotion regulation (Shafir, 2015), or in the model, ECBT (Embodied-CBT) that integrates CBT, neuroscience, and embodied cognition (Pietrzak, Lphr, Jahn, & Hauke, 2017). This treatment of emotional disorders merges between the top-down method of CBT and the bottom-up embodiment techniques such as movement synchrony and imitation (Ibid), as part of DMT components (Goggin, 2018).

In the current study, the combine effect of DMT with CBT, the conclusive term *effect* was refined into three distinctive main components of the therapy: The therapists' sense of *efficacy*, the *efficiency* of the treatment process, and the *effectiveness* of treatment – positive results for the patient indicating success of the therapy.

Self-efficacy relates to the person's level of confidence that he/she are able to successfully organize, perform and execute tasks (Bandura, 1989, 1997). In terms of self-efficacy, counselors, teaches, and nurses have been studied most commonly, and Expressive arts therapists rarely studied. Finding indicates that art therapists had low-level burnout and high-level self-efficacy, higher sense of self-efficacy enables therapists set high goals, enhance their ability to adopt changes and innovations (Gam, Kim, & Jeon, 2016). Qualified and experienced therapists, with strong self-efficacy usually manage to focus on their patients and the therapeutic process (Levenson & Davidovitz, 2000; McGuire et al., 2019). In the current study, the therapists' experience treating according to each approached was measured by the number of years they have practiced each approach.

Nonetheless, both in short-term treatment and in long-term therapeutic analysis, assuming that the therapist has the theoretical basis, knows treatment techniques, and has the competence to integrate the treatments' goals – can provide the therapist with a strong feeling of self-efficacy (Levenson & Davidovitz, 2000; Messer, 2001). This claim is supported by research on therapists' self-efficacy, that has identified association with higher levels of training (Melchert, Hays, Wiljanen, & Kolocek, 1996) and greater adherence to best-practices and evidence-based therapies (Kozina, Grabovari, & Stefano, 2010; Schiele, Weist, Youngstrom, Stephan, & Lever, 2014), especially when the therapist acquires a 'treatment map' that provides an overview of the planned treatment and allows to determine whether various treatment paths may lead to gaining the desired outcomes (Butler, 1998; Mace & Binyon, 2005).Therapists with a higher sense of self-efficacy set high goals for themselves and are willing to adopt changes and

innovations, whereas therapists with a low sense of self-efficacy are generally pessimistic regarding their ability to enact changes (Fullan, 2012; Guskey, 1988).

Treatment efficiency & effectiveness relates to determine whether an intervention produces the expected result and changes in emotions and symptoms. Studies that examined the relationship between therapists' characteristics and the effectiveness of treatment have looked at a variety of variables (Swain, Hancock, Hainsworth and Bowman, 2013). It is important to conduct research on the efficiency and effectiveness of therapeutic approaches, despite studies showing that the therapist's characteristics impact upon the treatment's outcome beyond a specific treatment method (Vocisano et al., 2004).

Attitudes and perceptions. Attitudes impact the way that information is processed, and therefore, they influence a person's self-image, behavior, and environment (Vogel & Wanke, 2016). They reflect the way people evaluate the world around them (Eagly & Chaiken, 2007; Stroebe, 2011). Attitudes include three main components: affect, cognition, and behavior. The ***affective component*** concerns negative and positive feelings and emotions the individual has towards an object or a phenomenon. The ***cognitive component*** refers to the beliefs and perceptions of the individual regarding an object or a phenomenon, and the ***behavioral component*** includes the overt reactions, actions and responses the individual. Therefore, measurement of attitudes should encompass all three components (Harmon-Jones, Armstrong, & Olson, 2018). The term 'perceptions' describe the cognitive component of attitudes which relates to the individual's conceptions, thoughts, knowledge, and beliefs regarding an object, processes or practices (Baron & Byrne, 2000). The current study examines the therapists' attitudes towards the combined effect of DMT and CBT, regarding: ***Affect (the emotional reaction)*** – what do the therapists feel about this phenomenon? ***Cognition (the cognitive reaction)*** – what do the therapists think about this phenomenon and how do they perceive it? ***Behavior (the behavioral reaction)*** – What do the therapists do (self-report) and how do they integrate it in their practice? Yet, the use of the combined DMT and CBT treatment depends on the ***therapists' attitudes*** towards it, regarding three distinct but interrelated components: The ***cognitive component*** of the attitudes, i.e., the perceived level of efficiency of the combined DMT and CBT treatment; the ***affective (emotional) component*** of the attitudes, i.e., their efficacy as therapists; the ***behavioral component*** of the attitudes, i.e., their reported actual use of the combination of DMT and CBT in treatment.

These attitudes were investigated within a comprehensive model which considered also the therapists' perceptions. The research is focused on the therapist's attitudes towards the combined

effect of DMT + CBT treatment. Figure 1 presents the components of the therapist's perceptions and attitudes:

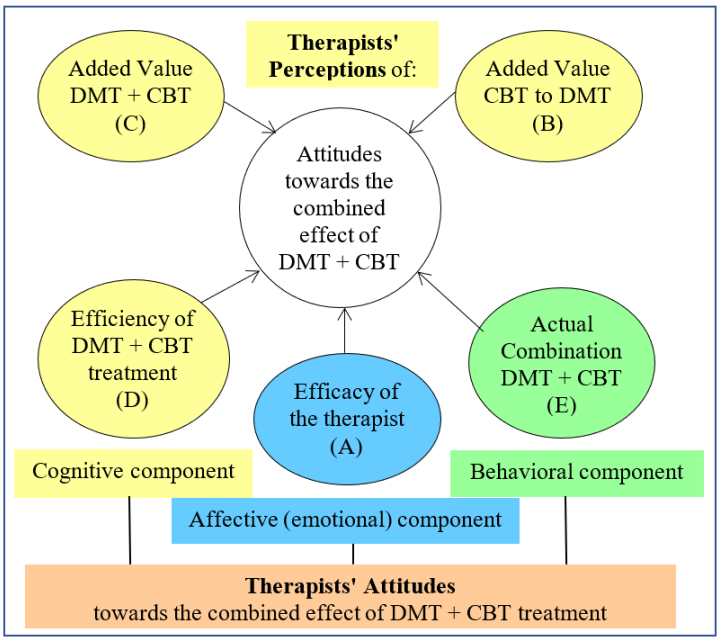

Figure 1. Model of therapists' attitudes towards, and perceptions of, the combined effect of DMT+CBT

CHAPTER 2. OUTLINE AND RESEARCH AIMS OF THE PRESENT DISSERTATION

The aim of the present study is to investigate therapists' attitudes towards the combined effect of DMT with CBT on the treatment of children with ADs. The research paradigm is a mixed methods approach – a combination of qualitative and quantitative inquiry methods (Creswell & Creswell, 2018). The research was conducted in three distinct consecutive studies: *Study 1* – addresses via a qualitative research approach (interviews with ten DMT+CBT therapists), the therapists' attitudes towards the combined effect of DMT and CBT on the treatment of children with ADs. A systematic content analysis was conducted to reveal themes and categories which were the basis for development and validation of a questionnaire "Therapists' Attitudes towards Treatment of Children with ADs (ATAD-Q)" *in Study 2*. The validation process of this initial questionnaire was conducted by (a) validation of six expert judges (qualitative), and (b) testing the psychometric qualities – the validity and reliability of the pilot questionnaire (quantitative) (N=32). The findings of all these procedures contributed to the design of the final structure of the questionnaire and to the verification of its credibility, reliability and validity as a research tool through determining internal validity and reliability,

discriminant validity, concurrent validity, and content and construct validity. In *Study 3* – the final quantitative questionnaire was administered to 99 therapists who use three types of treatment: DMT-only *(n* = 35), CBT-only *(n* = 42) and DMT+CBT (*n* = 22). The differences between the three research groups (DMT-only, CBT-only, DMT+CBT) were examined using Onaway ANOVA between groups with multiple comparisons (Scheffe's test); testing the proposed grounded theory model (produced in Study 2), a Structural Equation Modeling (SEM) was executed.

The research aims : (1) To investigate whether and how DMT+CBT therapists use both approaches in their work; (2) To identify ways in which, according to the therapists' perceptions, the principles of CBT may advance DMT treatment and principles of DMT may advance CBT treatment, in order to enhance the combined effect of DMT+CBT treatment among children with ADs; (3) To investigate the perceptions of three groups of therapists (DMT-only, CBT-only, DMT+CBT) regarding the combined effect of DMT principles with CBT principles on treatment of children with ADs; (4) To propose a grounded theory model – therapists' use of DMT+CBT treatment as a function of their attitudes and perceptions of its combined effect.

The research questions: (1) How do DMT+CBT therapists use both approaches in their work? (2) In what ways may principles of CBT advance DMT treatment, and principles of DMT advance CBT treatment – in order to enhance the combined effect of DMT+CBT treatment among children with ADs, according to therapists' perceptions? (3) How do therapists (DMT, CBT, DMT+CBT) perceive the combined effect of DMT principles with CBT principles on treatment among children with ADs?

The mixed methods research design in presented in Table 1.

Table 1
The Mixed Methods Research Design

Study #	Research approach	Methods/ instruments	analysis	Number of participants
Study 1	Qualitative	semi-structured interviews	Systematic content analysis	10 interviewees
Study 2	Qualitative and quantitative (pilot study)	construction and validation of an on-line self-report questionnaire	Reliability coefficients, frequencies and percentages, means and standard deviations, $\chi 2$, *Phi* and *Cramer's' V*, Pearson *r*	32 participants
Study 3	Quantitative	Administration of an on-line self-report questionnaire	ANOVA (analysis of variance) SEM (Structured Equation Modeling)	99 participants

The gap in knowledge. Existing literature relates to Dance-Movement Therapy (DMT) and Cognitive-Behavioral Therapy (CBT) as two separate therapeutic approaches, with almost no consideration of the possibility of combining or integrating the two. There are a few studies concerning the integration of arts therapy with CBT. There are more studies and books concerning the integration of dynamic therapy with CBT. As far as could be ascertained, no research has found differences in effectiveness between DMT and CBT. There appears to be a lack of knowledge concerning the combination of arts therapies with CBT in general, and in particular, the combination of DMT with CBT. In addition, no studies have examined therapists' attitudes and perceptions regarding the combined DMT and CBT approach, particularly regarding the treatment of children with ADs.

The research hypotheses: Hypothesis (1): A significant difference exists between therapists regarding the added value of their treatment to the other treatment, according to their own type of treatment. Specifically, therapists who combine both types of treatment (DMT+CBT) and therapists who use only one type of treatment (CBT or DMT) will rank the added value of the principles of their own treatment (CBT or DMT) significantly higher than therapists who use only the other type of treatment (DMT or CBT); Hypothesis (2): (2a) Efficiency of the combination of DMT with CBT: DMT+CBT and/or DMT-only therapists will perceive the combination of DMT with CBT as significantly more efficient than CBT-only therapists; (2b) Their efficacy, as therapists treating/working with children with ADs: DMT+CBT and/or CBT-only therapists will perceive their efficacy as significantly higher than DMT-only therapists; (2c) The use of the combined approaches (DMT+CBT) in treatment of children with ADs: DMT+CBT and/or DMT-only therapists will report significantly greater use of the combined treatment as compared to CBT-only therapists.

CHAPTER 3. STUDY 1: THERAPISTS' ATTITUDES TOWARDS THE COMBINED EFFECT OF DMT AND CBT ON THE TREATMENT OF CHILDREN WITH ADS

Design

Study 1 was conducted using a qualitative approach (Creswell & Poth, 2018), which is based on semi-structured interviews. In the current study, this investigative method characterizes the holistic view of the combination of DMT and CBT approaches in treatment, with the aim of understanding the phenomenon and situations relating to it as a complete entity (Lincoln & Guba, 2000).

Methodology

Participants and sampling. The participants were selected by a *non-probable purposive sampling procedure* (Mason, 1996; Shkedi, 2003). The participants in the current study are therapists who studied, were trained, and practice using DMT and CBT, and included criteria for academic-education and experience. The sample included ten female therapists who met the required criteria. All therapists live and work in Israel. All therapists have 11-34 years of DMT professional experience and 2-14 years of CBT professional experience. All the therapists studied CBT after studying DMT.

Research instrument. Study 1 utilized a ***semi-structured interview guide*** (Flick, 2006; Spradley, 1979), guided by the "Therapists' Attitudes towards Combining Principles of DMT and CBT". This tool was created and validated for the purpose of the current study. The aim of the semi-structured interview guide was to reveal the unique perspectives of therapists who treat children with Anxiety Disorders (ADs) in terms of their approaches to DMT and CBT – as independent treatments and a combined treatment. This includes their feelings, thoughts, and behaviors regarding the investigated phenomenon via examples from their own practices. In addition, the tool served as a way to expose the therapists' dilemmas and insights.

Constructing the interview guide. The interview guide was built on the basis of the research objectives and the research questions to clarify the therapists' perceptions of the combined influence of DMT+CBT on their work, the Therapeutic process, and the influence

on the patient. This is with regard to: (a) management of the therapy; (b) self-exposure and involvement of the therapist; (c) therapist's behavior; (d) the focus of the therapy (Perry, 2008).

Validating the interview guide. The first version of the interview guide went through a series of validation processes that included content validity, construct validity, and face validity (Creswell & Miller, 2000; Shkedi, 2003).

Procedure. The ten interviews took place on an individual basis. The interviews were conducted face to face, with time and place that was convenient for the participant which allowed the researcher to gather data directly from the primary source (Shkedi, 2003).

Analysis of the qualitative data was a hermeneutic process whose aim was to give meaning and interpretation to the topic of investigation (Strauss & Corbin, 1990). A systematic content analysis was conducted to reveal themes and categories (Lincoln & Guba, 2000; Strauss & Corbin, 1990).

Ethical considerations. The cooperation between the researcher and the participants in the qualitative study raised ethical dilemmas that stem from the desire to maintain respect and privacy for the individual, while at the same time, learn from the person's experience. To address these issues, the participants' anonymity was maintained in the writing of this project, as accepted in the ethics of conducting a research study.

False names were used in the written texts in order to maintain the participants' anonymity, and the recordings were securely kept by the researcher. The participants were aware of the purposes of the study, its procedure, and the conditions of participation. Participation was accepted upon informed consent and based upon their own desires, and participants could leave the study at any point.

Results

The summary of Study 1 findings are presented in Table 1.

Table 2
Summary of Findings of the First Qualitative Phase – Interviews

Themes	Sub-themes	Therapist	Treatment	Patient
The combining therapist	Personal approach	Personalizing the combined approach for the therapist	CBT combined with psychodynamic approaches	Integration of approaches in accordance with the patient, with attention given to the patient's body and movements
			CBT combined with movement, expression, creativity, and arts	

Themes	Sub-themes	Therapist	Treatment	Patient
			Treatment combined with approaches from the Third Generation of CBT	
	Development of the combined approach	Knowledge and experience with the two approaches	Treatment based on DMT and professional development with CBT	Process of looking for a treatment that is appropriate for the patient
		Openness to the combined approach		
The combined treatment	Methods of combining	Therapist's body serves as a means in the treatment process	Based on an order, one treatment after the other	In accordance with the patient, the goals and the purpose of the treatment
			Partial combination/integration	
			Combination according to the process	
	Managing the treatment	Intelligent management of the combined treatment in the beginning, middle, and end of the treatment	According to the terms and structure of CBT, integrating the principles of DMT	In accordance with the patient – the dominant approach changes
	Therapist's role	Balance between the therapist leading and the patient following; dominance; being creative	Leading, guiding, self-exposure, teaching, mentor (roles relating to CBT principles)	Echoing and listening to the patient. Accepting and reflecting the initial emotions
	Leading the treatment	Therapist leading the treatment and joining the patient	Joint leading of the treatment	Patient leading the treatment
	Efficiency	Increasing the therapist's efficacy and professionalism	Broadening the world of treatment: 'The best of both worlds'	Broadening the patient's means of expression and creativity
			A merge between the top-down method of CBT and bottom up embodiment techniques.	
Added value of each approach	DMT to CBT	The therapist's body is a means in the therapeutic process	Nonverbal intervention	Allows the patient to nonverbally express emotions and sensations
			Integrating body and movement with CBT processes	
			Flexibility	Focus on the patient's progress at his own pace based on his choices
			Creation and experience that influences change	Patient's pleasure, interest, and increased motivation
			Illustrating and understanding the terms through expression and movement	Appropriate as a means of communication and work with children
	CBT to DMT	Organizes, arranges and serves as an "anchor", "road map", and guiding pillar	Defines targeted and practical goals for the treatment process	Emphasizes cognitive aspects in the patient
			Treatment aims to be short term	
		Validates the DMT therapist's work	Strengthens and validates the body-mind connection	Emphasizes motivation for treatment and motivation for change in the patient

Themes	Sub-themes	Therapist	Treatment	Patient
Satisfaction	Cognitive	Challenge, thought, and interest	The integration is based on logic, intelligence, and appropriateness	For the benefit of the therapist (and not necessarily the particular approach)
		Upgrading and sharpening known treatment methods		
	Emotion	Positive emotions, when the combination is created in the therapist's head and it becomes a part of the treatment experience	Positive feeling when the creative toolbox contributes to the Cognitive-Behavioral work in the treatment process	Positive feeling when you see change and results
		Exciting to see the implementation of the combined treatment with children	Increases motivation for active participation in the meetings	
Reservations		Requires effort from the therapist	Not appropriate if forced to integrate	Lack of appropriateness for the patient (age, difficulty connecting to the body, difficulty with a structured and focused treatment)
		Requires creativity for the combination from the therapist		
		Requires knowledge and recognition with protocols that combine the approaches	Requires understanding of how to manage combine the approaches	The combined treatment can lead to overwhelming and confusion
			Adhering too closely to the CBT protocols can negatively impact upon DMT principles	Possible if there is resistance to one of the approaches

Based on the interviewees' answers to the interview questions, the findings suggest that DMT+CBT therapists do combine both approaches in their work because they believe that this combination is effective, both in terms of the therapist's role in the treatment process, as well as the benefits for their patients (children with ADs). Moreover, various forms of combination were found, all based on the practical experience and satisfaction of therapists and patients. The interviewees agreed that there is added value to combining DMT and CBT. For the therapists, when this combination is done right, it is highly satisfactory, accompanied by excitement and spiritual uplifting, which is expressed by words such as "*great*," "*powerful*," and "*winning*."

A central finding is that a necessary and important condition to ensuring the efficiency of the combined treatment is the experience and expertise of the therapist in both approaches. The therapists referred to CBT principles as those that contribute to the advancement and efficiency of therapy, which positively affects the therapists, the patients, and the therapeutic process. CBT was found to be an "*anchor*," a "*road map*," – i.e., an approach on which the therapist can lean and lead processes.

Another interesting finding relates to the opinion that CBT "*allows DMT to belong to something broader*." That is, CBT provides validity to the treatment principles of DMT, and thereby gives DMT legitimacy as an effective and efficient treatment. This finding is significant in light of the efforts to legislate DMT in Israel. To date, DMT is authorized and legal in other countries such as in England and the USA.

While mentioning the added value of DMT principles to CBT principles, an emphasis was put on the importance of widening the connection to the body, movement and dance – which create an experience and help the treatment to be more significant, meaningful and supportive of change. In addition, the interviewees extensively referred to the connection between body and movement as a basic and elementary factor that includes all of life's components. These include the treatment components and the experience and ease of the DMT therapist to refer to and lead processes with connection to sense and movement. These create a "language" that advances the connection to the body as an important aspect of CBT treatment according to the Third Generation of Cognitive-Behavioral approaches.

In summary, in order to further investigate therapists' perceptions and attitudes toward the combined treatment, the following five themes should be addressed: A. Therapists efficacy in treatment of children with Anxiety Disorder; B. The added value of CBT to DMT; C. The added value of DMT to CBT; D. Efficient of combination of DMT with CBT (The quality of treatment); E. Use of the combination of DMT and CBT. These themes were the basis for the quantitative questionnaire that was developed and validated (see Ch. 4).

Discussion

All of the therapists claimed that they combine the treatments, but in different ways and with different emphases. The Combining Therapists firstly emphasize the choice of the combined treatment that is appropriate for a particular patient and his/her functioning, while paying meaningful attention to the body, the breath, and movement. Similarly, they emphasized that the combination depends on the patient.

The interviewees explained that the process of developing a combined treatment emerged when the traditional treatment was questioned, due to a lack of a clear and appropriate treatment approached. This reasoning is in line with current research literature in CBT, which describes process-based treatments that are established based on functional analysis and ideographic approaches that focus on the unique aspects of each individual (Hayes & Hofmann, 2018). Based on the research findings, therapists may choose to combine or bridge between various

therapeutic orientations. In other words, the patient's characteristics serve as a marker that outlines the method of the selected integrative treatment, and the therapist's considerations in selecting a treatment rely less on the characteristics of the approaches to be combined.

Gross (2005), a DMT therapist, strengthens this argument from a different direction. She relates less to the theoretical tendencies of a DMT therapist and emphasizes the physical dimension and preserving an open channel with the body for the duration of treatment. This demonstrates that in DMT, there is room for the integration of theories other than the classical ones, which are already embedded in the movement therapists' body of knowledge. This claim places the physical aspects as having a unique meaning in therapy at the center of movement treatment itself, and in combination with other treatment approaches.

DMT and CBT therapists do combine both approaches in various ways, all based on the practical experience and satisfaction of therapists and patients. The therapists believe that this combination is effective both in terms of their role in the treatment process as well as the benefits to their patients – children with ADs., Therapists' efficacy, professional experience, and expertise in both approaches is necessary and important to ensure the efficiency of the combined treatment. Regarding the added value of each treatment, CBT was found to be an "anchor" or a "road map"; that is, an approach on which the therapist can "lean on" and lead processes. While mentioning the added value of DMT principles to CBT principles, an emphasis was put on the importance of nonverbal expression broadening the connection to the body, movement, and dance, which create a meaningful experience and enable the treatment to be more significant and supportive of change.

Possible limitations regarding the participants in Study 1, are that have more experience with DMT than with CBT and were initially trained in DMT (effect of order) – these might cause some common bias. Nevertheless, this sample of participants reflects well the relatively small population of therapists that to date combine DMT with CBT.

These finding are unique because they validate therapists' prior assumptions, experiences, and intuitions. No literature has been written from the perspective of the therapists themselves concerning the use of combined treatments, particularly that of DMT+CBT.

Increased the use of body and movement alongside a search for focused, effective, evidence-based therapies (such as CBT) and the combination of DMT and CBT, may assist and guide the development of therapies providing optimal responses for the patients. The therapists feel that each approach makes a unique contribution to the other to increase the efficiency of treatment

with children with ADs. The combination's effect on the therapists was clearly expressed by one of the interviewees (Nitzan):

"When the combination is going well, I feel like I am dancing!"

CHAPTER 4. STUDY 2: QUESTIONNAIRE DEVELOPMENT AND VALIDATION: "THERAPISTS' ATTITUDES TOWARDS TREATMENT OF ANXIETY DISORDERS AMONG CHILDREN"

Methodology

The current research describes the process of construction and validation of a self-report questionnaire: *"Therapists' Attitudes towards Treatment of Anxiety Disorders – ATAD-Q,"* which was developed in order to study therapists' attitudes towards, and perception of, the combined effect of DMT and CBT on treatment of children with ADs. The initial questionnaire was formulated according to the results of the systematic content analysis of the interviews that were conducted in Study 1, and the conclusions drawn from the literature review.

Construction of the questionnaire was conducted in stages including: Selection of five categories; Statements formulation; Examination of the extent to which they may answer the research questions; Expert validation; Determining the structure of the questionnaire: introduction, statements and personal and professional background; An initial empirical test of the questionnaire was conducted with a convenience sample of 32 therapists. On the basis of both statistical considerations and content considerations, the questionnaire was corrected again, statements were added and removed, and some of the items were reformulated.

The validation process of the initial questionnaire was conducted by (a) validation by six expert judges (qualitative), and (b) testing the psychometric quality – the validity and reliability of the questionnaire (quantitative) – the pilot questionnaire (N=32) and the final questionnaire (N=100) (repeated testing of reliability in the final sample). Similarly, the data from the final questionnaire was analyzed by two factor analyses – exploratory factor analysis (EFA) and confirmatory factor analysis (CFA).

Participants

The pilot sample included 32 therapists (30 woman and two men) aged 36 to 60 (*mean* 48.7, *SD*=6.41); 14 therapists combine DMT+CBT, nine DMT-only and nine CBT-only. Twenty-three (71.9%) treat children with ADs and nine (28.1%) do not work (in the present) with children with ADs. Twenty-two (68.8%) use DMT therapy and 23 (71.9%) use CBT therapy.

The Pilot Study for validation of the quantitative self-report questionnaire and testing the psychometric qualities includes the following stages: (a1) Reliability of categories and item analyses(α=.81 to α= .92); (a2) Correlations between categories (internal validity of the questionnaire): were found in accordance with the unique content of each category; (b) Discriminant validity - Comparison between agreement with statements and categories between the three groups: DMT (*n* = 9), CBT (*n* = 9), DMT+CBT (*n* = 14) (one-way Analysis of Variance (ANOVA) with multiple comparisons - *Scheffe*) – match the content of the statements and differences in agreement were in line with the groups' characteristics; (c) Concurrent validity: Correlation between statements and professional background variables.

The final questionnaire

The examination of the statements' distributions (frequencies and percentages; means and standard deviations) revealed that the respondents used all the range of the scale's values (1-5) in most of the statements. According to the answers, the background questions were rephrased, and open-ended questions were converted to closed questions. Categories B and C (added value of CBT to DMT/added value of DMT to CBT) included an option to check "don't know/not sure". Some of the respondents checked this option – and therefore it remained in the scale. Construct validity and internal reliability – The reliability coefficients for the categories were high (range Cronbach's α=.81 to α=.92); Content validity – Following consultations with the research supervisor and an expert on research methods, measurement and evaluation, the wording of some items was changed in order to refine their intention. In addition, statements that had more than one focus were split into two or more statements; Discriminant validity – The differences between the groups are consistent with the content of the statements in terms of the differences between the participants of each group; Concurrent validity – The significant patterns of correlations that were found are consistent with the basic assumptions of the study as well as with the distinction between the approaches; Content and construct validity, EFA and CFA. Results of the EFA contributes to the content and construct validity of the final

questionnaire. Results of the CFA revealed a good fit between the theoretical and empirical models, and thus strengthens the construct validity of the final questionnaire.

CHAPTER 5. STUDY 3: THE EFFECT OF DMT AND CBT ON TREATMENT OF ANXIETY DISORDERS IN CHILDREN: A COMPARISON AMONG THERAPISTS (DMT, CBT, DMT+CBT)

Design

The scientific investigation is based on a Quantitative research approach (Creswell & Creswell 2018). An attitudes and perceptions survey via an online questionnaire. In the current study, the variables were produced from the interview findings. The independent variables were: the therapists' type of treatment, personal characteristics, qualification characteristics and professional characteristics. The dependent variables were: attitudes and perceptions of the combined treatment DMT+CBT: Therapists efficacy, the added value of CBT to DMT, the added value of DMT to CBT, the extent to which the combination is perceived efficient and the use of the combination of DMT and CBT.

Methodology

The **participants** were selected using a *non-probable purposive sampling procedure*. The final sample included 99 participants in three groups: DMT- only *(n* = 35), CBT-only *(n* = 42), and DMT + CBT (*n* = 22). The DMT-only and the DMT+CBT groups were solely female while the CBT-only group was 85.7% female. Participants' mean age was 48.33 (*SD* = 7.38). All the therapists live and work in Israel and have a similar background. Most of them work (88%) or have worked (91%) with children with ADs. On average, the therapists treat about three types of ADs, mostly GAD (64%).

The **research instrument** was a new questionnaire that was constructed, developed, and validated for the current study: Therapists' Attitudes towards Treatment of Anxiety Disorders among Children (Based on the findings of interviews conducted in a qualitative research).

Data analyses. The responses (*N* = 99) were collected into an excel worksheet and transformed into an SPSS file. Data analysis included Reliability coefficients (Cronbach's α);

descriptive statistics (discrete variables – frequencies and percentages, continuous variables – means and SDs; Analysis of Variance (ANOVA) between groups (type of treatment) in continuous variables: One-way ANOVA with multiple post-hoc comparisons (Scheffe's test).

Results

A summary of therapists' attitudes towards treatment of ADs among children is presented in Figure 2.

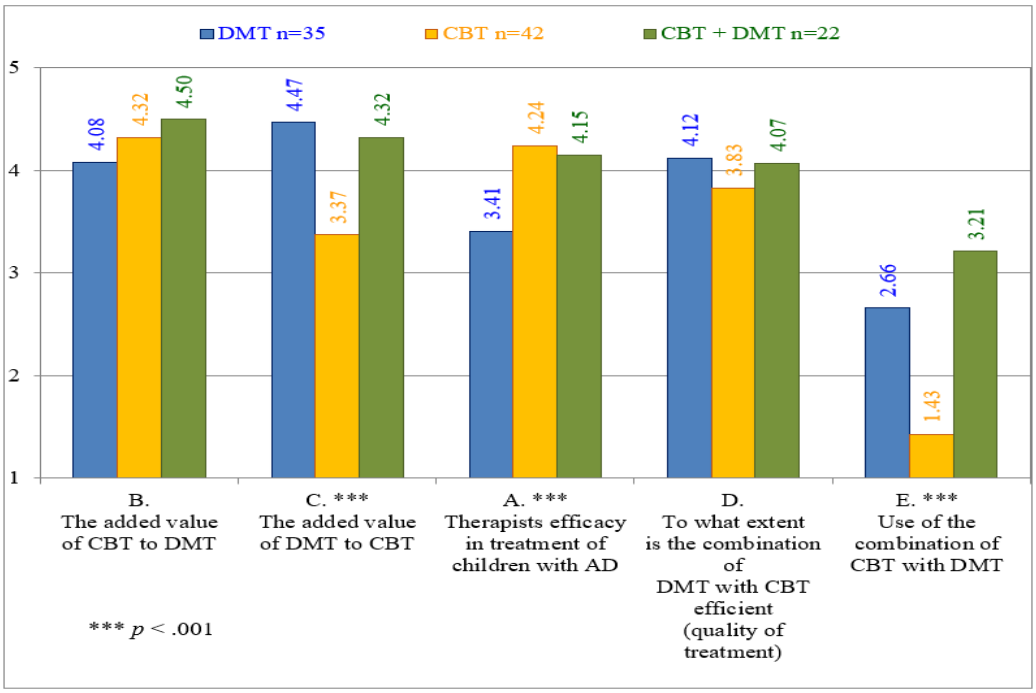

Figure 2. Summary of findings: Therapists' attitudes towards treatment of ADs among children by type of treatment

Added values (research question 2). The added value of CBT to DMT. The therapists perceive a high added value of CBT principles to DMT treatment. In particular, DMT+CBT therapists and CBT-only therapists agreed that "CBT combines psycho-educational explanations to enhance patients' understanding of the diagnosis and treatment" (item 17), "validates the importance of body sensations and physical expression of the patient's feelings and thoughts" (item 11), and "provides tools to establish a diagnosis and choose treatment ways" (item 16). In addition, all participants strongly agreed that "CBT defines applicable and measurable targets for the therapeutic process" (item 13), "emphasizes the cognitive and behavioral components of therapy" (item 9), and "focuses the treatment" (item 14).

The added value of DMT to CBT. DMT+CBT and CBT-only therapist lies mainly in the following principles: “DMT enables non-verbal expression of feelings and sensations, which create an emotional and physical DMT+CBT language” (item 20), which “expands the behavioral and physiological aspects of CBT” (item 18). In addition, “DMT enables flexibility of the therapeutic process in accordance with the patient” (item 22), “enables a meaningful experience of creation which advances coping and change” (item 23), and “because DMT stems from a primary and natural source for children – it enables to combine movement in all of the therapy's components” (item 19), and “realization and understanding of CBT's abstract concepts and processes of therapy” (item 21). However, the therapists’ perceptions are relatively similar regarding the added value of CBT to DMT. However, regarding the added value of DMT to CBT, the gap in the levels of agreement between CBT-only therapists and DMT+CBT and CBT-only therapists is much larger. Therefore, hypothesis (1) was confirmed: A difference was found between therapists, according to their type of treatment, regarding the added value of their treatment to the other treatment; Therapists who combine both types of treatment and therapists who use only one type of treatment (CBT or DMT) ranked the added value of the principles of their treatment higher compared to therapists who use only the other type of treatment (DMT or CBT).

Therapists' perceptions of the combined effect of DMT and CBT (research question 3). The six items that describe **reasons** for the efficiency of the combined treatment and **conditions** for professionalism of the therapist were ranked higher by DMT+CBT and CBT-only therapists in comparison to CBT-only therapists. In addition, DMT+CBT and CBT-only therapists agreed that, “The DMT+CBT therapy process is based on research and concurrently experiential” (item 27); “The DMT+CBT therapy is efficient because it includes both verbal and nonverbal expression” (item 29); “The combination of both approaches is efficient because it sets defined targets and provides clear and precise tools along with pleasure and fun for the children” (item 24); and, “The combination raises interest, encourages rethinking and sets challenges for the therapists” (item 28). Regarding **conditions** for the efficiency of the combined treatment, DMT+CBT and CBT-only therapists agree more than CBT-only therapists that “In order for the DMT+CBT treatment to be efficient, the therapist acquires professional experience in both approaches” (item 26) and that, “In order for the DMT+CBT treatment to be efficient, the therapist must have appropriate professional training in both approaches” (item 25). However, two items that focused on the patient were ranked higher by DMT-only and CBT-only therapists and lower by DMT+CBT therapists: “The DMT+CBT therapy is effective, on condition that it does not cause the patient to feel confused and overwhelmed” (item 31), and, “The DMT+CBT

therapy is effective when the child has the ability to connect to their body and movements" (item 30). Although the difference between the therapists was not significant, nevertheless, the pattern of the responses to these two items is different than the former pattern. Finally, all the therapists "do not agree" that "the approaches are inherently contradictory" (item 39). Therefore, hypothesis (2) was confirmed. *i.e.*, differences were found between therapists, according to their type of treatment, regarding three sub-hypotheses: (a) Efficiency of the combination of DMT with CBT is perceived as more efficient by DMT+CBT and/or DMT-only therapists compared to CBT-only therapists; (b) The DMT+CBT and/or CBT-only therapists perceive their efficacy among children with ADs as higher than DMT-only therapists; (c) DMT+CBT and/or DMT-only therapists reported greater use of the combined approaches (DMT with CBT) in treatment of children with ADs compared to CBT-only therapists.

Grounded theory model – the combined effect of DMT and CBT (research aim 4). According to the SEM results, the fit indices, the theoretical model has a good fit to the empirical data (χ^2/df = 1.48, *NFI* = .92, *TLI* = .93, *CFI* = .97, *RMSEA* = .07). The results are presented in figure 3.

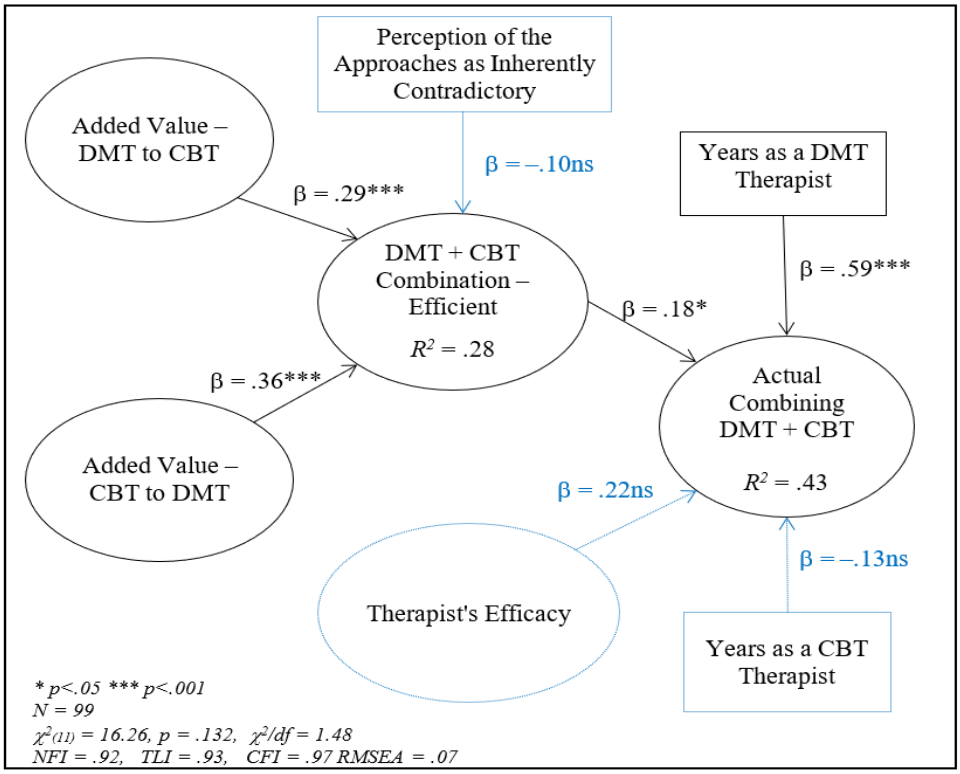

Figure 3. SEM explaining the variance of actual combining DMT+CBT among all therapists

The results of the path analysis revealed that 28% of the variance in therapists' perceptions of the quality of treatment (efficiency of the combination of DMT with CBT) is significantly explained by perceiving a high added value of CBT to DMT ($\beta = .36$, $p < .000$), DMT to CBT ($\beta = .29$, $p < .000$). In other words, the more that the therapist perceives the added value of each approach to the other – the more the therapist tends to perceive the combined DMT+CBT treatment as more efficient. Perception of the approaches as not contradictory raises the perception of the combined treatment as effective, but not significantly. In addition, 43% of the variance in therapists' use of the combined approaches (DMT with CBT) in treatment of children with ADs is significantly explained by therapists' perception of the quality of treatment (efficiency of the combination of DMT with CBT) ($\beta = .18$, $p < .05$), and the number of years they have been practicing as DMT therapists ($\beta = .59$, $p < .000$), but not by their perception of their efficacy in treatment of children with ADs ($\beta = .22$, $p = .368$), nor the number of years they have been practicing as CBT therapists ($\beta = -.13$, $p = .286$). That is, the more the combined treatment is perceived as efficient and the longer they have been working as DMT therapists, the more they tend to use the combined treatment among children with ADs. However, the variance in therapists' use of the combined approaches is not significantly explained by their efficacy in treatment of children with ADs or the number of years they have been working as CBT therapists.

Discussion

As hypothesized, a difference was found between therapists, according to their type of treatment, regarding the added value of their treatment to the other treatment. Combining therapists and therapists who use only *one* type of treatment (CBT-only or DMT-only) perceive a higher added value of the principles of their treatment compared to therapists who use only *the other type* of treatment. This finding is in line with the definition of attitudes, as representing the way individuals evaluate their world, both personal and professional (Stroebe, 2011). Therefore, the quantitative questionnaire, which was designed to evaluate attitudes and perceptions, was found to be a reliable and trustworthy instrument to expose the complex perceptions of the added values of each approach to the other (Vogel & Wanke, 2016).

A significant difference with a medium effect size was found in the added value attributed to each approach versus the other by therapists according to their type of treatment. All therapists perceived a high added value of CBT to DMT, whereas the added value of DMT to CBT was perceived significantly lower by CBT-only therapists compared to Combining

Therapists and DMT-only therapists. This difference is in line with the literature, according to which CBT is a recognized in the past decades as an organized treatment practice, based on both theory and research. It has been proven to be an effective approach to treating ADs in both adults and children (Banneyer et al., 2018; Beck, 2011; Butler et al., 2006; Hofmann et al., 2012; Kendall, 2012).

The concordance between the findings and the literature also may explain the complementary finding, that CBT-only therapists perceive a lower added value of DMT to CBT, compared to the Combining Therapists or DMT-only therapists. One possible explanation for this is that they do not know or are only somewhat familiar with DMT principles. They do not see a need to integrate the DMT approach in their work. However, since ADs are often characterized by physical and behavioral symptoms (Egger at al., 1999; Hofflich et al., 2006; Ramsawh et al., 2010), it may have been expected that CBT therapists (who only moderately agreed with statements describing the added value of DMT principles to treatment children with ADs), would attribute a higher added value to DMT principles, and believe that effective results may be achieved by combining movement and work with the body, as a therapeutic goal.

In contrast to CBT therapists, DMT-only therapists attributed greater added value of CBT, more than the added value that CBT-only therapists attributed to DMT. This finding also supports the conclusion that CBT principles are relatively known, recognized, and evidence-based (Butler et al., 2006; Hofmann et al., 2012; Kendall & Hedtke, 2006; Rapee et al., 2009), more than DMT's principles (Koch et al., 2014). This finding may be explained by the fact that historically DMT developed from established humanistic and dynamic approaches. Yet, the body of knowledge that validates the effectiveness of the approach in treating ADs, is sparse (Ritter & Low, 1996). Consequently, DMT therapists aim to integrate other evidence-based and therapeutically valuable approaches into their treatment, which can contribute to the recognition of their approach and the validation of its existence and effectiveness. It can thus be concluded that CBT provides DMT therapists with justification and validation of their basic principles, methods, and processes, at a basis for their therapeutic work. This explanation is supported the finding, according to which the Combining Therapists attributed high added values to each of the approaches, similar to the added values attributed by each single approach therapists to their own approach. While CBT validates DMT principles (the importance of body sensations and physical expression of the patient's feelings and thoughts) and DMT expands the behavioral and physiological aspects of CBT – it seems that they share connections and common principles. In other words, therapists who combine approaches recognize the common factors of the two approaches that contribute to the effectiveness of the integration in treatment of ADs

(Shafir, 2015; Wampold, 2015). This recognition may lead to the continued development of the combined treatment as an integrative therapy, according to the Common Factors Approach (Stricker, 2010). The implication is that Combining Therapists (who ranked a high added value to each of the two approaches) organize their therapeutic work based on the identification of common factors that are best suited to the unique treatment needed for each patient – from among factors they perceive as possibly effective from each of the two approaches. In line with the factors that they select, the Combining Therapists adapt techniques and therapeutic interactions that can promote the success of the combined treatment (Wampold, 2015).

Concurrently, the overt difference between the approaches contributes to the wide variety of combined treatment options and broader possibilities in which various components and principle complement each other. While CBT emphasizes the cognitive aspects, provides a defined structure, applicable and measurable targets and tools on the one hand, on the other hand, DMT enables a meaningful experience of creation and non-verbal expression.

The added value of CBT to DMT. DMT+CBT therapists and CBT-only therapists agreed (significantly more than DMT-only therapists) that CBT combines psycho-educational explanations to enhance patients' understanding of the diagnosis and treatment, validates the importance of body sensations and physical expression of the patient's feelings and thoughts, and provides tools to establish a diagnosis and choose treatment ways. These three items represent the unique aspects of the added value of CBT to DMT, beyond the obvious principles upon which all the therapists agree. They are recognized especially by therapists who are well acquainted with CBT (they learned CBT and work as CBT therapists), because they connect theory and practice. For an integrative approach to evolve at a high level, practitioners need to be well acquainted with the theory at the root of their work (Stricker, 2010). To enable an integrative approach to be effective when it is implemented by CBT therapists for whom it is not their primary approach, these three principles should be included in a training or professional development program for those who combine CBT in their work: (1) Combining psycho-educational explanations to assist patients' understanding of the diagnosis and treatment, (2) providing tools by focusing on body sensations, and (3) physical expression of feelings and thoughts. In comparison, the obvious principles of CBT (emphasizing the cognitive and behavioral components of therapy, focusing on the treatment, and therefore offering short-term treatment, providing a defined structure, applicable and measurable targets, and strengthening the physiological aspect (working with the body) of treatment processes, according to DMT) seem to reflect characteristics of CBT that were studied, and were found effective and recognized by the professional community of therapists in general, and those who

treat ADs in particular (Kendal, 2012). The original finding in this study is that *DMT-only* therapists, who did not learn CBT in depth, see the treatment's characteristics as important and necessary for treating children with ADs. The three CBT principles are not known by the DMT therapists, because they have not learned them, and thus, differences were found between the groups.

The added value of DMT to CBT. Even while CBT-only therapists are less familiar with DMT, they understand its unique aspects that can be integrated with CBT to better help children for whom CBT alone is not sufficient (James et al., 2013; Walczak et al., 2019). DMT+CBT and CBT-only therapists agree (significantly more than CBT-only therapists) with all the items that depict the added value of DMT to CBT, which may be summarized as follows: Focusing on the body according to DMT expands the behavioral and physiological aspects of CBT and enables non-verbal expression of feelings and sensations, creates a meaningful experience of creation that advances coping and change, and enables to combine movement in all of the therapy's components. In other words, the added value of DMT is reflected primarily in the addition of a dimension of a creative experience and the ability to allow nonverbal expression using the body.

These unique factors are especially essential when treating children in general (Tortora, 2016), and children with ADs in particular, with their accompanying physiological symptoms (Ramsawh, Chavira, & Stein, 2010). It is necessary to relate to these aspects, but they might not be sufficient. Therefore, the treatment may need to be complemented with CBT principles.

DMT has been found to be effective in treating ADs through qualitative studies (Koch et al., 2014), and CBT has been found effective primarily using quantitative studies (Butler et al., 2006; Hofmann et al., 2012). The practical implication is that the effectiveness of each approach separately has been, at least partially, recognized and established. Nevertheless, confirmation of the effectiveness of each approach independently does not necessarily suggest that combining them will be beneficial. However, in the current mixed-methods study, the similarity between DMT+CBT and CBT-only therapists in evaluating the added value of DMT – validates the perceived effectiveness of the combined treatment, due to addition of DMT principles.

Efficiency of the combination of DMT with CBT. The hypothesis that DMT+CBT and/or DMT-only therapists will perceive the combination of DMT with CBT as more efficient than CBT-only therapists was supported by the findings. Nevertheless, all the therapists perceived the combined effect of DMT principles with CBT principles on treatment among children with

ADs as very efficient. The literature that refers to the higher efficiency of combined treatments reveals how to target relevant and largely transdiagnostic processes to promote healthy growth and development based on a variety of approaches and interventions. Hayes and Hofmann (2018) have shown how focusing on process may settle arguments between approaches (i.e., CBT and "waves") and turn them into manageable empirical discussions while considering their philosophical differences (i.e., PB-CBT). Other integrative approaches exist, such as Cognitive Analytic Therapy (CAT, Ryle & Kerr, 2002) and the Mentalistic approach based on Theory of Mind (Fonagy & Bateman, 2006). In addition, a Third Generation of Cognitive-Behavioral approaches were developed, derived from CBT, combining body and mind intervention techniques, such as Mindfulness (Weiss, 2009); Dialectical Behavior Therapy (Linehan, 2018), Schema Therapy approach (Young et al., 2003), Cognitive-Behavioral approaches and dynamic and interpersonal approaches. All these combined approaches have been investigated and found empirically efficient – and are still under investigation. Therefore, it is suggested that the efficiency of DMT+CBT according to various forms of combination of their principles should be investigated.

Therapists' efficacy in treating children with ADs. Regarding the therapists' efficacy in treating children with ADs, supporting the study's hypothesis, results showed that DMT+CBT and CBT-only therapists reported strong efficacy in treating children with ADs, higher than DMT-only therapists, who also reported strong self-efficacy but lower than the former two groups. CBT therapists usually report strong self-efficacy in treatment, which may be explained by greater adherence to best-practices and evidence-based therapies (Kozina et al., 2010; Schiele et al., 2014). Nevertheless, because all participants were chosen due to their experience treating ADs, the finding that all of them have a strong sense of efficacy is expected.

The largest difference between therapists was found regarding the efficiency of the **tools** that their treatment approach provides them in order to successfully treat children with ADs; DMT+CBT and CBT-only perceive these tools more sufficient in comparison to DMT-only therapists. This finding is in accordance with the literature that shows that strong efficacy is related to having a sound theoretical basis, knowing many treatment techniques, and having the ability to professionally integrate the treatment goals (Levenson & Davidovitz, 2000; Messer, 2001). Research findings indicate that therapists with a strong self-efficacy tend to set high goals and to achieve them; they tend to adopt changes and innovations (Fullan, 2012; Guskey, 1988). Self-efficacy is expressed, among other ways, when the therapists acquire a 'treatment map' that allows them to construct an overview to determine whether they are on the right track path to achieve the desired results (Butler, 1998; Mace & Binyon, 2005).

CBT enhances self-efficacy because it helps the therapists organize their work and it support clinical understanding. It also helps to define the primary goal of the therapeutic session and intervention in light of the specific patient's behaviors, thoughts, and feelings (Sim & Gwee, 2005). However, additional research is needed to map the tools available to each approach, document the theory upon which each tool is based, and review existing studies that demonstrate the efficacy of the tool in treating children with ADs. Further to the current study, it would be prudent to conduct an experimental study comparing the effectiveness of different tools and their combination. Most participants in the current research were women; a meta-analysis of 58 studies (Swain, Hancock, Hainsworth, & Bowman, 2013) asserted that female therapists are slightly but significantly more effective than male therapists regarding the success of the treatment. Similarly, about a fifth of the participants are social workers or psychologists – two professions that were found effective in treatment of ADs (Vocisano et al., 2004). While each of the approaches uses different tools for treating children with ADs, those of CBT were found more effective, both theoretically and empirically (Beck, 2011; Butler et al., 2006; Hofmann et al., 2012). Similarly, CBT is based on continuous developing formulation (Beck, 2011).

The use of the combined approaches (DMT+CBT) in treatment of children with ADs. The study supports the hypothesis that DMT+CBT and/or DMT-only therapists will report greater use of the combined treatment, as compared to CBT-only therapists. Results showed frequent use of the combined approaches (DMT+CBT) by DMT+CBT therapists, and sometimes by DMT-only therapists, who use it more frequently than CBT-only therapists, who reported using it rarely. According to DMT+CBT and CBT-only therapists, using the combined treatment was determined according to **particular reasons**: the target of the therapy, the specific patient, the age of the patient, as well as the stage of the treatment. These characteristics describe the obvious considerations of therapy in general. The low frequency reported by CBT-only therapists is an outcome of the fact that they actually don't combine these two approaches, as pre-defined. In contrast, the DMT-only therapists reported using the combined treatment sometimes – more than expected from the definition of their group. DMT therapists seem to be searching for evidence-based therapy approaches, particularly CBT, to strengthen and validate in their work. They therefore combine CBT more often than was expected. The relatively frequent use of the combined approaches that was reported by DMT+CBT therapists may be explained on the basis of the fact that most of them were qualified in CBT after working as a DMT therapist. It is recommended to conduct further research to expose possible reasons that encourage DMT therapists to seek additional qualification in new treatment approaches. The

findings may contribute to recruiting additional therapist to use combined and more effective treatments and help design appropriate training programs.

DMT+CBT and the DMT-only therapists reported that they also use **various forms** of the combined approach, seldom or sometimes: and combine approaches by beginning with one and continuing with the other. This finding demonstrates that the combination of these two approaches is in its initial stages and there is still a long way to go before DMT+CBT is an accepted integrated approach. Moreover, there is still no combined approach that is evidence- and research-based in terms of its success and its efficacy.

In the current study, participants who combine therapies use three of the four methods of integration according to Stricker (2010): Technical Eclecticism (based on a comprehensive diagnosis of the patient's needs), Common Factors (common factors are identified and used to organize the therapist's work), and Assimilative Integration (mixes integration of theory with certain techniques). There is a necessity to research and analyze the combined therapies and invest efforts to develop the fourth type – Theoretical Integration, on the basis of a sound and well-established integrative theory. In this context, an important finding is that the DMT+CBT and the DMT-only therapists reported that they actually combine both approaches but have no systematic body of knowledge or an organized model of treatment to guide them in combining both approaches. This strengthens the central conclusion of the study that in order for the combined treatment to be perceived and implemented as a legitimate, recognized, and research-based therapeutic approach, efforts need to be made no only in combining the two approaches in training, but in establishing and nurturing a professional community of therapists who combine these two approaches. This will help build a pool of knowledge and professional experience and advance the conceptualization and construction of a theory that will support a practice that combines DMT and CBT, validate it, and prove its effectiveness, both empirically and theoretically.

Grounded theory model –the combined effect of DMT and CBT (aim 4). The theoretical model was found to have a good fit to the empirical data; 28% of the variance in therapists' perceptions of the quality of treatment (efficiency of the combination of DMT with CBT) is significantly explained by perceiving high added values of both CBT to DMT and DMT to CBT. The perception of the combined DMT+CBT treatment as more efficient relies on not just being aware of the existence of a treatment approach, knowing its principles and even learning it; therapists also need to recognize the unique added value of each approach to other available treatment approaches. Prior theoretical and practical attempts were done in order to create new,

efficient treatments, based on the perceived added value of various approaches (Linehan, 2018; Stricker, 2010; Wachtel, 1977; Young et al., 2003). In addition, 43% of the variance in therapists' use of the combined approaches in treatment of children with ADs is significantly explained by their perception of the combined treatment as efficient, and the numbers of years of experience they have practicing DMT, but not the number of years of experience practicing CBT. The influence of therapists' perception on their actual use of the combined approaches can be explained by the expected concordance among the affective, cognitive, and behavioral components of one's attitudes (Harmon-Jones et al., 2018). Therapists who perceive the combined treatment as effective (cognition) and believe it is efficient (affect) will manifest their perceptions and beliefs in overt responses and actions (behavior) (Eagly & Chaiken, 2007). In line with the findings regarding the added value of DMT to the combined treatment (which was recognized both by DMT+CBT therapists and DMT-only therapists), the numbers of years of experience practicing DMT was found to significantly explain the variance in therapists' use of the combined approaches in treatment of children with ADs.

Therapists' use of the combined approaches is not explained significantly by their efficacy, maybe because effective performance of the combined treatment requires skill and knowledge that are not developed yet (Bandura, 1989). All therapists expressed a strong sense of self-efficacy and belief that they are able to successfully organize and treat children with ADs (Gam, Kim, & Jeon, 2016).

CHAPTER 6. SUMMARY, DISCUSSION, AND CONCLUSIONS

Summary of the research findings

Whether and how DMT+ CBT therapists use both approaches in their work. The combination of DMT+CBT is perceived *effective* due to the *efficiency* of the treatment process, its *effectiveness* in providing better accommodation to the patients' needs (children with ADs) and improving therapists' *efficacy.* Therapists develop professionally by gaining experience and expertise in planning and implementing integrative treatments according to the children's unique needs, which are multi-faceted and diverse.

DMT and CBT therapists combine the two approaches in three main ways, based on their practical experience and satisfaction from the combined treatment: a sequential approach (each therapy approach is used separately, one following the other), partial combination (one dominant approach in which the principles of the other are implemented), and combination in

accordance with the process (the connections between the treatments are constructed in a dialectic manner that creates unity). Nonetheless, some of the therapists only partially combine these treatments, due to insufficient practical and theoretical knowledge regarding combined treatment processes. In sum, five main themes were produced from the qualitative interviews: (A) Therapists' efficacy in treatment of children with ADs; (B) The added value of CBT to DMT; (C) The added value of DMT to CBT; (D) Efficient of combination of DMT with CBT (The quality of treatment); and, (E) Use of the combination of DMT and CBT.

DMT and CBT – the combined effect on treatment of children with ADs. According to interviewed therapists, principles from DMT contribute and complement treatments using CBT and vice versa. The added values of CBT principles to DMT are that CBT serves as an "anchor" or a "road map", and a "guiding pillar," i.e., an approach on which they "lean on" and that leads therapeutic processes because it is structured and based on protocols,. The core principles of CBT help DMT therapists define targeted and practical goals by emphasizing cognitive processes, allowing a short-term treatment, which is in line with the need to provide a relatively immediate effect on children with ADs. CBT also validates the DMT therapist's work while strengthening and validating the body-mind connection, a core principle of DMT. This is important in developing DMT into an integrative psychotherapy, i.e., a legitimate, certified, and organized treatment approach, with a clear conceptualization.

The added value of DMT principles to CBT rests on three main notions that enable the treatment to be more significant and supportive of change: *Nonverbal expression of feelings and sensations, connection to the body, movement, and dance (both patient and therapist) as a transformative means by being a tool for change*, and *enabling a creative, flexible and meaningful experience*. These unique findings validate therapists' prior assumptions, experiences, and intuitions. All therapists perceive the added value of CBT to DMT, but DMT+CBT and CBT-only therapists perceive a higher added value of DMT to CBT in comparison to CBT-only therapists. The conclusion is that although ADs have both physical and behavioral symptoms, CBT-only therapists do not perceive DMT as an option to improve the treatment of children with ADs. **Therefore, hypothesis (1) was confirmed regarding the added value of CBT to DMT but not for DMT to CBT.**

Differences in perceptions of the combined effect of DMT and CBT. The DMT and CBT combination may develop therapies that provide each child with ADs with an optimal unique response. This is because each approach contributes unique therapeutic principles to the other, and thereby increases their efficiency and effectiveness as well as the therapist's efficacy. In

other words, the combination integrates the *"the best of both worlds"* by merging between the top-down methods of CBT (Goggin, 2018) with the bottom-up methods of DMT. The therapists' satisfaction with the combined treatment is based on its *cognitive aspects* (challenging, demands thought, interesting), the *positive emotions* it produces and especially, the children's motivation and satisfaction. Nevertheless, the therapists recognize that the combined treatment requires additional effort and creativity, unique knowledge and recognition of various protocols, and sometimes might not end successfully. This leads to the conclusion that additional "meta approaches" should be developed and piloted (see for example, Parsons et al., 2019). Thus, in order to practice the combined treatment successfully, professional and constructed guidance, mentoring, and supervision are needed.

In accordance with the interview findings, the primary reasons for the perceived **efficiency** of the combined treatment are that it is based on research and involves creative experience, merging verbal and nonverbal expression. Therefore, it facilitates defining targets and providing clear and precise tools. The children enjoy the therapeutic process whilst the therapists face challenges and need to rethink their work, in addition to acquiring professional training and experience in both approaches. Nevertheless, the DMT+CBT therapists agreed less than DMT-only and CBT-only therapists with **conditions for efficiency of the combined treatment.** Specifically, treatment should not be confusing or overwhelming for the children**,** and they should have the ability to connect to body and movements. **Therefore, hypothesis (2a) was confirmed.**

(b) DMT+CBT and CBT-only therapists reported strong efficacy in treating children with ADs, higher than DMT-only therapists, who also reported strong self-efficacy, but lower than the former two groups. In line with the findings of the interviews, DMT+CBT and CBT-only therapists perceive the tools their treatment approach provides them as more sufficient than the tools DMT-only therapists have to successfully treat children with ADs. **Therefore, hypothesis (2b) was confirmed.**

(c) DMT+CBT and CBT-only therapists reported greater use of the combined treatment, as compared to CBT-only therapists, **according to the hypothesis (2c).** Therapists use the combined treatment according to **particular reasons**: The target of the therapy, the specific patient, the age of the patient, as well as the stage of the treatment. In line with the qualitative findings, **various forms** of the combined approach were reported by DMT+CBT and CBT-only therapists, such as: Partially combined treatment, use of one major approach and adding the other, choosing to combine approaches when the single approach therapy is inefficient.

The results of the SEM path analysis revealed that the more the therapists recognize the added values of both DMT and CBT to the combined treatment the more they perceive it as efficient. This perception, along with many years of experience practicing DMT (but not necessarily CBT), influences the therapists' actual use of the combined approaches in treatment of children with ADs.

Theoretical contributions

In the current study, a distinction was formulated between three different meanings of the term *effect* (in Hebrew – "Hashpa'aa") regarding the three main components of the therapy: The therapists *efficacy* (in Hebrew – "Mesugalut ha'metapel"); The *efficiency* of the treatment process (in Hebrew – "ye'ilut ha'tipul"); The *effectiveness* of treatment – positive results for the patient indicating success of the therapy (in Hebrew – "Ye'ilut ha'toza'ot mibhinat ha'metupal'). This study aims to form a proposed theoretical model that explains the variance of use of the combined treatment among children with ADs, as a function of the perceptions of each treatment separately as well as efficiency of combined DMT+CBT treatment (the **cognitive** component of their attitudes), the reported efficacy of the therapist (the **affective-emotional** component of their attitudes), and the actual use of this combination (the **behavioral** component of their attitudes).

DMT and CBT cultures, as treatment and research approaches, seem to develop in stages and in different pace, regarding both as a single treatment method and as part of a combination with other therapies. This development creates a wide pool of practical latent knowledge that may advance and evolve into a well-established theory. Indeed, very few studies have focused on therapists, and the current study directly investigated their perceptions and attitudes using two research methods: qualitative interviews and a quantitative questionnaire, as a path to construction of a theoretical framework that will enable further research on combining therapies. The grounded theory model which was produced from the findings of the interviews is embedded in the new validated questionnaire that was constructed in this research "Therapists' Attitudes towards Treatment of Anxiety disorders among Children (ATAD-Q)".

Practical applications and recommendations

In Israel, about 15-20% of children and adolescents suffer from ADs. The findings of this study may contribute to the education system and expressive arts therapists who work also in the schools by offering a combined DMT+CBT therapy for treating children with ADs.

Additionally, the findings of the study may advance legislation for Expressive Arts Therapies, including DMT. Sharing different forms of integration generally, and DMT+CBT particularly, around the world, may broaden the scope of efficient practices. It can also help therapists write protocols and validate them for the treatment of ADs as well as create an integrative theory in the future. To date, the combing therapists which use both approaches (regarding their theoretical and practical aspects), work separately and have no affiliation group, mainly because most of them are not aware that other combining DMT+CBT therapists exist. Thus, an international professional community of combining therapists should be founded and developed. It is important to create this professional community in order to collect and share practical experience and empirical, evidence-based knowledge alongside with construction of new programs focusing on training in the combined DMT+CBT approaches.

Limitations and suggestions for further research

The current study examined therapists' attitudes only in relation to the added value of each one of the approaches: DMT and CBT. Therefore, their perceptions of the nature and effectiveness of the actual implementation of the combined treatment should be explored. In addition, there is a need to understand how therapists treating children with various ADs identify and determine the most effective treatment for these children and what tools the therapists must use. Therefore, further research is needed to map the tools available to each approach, document the theory upon which each tool is based, and review existing studies that demonstrate the efficacy of the tool in treating children with ADs. It is also recommended to observe and document therapeutic sessions (DMT-only, CBT-only and DMT+CBT) – in order to validate the findings and conclusions of the current study. One possible limitation of the current research' approach is investigating subjective perspectives, i.e., attitudes and perceptions. Therefore, the investigation of subjective aspects regarding the efficacy of DMT+CBT should be examined in future research with additional objective components and methodologies (RCTs regarding both efficacy and mechanisms of change in children with ADs). Also, the parents' attitudes regarding their children's treatment experiences and outcomes (as told by the children).

Future research should establish the contribution of DMT and CBT principles to treating children with ADs, by conducting action research, interviewing professional and the children themselves, and documenting therapy sessions (observations, video recordings and documental analysis). The grounded theory model can be applied to research on other combinations of treatments in the fields of Expressive Arts Therapies and even other traditional therapeutic

approaches and may be applied on other age groups as well as additional disorders.

Conclusions

The main conclusion, based on the findings of the mixed methods research, is that therapists, who work with both approaches and combine them, are aware of and recognize the added values of each approach to the other approach, within the framework of a combined effective treatment for children with ADs. Therefore, they constantly and continuously create new knowledge that promotes integration of these approaches. It is essential to close the gap between theory and practice, and not only base new theories on merely the cumulative practical experience in both approaches, in order to develop in the future and with additional research, an integrative treatment based on theory and research. Following additional research, a new, comprehensive theoretical and practical definition of DMT and CBT, as an integrative approach, may be formed.

The findings shed light on the well-established CBT approach, by enlightening aspects and gaining insights which have the potential to facilitate in the future the integration of CBT with DMT, both theoretically and practically. For example, the structured, target oriented therapy that CBT offers, provides therapist (from various approaches, including DMT) a "road map" and an "anchor" which increase their awareness and enhance their self-efficacy. Nonetheless, CBT provides validity to the principles of DMT and establishes the central place and importance of body sensations and physical expression of feelings and thoughts, in the process of treatment.

However, DMT, as a humanistic approach, sets the child in the center of the therapeutic process. Therefore, it also broadens and expands the behavioral aspects and physiological dimensions of CBT. It enables flexibility, nonverbal expressions of feelings, emotions and thoughts, through a creative process of experience-focused treatment.

The connections and common principles of the two approaches, alongside with the differences between them, as examined in this research, may form, following additional research, in the future, an integrated treatment in which each approach can complements the other and may forms a whole which is larger than the sum of its parts – **DM-CB-T**. This integration, based on future research, is highly important, significant and essential for effective treatment of children in general and children with ADs especially.

References

ADTA. (2019). Homepage of the American Dance Therapy Association. *What is dance/movement therapy?* Retrieved from: http://www.adta.org/

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. Washington, DC: American Psychiatric Publishing.

Bandura, A. (1989). Regulation of cognitive processes through perceived self-Efficacy. *Developmental Psychology, 25*(5), 729.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Macmillan.

Banneyer, K. N., Bonin, L., Price, K., Goodman, W. K., & Storch, E. A. (2018). Cognitive Behavioral therapy for childhood anxiety disorders: A review of recent advances. *Current psychiatry reports, 20*(8), 65.

Baron, R. A., & Byrne, D. (2000). *Social psychology*. MA, US: Allyn & Bacon.

Beardall, N., & Surrey, J. (2013). Relational mindfulness and relational movement in training dance/movement therapists. In L. Rappaport (Ed.), *Mindfulness and the arts therapies: Theory and practice* (pp. 276-287). London, United Kingdom: Jessica Kingsley.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: New American Library

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond*. New York: Guilford.

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of Cognitive-Behavioral therapy: A review of meta- analyses. *Clinical Psychology Review, 26*(1), 17-31.

Butler, G. (1998). Clinical formulation, In A. S. Bellack & M. Hersen (Eds.), *Comprehensive clinical psychology* (volume 6, pp. 1-24). Oxford, United Kingdom: Pergamon.

Chavira, D. A., Stein, M. B., Bailey, K., & Stein, M. T. (2004). Child anxiety in primary care: Prevalent but untreated. *Depression and Anxiety, 20*(4), 155-164.

Costello, E. J., Egger, H. L., & Angold, A. (2004). Developmental epidemiology of anxiety disorders. In T. H. Ollendick & J. S. March (Eds.), *Phobic and anxiety disorders in children and adolescents* (pp. 61-91). New York: Oxford University.

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th Ed.). Thousand Oaks, California: Sage.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice, 39*, 124-130.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th Ed.), Thousand Oaks, California: Sage.

Czamanski-Cohen, J. (2012). The use of art in the medical decision-making process of oncology patients. *Art Therapy, 29*(2), 60-67.

EADMT. (2019). Webpage of the European Association of Dance Movement Therapy. Retrieved from http://www.eadmt.com.

Eagly, A. H., & Chaiken, S. (2007). The advantages of an inclusive definition of attitude. *Social Cognition*, *25*(5), 582-602.

Egger, H. L., Costello, E. J., Erkanli, A., & Angold, A. (1999). Somatic complaints and psychopathology in children and adolescents: Stomach aches, musculoskeletal pains, and headaches. *Journal of the American Academy of Child and Adolescent Psychiatry*, *38*(7), 852-860.

Ellis, A. (1962). *Reason and emotion in psychotherapy*. New York: Lyle Stuart.

Farrell, L. J., Ollendick, T. H., & Muris, P. (Eds.) (2019). *Innovations in CBT for childhood anxiety, OCD, and PTSD: Improving access and outcomes*. Cambridge: Cambridge University.

Flick, U. (2006). *An introduction to qualitative research* (2nd Ed.) London: Sage.

Fonagy, P., & Bateman, A. W. (2006). Mechanisms of change in mentalization-based treatment of BPD. *Journal of clinical psychology*, *62*(4), 411-430.

Fullan, M. (2012). *Change forces: Probing the depths of educational reform*. London: Routledge.

Gam, J., Kim, G., & Jeon, Y. (2016). Influences of art therapists' self-efficacy and stress coping strategies on burnout. The Arts in Psychotherapy, 47, 1-8.

Goggin, C. (2018). The efficacy of Dance/Movement Therapy for trauma affected youth: A literature review. *Expressive Therapies Capstone Theses*, 93. Retrieved from: https://digitalcommons.lesley.edu/expressive_theses/93

Gross, A. (2005). Mavo l'tipul b'tnua [Introduction to movement therapy]. In A. Or & D. Amir, *B'safa axeret: Terapia b'omanuyot sipurei tipul* [In other words: Arts therapies treatment stories]. Ben Shemen, Israel: Modan. (in Hebrew)

Gullone, E. (2000). The development of normal fear: A century of research. *Clinical Psychology Review, 20*(4), 429-451.

Guskey, T. R. (1988). Teacher efficacy, self-concept and attitudes toward the implementation of instructional innovation. *Teaching and Teacher Education, 4,* 63-69.

Harmon-Jones, E., Armstrong, J., & Olson, J. M. (2018). The Influence of Behavior on Attitudes. In D. Albarracin, B. T. Johnson (Ed.), *The Handbook of Attitudes, Volume 1: Basic Principle*. New York*:* Routledge.

Hayes, S. C. & Hofmann, S. G. (2018). (Eds.) *Process-based CBT: The science and core clnical competencies of cognitive beahvioral therapy.* Oakland, California: New Harbinger.

Higa-McMillan, C. K., Francis, S. E., Rith-Najarian, L., & Chorpita, B. F. (2016). Evidence base update: 50 years of research on treatment for child and adolescent anxiety. *Journal of Clinical Child & Adolescent Psychology*, *45*(2), 91-113.

Hofflich, S. A., Hughes, A. A., & Kendall, P. C. (2006). Somatic complaints and childhood anxiety disorders. *International Journal of Clinical and Health Psychology*, *6*(2), 229-242.

Hofmann, S. G., Asnaani, A., Vonk, I. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of Cognitive-Behavioral therapy: A review of meta-analyses. *Cognitive Therapy and Research*, *36*(5), 427-440.

James, A. C., James, G., Cowdrey, F. A., Soler, A., & Choke, A. (2013). Cognitive behavioral therapy for anxiety disorders in children and adolescents. *Cochrane database of systematic reviews*, (6). Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/23733328

Kendall, P. C. (2012). Anxiety disorders in youth. In P. C. Kendall (Ed.), *Child and adolescent therapy: Cognitive-behavioral procedures, 4th edition* (pp. 143-189). New York, NY: Guilford.

Kendall, P.C., & Hedtke, K. (2006). *Cognitive-behavioral therapy for anxious children: therapist manua*l. (3rd ed.) Ardmore, PA: Workbook.

Koch, S., Kunz, T., Lykou, S., & Cruz, R. (2014). Effects of dance movement therapy and dance on health-related psychological outcomes: A meta-analysis. *The Arts in Psychotherapy, 41*(1), 46-64.

Koch, S. C., Riege, R. F. F., Tisborn, K., & Biondo, J. (2019). Effects of dance movement therapy and dance on health-related psychological outcomes. A meta-analysis update. *Frontiers in psychology*, *10*, 1806.

Kozina, K. Grabovari, N., Stefano, J. D., & Drapeau, M. (2010). Measuring changes in counselor self-efficacy: Further validation and implications for training and supervision. *The Clinical Supervisor, 29*(2), 117-127.

Lahad, M. Farhi, M. Leykin, D., & Kaplansky, N. (2010). Preliminary study of a new integrative approach in treating post-traumatic stress disorder: See Far CBT. *Arts in Psychotherapy, 37*(5), 391-399.

Levenson, H., & Davidovitz, D. (2000). Brief therapy prevalence and training: A national survey of psychologists. *Psychotherapy, 37,* 335-340.

Lincoln, Y. S., & Guba, E.G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin, Y. S. Lincoln (Eds.), *The handbook of qualitative research* (2nd ed., pp. 163-188). Beverly Hills, California: Sage.

Linehan, M. M. (2018). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford.

Mace, C., & Binyon, S. (2005). Teaching psychodynamic formation to psychiatric trainees, part 1: Basics of formulation. *Advances in Psychiatric Treatment, 11,* 416-423.

Malchiodi, C. A., & Rozum, A. L., (2012). Cognitive behavioral and Mind-body approaches. In C. A. Malchiodi (Ed.), *Handbook of art therapy* (pp. 89-102), New York: Guilford.

Mason, J. (1996). *Qualitative researching*. London: Sage.

McGuire, J. F., Caporino, N. E., Palitz, S. A., Kendall, P. C., Albano, A. M., Ginsburg, G. S., ... & Piacentini, J. (2019). Integrating evidence-based assessment into clinical practice for pediatric anxiety disorders. *Depression and anxiety*, *36*(8), 744-752.

Melchert, T. P., Hays, V. L., Wiljanen, L. M., & Kolocek, A. K. (1996). Testing models of counselor development with a measure of counseling self-efficacy. *Journal of Counseling & Development, 74*(6), 640-644.

Messer, S. B. (2001). What makes brief psychodynamic therapy time efficient? *Clinical Psychology: Science and Practice, 8,* 1-18.

Parsons, A., Omylinska-Thurston, J., Karkou, V., Harlow, J., Haslam, S., Hobson, J., ... & Griffin, J. (2019). Arts for the blues – a new creative psychological therapy for depression. *British Journal of Guidance & Counselling,* 1-16. Retrieved from: http://bit.ly/2G7l8jB

Payne, H. (2003). Shut in, shut out: Dance movement therapy with children and adolescents. In H. Payne (Ed.), *Dance movement therapy: Theory and practice,* (pp. 53-94). United Kingdom: Routledge.

Perry, T. (2008). Tipul psychodynami v'tipul cognitivi hitnahaguti: Shiluv efshari [Psychodynamic therapy and Cognitive-Behavioral therapy – A possible combination]. *Sihot, 22,* 2. (in Hebrew)

Pietrzak, T., Lohr, C., Jahn, B., & Hauke, G. (2017). *Embodying cognition in Cognitive-Behavioral Therapy*. Preprints 2017, 2017090065.

Ramsawh, H. J., Chavira, D. A., & Stein, M. B. (2010). Burden of anxiety disorders in pediatric medical settings: prevalence, phenomenology, and a research agenda. *Archives of Pediatrics & Adolescent Medicine*, *164*(10), 965-972.

Rapee, R. M., Schniering, C. A., & Hudson, J.L. (2009). Anxiety disorders during childhood and adolescence: Origins and treatment. *Annual Review of Clinical Psychology*, *5*, 311-341.

Regev, D., & Snir, S. (2016). Tipul b'emtzaut omanut b'maarehet hahinuch b'medinat Israel; Temunat matzav [Arts therapies in the Israeli education system: An update]. *Tipul Beomanuyot: Mehakar V'yitzira B'maaseh Hatipuli [*Arts Therapies: Research and Creativity in the Therapeutic Process], *6*(1), 575-591. (in Hebrew)

Ritter, M., & Low, K.G. (1996). Effects of dance/movement therapy: A meta-analysis. *The Arts in Psychotherapy*, *23*(3), 249-260.

Robichaud, M., Koerner, N., & Dugas, M. J. (2019). *Cognitive behavioral treatment for generalized anxiety disorder: From science to practice*. New York: Routledge.

Ryle, A., & Kerr, I. (2002), *Introducing cognitive analytic therapy: Principles and practice.* Chichester: John Wiley & Sons.

Schiele, B. E., Weist, M. D., Youngstrom, E. A., Stephan, S. H., & Lever, N. A. (2014). Counseling self-efficacy, quality of services and knowledge of evidence-based practices

in school mental health. *Professional Counselor, 4*(5), 467-480. doi:10.15241/bes.4.5.467

Shafir, T. (2015). Body-based strategies for emotion regulation. In M. L. Bryant (Ed.), *Handbook on emotion regulation: Processes, cognitive effects and social consequences,* (pp. 231-249). United Kingdom: Nova Science.

Sharon, Y. (2018). Tipul cognitivi hitnahaguti b'emtzaut omanuyot [Cognitive behavioral therapy using the arts]. In S. Snir, & D. Regev (Eds.), *K'shehatipul b'emtzaut omanuyot pogesh et ma'arexet haxinux b'israel [When treatment with the arts meets the Israeli educational system]*. Haifa, Israel: University of Haifa. (in Hebrew)

Shelby, J. S., & Berk, M. S. (2009). Play therapy, pedagogy, and CBT: An argument for interdisciplinary synthesis. In A. A. Drewes (Ed.), *Blending play therapy with Cognitive-Behavioral therapy: Evidence-based and other effective treatments and techniques* (pp. 17-40). Hoboken, New Jersey: John Wiley & Sons.

Shkedi, A. (2003). *Milim hamenasot lagaat: Mexkar eixutani, teoria, v'yisum* [*Words that try to touch – Qualitative research – Theory and practice]*. Tel Aviv: Tel Aviv University: Ramot.

Sim, K., & Peng Gwee, K. (2005). Case formulation of psychotherapy: Revitalizing its usefulness as a clinical tool. *Academic Psychiatry, 29,* 289-292.

Spradley, J.P. (1979). *The ethnographic interview*. New York: Holt, Rinehart, & Winston.

Strauss, A & Corbin, J. (1990). B*asics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, California: Sage.

Stricker, G. (2010). Psychotherapy integration. *Psychotherapy Bulletin, 410,* 25.

Stroebe, W. (2011). *Social psychology and health*. United Kingdom: McGraw-Hill Education.

Swain, J, Hancock, K, Hainsworth, C., & Bowman, J. (2013). Acceptance and commitment therapy in the treatment of anxiety: A systematic review. *Clinical Psychology Review, 33*(8), 965-978.

Tortora, S. U. Z. I. (2016). Dance/movement psychotherapy in early childhood treatment. In S. Chaiklin & H. Wengrower (Ed.), *the art and science of dance/movement therapy: Life Is Dance* (pp.159-180). London, United Kingdom: Routledge.

Treadwell, T. W., Dartnell, D., Travaglini, L. E., Staats, M., & Devinney, K. (2016). *Group therapy workbook: Integrating Cognitive-Behavioral therapy with psychodramatic theory and practice*. Denver, Colorado: Outskirts.

Vocisano, C., Klein, D., Arnow, B., Rivera, C. Blalock, J. A., Rothbaum, B., Vivian, D., et al. (2004). Therapist variables that predict symptom change in psychotherapy with chronically depressed outpatients. *Psychotherapy: Theory, Research, Practice, Training, 41*(3), 255-265. http://dx.doi.org/10.1037/0033-3204.41.3.255

Vogel, T., & Wanke, M. (2016). *Attitudes and attitude change*. New York: Routledge.

Wachtel, P. L. (1977). *Psychoanalysis and behavior therapy: Toward an integration*. New York: Basic.

Wachtel, P. L. (2014). *Cyclical psychodynamics and the contextual self: The inner world, the intimate world, and the world of culture and society*. New York: Routledge.

Walczak, M., Breinholst, S., Ollendick, T., & Esbjørn, B. H. (2019). Cognitive behavior therapy and metacognitive therapy: moderators of treatment outcomes for children with generalized anxiety disorder. *Child Psychiatry & Human Development, 50*(3), 449-458.

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*(3), 270-277.

Wengrower, H. (2016). The creative–artistic process in dance/movement therapy. In S. Chaiklin & H. Wengrower (Ed.), *The art and science of dance/movement therapy: Life Is Dance* (2nd ed., pp.45-64). London, United Kingdom: Routledge

Weiss, H. (2009). The use of mindfulness in psychodynamic and body orientated psychotherapy. *Journal of Body, Movement and Dance in Psychotherapy, 4*(1), 5-16.

Young, J. E., Klosko, J. S., & Weishaar, M. (2003). *Schema therapy: A practitioner's guide.* United Kingdom: Guilford.