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To cite this article: Alison Phillips Sheesley, Mark Pfeffer & Becca Barish (2016) Comedic Improv Therapy for the Treatment of Social Anxiety Disorder, Journal of Creativity in Mental Health, 11:2, 157-169, DOI: 10.1080/15401383.2016.1182880

To link to this article: http://dx.doi.org/10.1080/15401383.2016.1182880

Published online: 13 Jun 2016.

Article views: 8

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Comedic Improv Therapy for the Treatment of Social Anxiety Disorder

Alison Phillips Sheesley, Mark Pfeffer, and Becca Barish

Comedic improv therapy, a group therapy model inspired by the practice of improv comedy, provides a novel treatment for social anxiety disorder by harnessing the following therapeutic elements: (a) group cohesiveness, (b) play, (c) exposure, and (d) humor. This article outlines the theoretical basis for this creative treatment and discusses important considerations for the practical application of this mode of therapy, such as the combination of comedic improv therapy with other modes of therapy. Lastly, this article describes an existing clinical program called Improv for Anxiety that integrates comedic improv therapy with group cognitive behavioral therapy for the treatment of social anxiety disorder.

The hallmark of social anxiety disorder (SAD) is “marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others” (American Psychiatric Association, 2013, p. 202). Comedic improv therapy (CIT) is a novel approach for the treatment of SAD derived from improvisational comedy (i.e., improv comedy). The practice of improv comedy exposes participants to potentially anxiety-producing scenarios where theatrical performance without a script is demanded. Under the guidance of one or more skilled mental health professionals, participation in CIT could provide a corrective emotional experience for individuals experiencing SAD. Using the curative elements of (a) group cohesiveness, (b) play, (c) exposure, and (d) humor, CIT offers an innovative group therapy model for the treatment of SAD.

SAD

SAD is a common, though often untreated, mental health issue (Weiller, Bisserbe, Boyer, Lepine, & Lecrubier, 1996). According to the National Comorbidity Survey-Replication, SAD has a lifetime prevalence of 12.1%, which is among the highest of all anxiety disorders (Kessler, Chiu,
For adolescents with SAD, frequent loneliness and avoidance of social situations are reported, such as “asking a teacher a question,” “walking in the hallways,” and “dating” (Mesa, Beidel, & Bunnell, 2014, p. 1). For adults, SAD is associated with lower quality of life and reduced income earnings (Andlin-Sobocki, Jönsson, Wittchen, & Olesen, 2005). Given these negative repercussions, effective treatment is important to improve the outcome and life satisfaction of individuals experiencing SAD.

Most published studies examining the efficacy of treatment for SAD focus on cognitive behavioral therapy (CBT) and group cognitive behavioral therapy (GCBT). A recent meta-analysis by Wersebe, Sijbrandij, and Cuijpers (2013) concluded that GCBT offers a “moderate, but significant effect in the treatment of SAD compared to control” (p. 3). The treatment mechanism of GCBT is exposure to feared social stimuli with opportunity for processing and cognitive restructuring led by the group therapists. The group dynamic presumably exposes a client to more feared social stimuli than a counselor–client dynamic alone. Yet a study by Eng, Coles, Heimberg, and Safren (2001) showed that 36% of clients with SAD were “nonresponders” to GCBT. Similarly, Kashdan and Steger (2006) concluded that current interventions for SAD, such as CBT, “may not be sufficient to enhance appetitive goals and activities and positive emotions” because the primary focus is altering negative cognitions (p. 126). GCBT can be combined with CIT, which may reduce the percentage of “nonresponders” by virtue of emphasizing “positive emotions” such as laughter described later in this article.

**Background of improv comedy**

*Improv* (i.e., improv comedy or improvisational theater) refers to any theatrical performance occurring without a script. Mick Napier, Director and Artistic Consultant at The Second City and Founder and Artistic Director at The Annoyance Theatre in Chicago, defines *improv comedy* as “the art of not knowing what the hell you’re going to do or say and being completely okay with that” (ChicagoIdeasWeek, 2012). Improv comedy, Trew and Nelson (2013) added, “has the ability to surprise and move even the most experienced improviser/audience” (p. i). Most improv comedy takes place in groups of individual players, also known as “teams,” who practice regularly.

The roots of modern improv comedy can be traced from *commedia dell’arte* in 15th-century Italy to America in the late 1930s when Viola Spolin, as a means of engaging children in community theater, developed many of the quintessential improv exercises still used today (Salinsky & Frances-White, 2008). For example, to inspire the improvised performance,
Spolin would first ask for “a suggestion from the audience” (Salinsky & Frances-White, 2008, p. 3). As the discipline of improv comedy evolved, two major institutions were established: The Second City (founded by Bernard Sahlins, Howard Alk, & Paul Sills, son of Viola Spolin) and ImprovOlympic (founded by Del Close & Charna Halpern; Salinsky & Frances-White, 2008).

One of the most commonly used improv exercises is called, “Yes, and . . .,” an exercise intended to strengthen the skills and relationships among team members. Two improvisers stand or sit facing each other. The first improviser starts with a premise, a single statement as simple or complicated as desired (e.g., “The sky is blue”). The second improviser responds with “Yes, and . . .,” adding to the premise (e.g., “Yes, and there is a cloud in the sky that looks like an elephant”). In turn, each improviser continues to respond to the other with “Yes, and . . .,” building on each other’s ideas. The crucial component of this exercise as explained by Salinsky and Frances-White (2008) is the absence of rejection: “Saying yes to your partner’s idea represents a risk. You have to let an alien idea in and, if you have to build on it, you have to let it influence you” (p. 61).

Interest in improv comedy has recently expanded beyond comedic entertainment; the psychological, intellectual, relational, social, and even economic benefits of practicing improv comedy appear vast. Writing about the application of improv comedy in the workplace, Leonard and Yorton (2015) contend: “When we are fiercely following the elements of improvisation, we generate ideas both quickly and efficiently; we’re more engaged with our coworkers; our interactions with clients become richer . . . we don’t work burdened by a fear of failure” (p. 1). Patricia Ryan Madson, an improv consultant to organizations, agrees: “[E]xecutives and engineers and people in transition are looking for support in saying yes to their own voice. Often, the systems we put in place to keep us secure are keeping us from our more creative selves” (Rae-Dupree, 2008, p. 10).

Because improv comedy by its very nature appears to create opportunities for personal growth and exploration, this framework can be adapted by a skilled mental health professional in the context of group therapy for the treatment of psychological issues, such as SAD. As explained cogently by Steitzer (2011), who recognized the benefits of applying improv comedy in the context of social work groups and first published seminal academic literature on this topic, the advantages of practicing improv comedy include “active listening,” “risk-taking,” and “group-mind.” In this article, we offer an original approach for the treatment of SAD more closely aligned with counseling theory and research and label this theoretical model comedic improv therapy (CIT). This article also explains how to implement specific CIT exercises and combine CIT with other therapy models, such as GCBT, as currently applied in our clinical practice for the treatment of SAD.
CIT: Theoretical treatment mechanisms and examples of exercises

CIT integrates several healing elements from multiple modalities of therapy to potentially provide effective treatment for clients with SAD: (a) group cohesiveness, (b) play, (c) exposure, and (d) humor. Below, a description of specific improv comedy exercises to be utilized by the group therapy leader follows a discussion of each element. Although this article outlines specific exercises, with further improv comedy training, mental health professionals also can support the creation of fully developed scenes involving more complex characters and storylines.

Group cohesiveness

Group cohesiveness is arguably the most vital component of CIT and equally essential to the practice of improv comedy. Irvin Yalom (2005), in his groundbreaking work *The Theory and Practice of Group Psychotherapy*, defined group cohesiveness as “the individual’s relationship to the group therapist, to the other group members, and to the group as a whole” (p. 54). Group cohesiveness is essential in the context of group therapy for the treatment of SAD because individuals with SAD often view themselves as unacceptable to others and believe that their own behaviors will lead to humiliation and rejection (Kashdan & Steger, 2006). The therapeutic mechanism underlying group cohesiveness lies in the acceptance of others: “To be accepted by others challenges the client’s belief that he or she is basically repugnant, unacceptable, or unlovable” (Yalom, 2005, p. 56). Moreover, Kashdan and Steger (2006) suggested that treatments for SAD should focus on “facilitating an accepting, nonjudgmental stance” towards feelings of social anxiety (p. 126).

CIT attempts to create a social environment wherein individual group members experience feelings of group cohesiveness while confronting feelings of social anxiety. When guided by a sensitive and experienced group facilitator, this therapeutic model could serve to alleviate symptoms of SAD. The following improv comedy exercise can be used to strengthen group cohesiveness within the framework of CIT for the treatment of SAD.

“I’m a …”

In this universally known improv exercise, group members begin by standing in a line. One person selected by the group leader steps out and announces “I’m a . . .,” completing the sentence with an example of an object. The group member also uses his/her body to act out the object. For example, a group member declares, “I’m a tree” and puts his hands up and sways gently. One by one, group members step forward and state “I’m a . . .” and add to the scene. For example, subsequent group members could respond with “I’m a
flower” or “I’m a sun.” This pattern continues until every group member has contributed to create a stage picture that includes all of the objects.

In CIT, the group leader can focus on facilitating group cohesiveness by responding positively to every group member’s named object and encouraging other group members to also respond energetically. In doing so, the group leader hopes to encourage each group member to ask internally “How can I be of service to others?” instead of remaining focused on the self-critical internal dialogue that prevents social engagement. In the popular literature on improv comedy found in books and online sources, there are many other similar improv exercises designed to facilitate group cohesiveness, as it is essential to skillfully executed improv comedy: “When an improviser lets go and trusts his fellow performers, it’s a wonderful, liberating experience that stems from group support” (Halpern, Close, & Johnson, 1994, p. 16). All of the improv comedy exercises promoting group cohesiveness facilitate an environment of acceptance of others and of oneself that is crucial to alleviating symptoms of SAD.

**Play**

Another therapeutic element of CIT potentially beneficial for the treatment of SAD is play. Mental health professionals have long recognized the healing powers of play for children and adults alike. Two forms of established group play therapy for adults have their foundation in theatrical improvisation—psychodrama, developed first, and drama therapy. According to Kedem-Tahar and Kellermann (1996), both psychodrama and drama therapy use techniques such as “role playing, impersonation, enactment and improvisation for the purpose of helping people to deal with various aspects of their lives” (p. 27). In the early 1920s, Joseph Moreno developed psychodrama after becoming interested in the therapeutic impact of “completely spontaneous theater” (Kedem-Tahar & Kellermann, 1996, p. 27). Kellermann (1992) described the basic framework of psychodrama:

> A number of scenes are enacted depicting, for example, memories of specific happenings in the past, unfinished situations, inner dramas, fantasies, dreams, preparations for future risk-taking situations or unrehearsed expressions of mental states in the here and now. … If required, other roles may be taken by group members or by inanimate objects. (p. 20)

According to Moreno, the therapeutic mechanism of psychodrama includes the activation of an individual’s creativity through physical involvement and spontaneity. Blatner (2002), in *Play Therapy with Adults*, explained Moreno’s theory: “Active physical involvement adds to the warming-up to spontaneity because the active involvement opens up a corresponding flow of intuitions, images, feelings, and insights that are otherwise distanced and blocked by
more passive verbal modes of exchange” (p. 35). Activating creativity improves the individual’s ability to respond differently to the presenting problem instead of conforming to habits of thought and behavior that are contributing to pathology.

Drama therapy developed during the 1960s under the framework of experimental theater (Kedem-Tahar & Kellermann, 1996). In contrast to the more rigid parameters of psychodrama, drama therapy emphasizes “spontaneity, creativity, and play” (Kedem-Tahar & Kellermann, 1996, p. 28). Drama therapists use a wide-range of techniques including music, movement, props, and improvisation (Kedem-Tahar & Kellermann, 1996). A search of the literature identified few empirical studies using drama therapy in the treatment of SAD. In one study, Dadsetan, Anari, and Sedgepour (2008) randomly selected 16 children (10–11 years) to receive weekly 2-hr sessions of drama therapy for 6 weeks. At the end of the 6 weeks, the children reported significantly lower scores on the Liebowitz Social Anxiety Scale for Children and Adolescents (LSAS-CA) than the control group (Masia, Klein, & Liebowitz, 1999).

The keystone of both psychodrama and drama therapy is active play from participants. The act of playing, in addition to inspiring creativity, can give participants the needed permission for cathartic emotional expression. Blatner (2002) insightfully explained the role of play within therapy sessions: “This makes the therapy session into a kind of ‘fail-safe’ laboratory in which participants can explore self-expression of feelings that are not generally acceptable in conventional society, much less in the sensitive context of many families” (p. 35). Essentially, the proposed CIT attempts to harness the therapeutic powers of play through spontaneity and creativity, as emphasized earlier in psychodrama and drama therapy, in an effort to reduce social anxiety. In particular, the therapeutic power of play in CIT benefits individuals with SAD by expanding the creativity necessary to choose a different response in social situations, a response that engenders deeper social connections instead of a response that focuses on feelings of anxiety and avoidance. The following improv comedy exercise is designed to promote play among group members.

**Panel**
The group leader assigns a different occupation to each group member. The members are then instructed to invent characters with those occupations and respond accordingly to questions asked by the group leader and other group members. For example, if someone is assigned to the occupation of jeweler and then asked, “What is the meaning of life?” they might respond, “The meaning of life is to surround yourself with as many beautiful things as possible.” The group leader and group members then ask follow-up questions in turn, ideally open-ended, that delve deeper into the character, such as “How does your focus on material objects impact your relationships with others?”
This exercise encourages group members to act spontaneously and creatively in developing questions and answers in the moment. The group environment becomes the “fail-safe” laboratory in which group members can experiment or “play” with different aspects of their personalities. According to Blatner (2002), the practice of answering questions spontaneously can increase the individual’s “flow of intuitions, images, feelings, and insights” regardless of whether the answers are based in the personhood of the participant or invented (p. 35). Following this activity, the group leader can ask process-oriented questions intended to deepen the participants’ self-awareness of the creativity that emerged during the exercise.

**Exposure**

Exposure to feelings of social anxiety is an important therapeutic aspect of CIT and crucial to the treatment of SAD. Gelatophobia, the fear of being laughed at and appearing ridiculous to social partners, frequently accompanies SAD (Carretero-Dios, Ruch, Agudelo, Platt, & Proyer, 2010) and stimulates feelings of shame that can inhibit happiness (Platt & Ruch, 2009). Albert Ellis (1987) developed several exposure-based techniques for treating this aspect of social anxiety and labeled them *shame-attacking exercises*. For example, Ellis encouraged socially anxious clients to stop strangers in public and say, “I just got out of the mental institute. What month is it?” In performing shame-attacking exercises, an individual is forced to challenge the assumption that being negatively evaluated or appearing foolish in public is harmful and intolerable. Hofmann and Otto’s (2008) manual for the treatment of SAD includes other shame-attacking exercises such as singing “God Bless America” in a subway station for 30 min or asking a bookstore clerk where to find books on certain bodily functions.

By its very nature, the proposed CIT model provides ample opportunity for exposure to feelings of embarrassment and shame as many improv comedy exercises are specifically designed to confront barriers that inhibit creative expression. The following exercise generates exposure to these uncomfortable feelings but then allows processing in the context of an accepting group.

**Small talk initiation**

In this exercise, one to three participants are asked to leave the room. While they are gone, the remaining group members break into smaller groups of two to three. The group leader then assigns each group with a different “difficulty level” indicating how difficult it will be for an outsider to join their conversation. When the absent participants reenter the room, each must attempt to enter into a group’s conversation by practicing various initiation skills previously taught by the group leader (e.g., listening and finding a jump-in point, asking questions, sharing a story or joke, commenting on
something said). After 3 to 5 min with each group, the leader will then tell participants to switch groups and try again to enter the conversation. Following the exercise, the group leader can ask process questions intended to explore any feelings of embarrassment and shame provoked by the exercise, especially as the “difficulty level” increased or decreased. Group leaders should also interview group members to uncover their unique, most-anxious social situations and then work to develop specific improvised exposure activities dubbed “strategic improv” based on these specific needs.

**Humor**

Although “being funny” is by no means required of participants, humor and laughter typically emerge in CIT as group cohesiveness builds and the group becomes more authentic. As improvisers Halpern et al. (1994) observed, “When we’re relaxing, we don’t have to entertain each other with jokes. And when we’re simply opening ourselves up to each other and being honest, we’re usually funniest” (p. 15). The CIT model emphasizes humor and laughter because of the beneficial physiological changes that occur during laughter and the perspective-taking that humor encourages. Jacobs (2009) reminded us, “Although laughing and crying are two basic inborn emotional relations, psychoanalysts and psychotherapists have been much more interested in the phenomenon of crying than laughing” (Strean, 1994, p. 499). CIT, in contrast to psychodrama and drama therapy, is innovative because it explicitly emphasizes humor and laughter.

In the fields of physiology, neurology, and psychoneuroimmunology, recent studies have documented that the use of humor strengthens the immune system and speeds recovery from both physical and psychological illness. During laughter, various beneficial physiological changes occur in the body. Laughter can lead to muscle relaxation, and recent studies suggest that the physiologically stress-relieving process of laughter could reduce anxiety independently from the psychological mechanisms (Bennett & Lengacher, 2008). For example, Overeem, Taal, Öcal Gezici, Lammers, and Van Dijk (2004) found that spinal motor excitability measured by the Hoffman reflex decreased following genuine laughter.

Humor and laughter go hand-in-hand, and both can develop naturally in CIT. Under the category of “Proposed Axes for Further Study,” the DSM-IV-TR (2000) defines humor as coping with “emotional conflict or external stressors by emphasizing the amusing or ironic aspects of the conflict or stressor” (p. 812). The DSM-IV-TR (2000) places humor at the highest adaptive level. In *The American Journal of Family Therapy*, Panichelli (2013) wrote astutely about humor in psychotherapy: “[J]okes can be used to talk about the problem without talking about the problem, bringing more safety into the interaction: ‘the message is given in a
disguised way’ (Nardone & Portelli, 2007, p. 88)” (p. 444). CIT, through its emphasis on humor and laughter, allows individuals with SAD to confront their struggles with a new perspective and promotes curative physiological responses to anxiety. The following exercise can invoke humor and laughter among group members.

1,001

The group leader assigns a group member any particular noun. Upon receiving the word, the group member must immediately create a joke based on the following framework. For example, if the group member receives the word *bananas*, they would begin: “1,001 bananas walk into a restaurant. The waiter says, “We don’t serve bananas.” The bananas say, “Why not?” and the waiter responds, “Because [as improvised by the group member] you always sit in a big bunch and leave a slippery mess!” Regardless of the quality of the joke, once the participant is finished, the rest of the group applauds and laughs uproariously. The group member then provides the word for the next individual in the circle. After the first round, group members are instructed to repeat the process, but this time, repeat the joke as if they were famous comedians with the objective of telling the joke more confidently. At the conclusion of the exercise, the group leader can ask process questions to encourage self-awareness of the therapeutic power of laughter, both physiologically and emotionally. A reflective process led by the group leader can also guide and encourage group members to embrace a humorous perspective of social anxiety; feeling ridiculous is part of the human experience.

**Current clinical practice**

Since 2012, the authors Mark Pfeffer and Becca Barish have facilitated a program known as *Improv for Anxiety* for the treatment of SAD in adults and adolescents. *Improv for Anxiety* operates in partnership with The Second City Training Center in Chicago, led by Kerry Sheehan, and involves group members meeting twice a week for a period of 8 weeks. The first 2.5-hr session of each week provides an opportunity for group members to engage in a traditional improv comedy class led by skilled improvisers at The Second City Training Center who are sensitive to SAD. The second 2-hr session of each week uses the proposed CIT model and involves practicing selected improv comedy exercises (i.e., strategic improv) led by two mental health professionals experienced in group facilitation and in improv comedy. In this second session, group members also discuss issues that have emerged and check-in with other group members in order to strengthen group cohesion. Lastly, the group leaders engage the group in important aspects of GCBT such as providing psychoeducation about unhelpful thinking styles and discussing methods of cognitive restructuring. Depending on the
professional training of the group leader(s), the proposed CIT model can also be implemented in conjunction with other models of therapy empirically evaluated for effectiveness in the treatment of SAD. Furthermore, in the Improv for Anxiety program, individual therapy of any method is recommended but not required. Improv for Anxiety has received positive responses from its over 350 participants and is currently being empirically evaluated by Greg Poljacik at the University of Chicago using the Liebowitz Social Anxiety Scale (Liebowitz, 1987).

Requirements and limitations

Our personal experience in the practice of improv comedy informs the strong suggestion that implementing CIT for the treatment of SAD requires a group leader who is both experienced in group facilitation and familiar with improv comedy. The group leader can guide the group as it progresses from group improv comedy exercises, such as the ones described in this article, to the development of full scenes with complex characters and storylines. The group leader must possess the skill to pause the group for therapeutic processing at important junctures in order to truly harness the therapeutic powers of group cohesiveness, play, exposure, and humor emphasized in CIT. The mental health professional should, at minimum, seek out basic training in improv comedy and/or the CIT model to ethically provide this treatment.

In addition to the training of the group leader, another important consideration is the careful selection of group members by the group leader. As indicated in group therapy literature, group members should be chosen with consideration to the severity of their symptoms and the similarity of their presenting problems. Group leaders must acknowledge that comorbid conditions are common among individuals with SAD and that group therapy is not appropriate for all individuals with SAD, especially in the case of trauma. Multicultural considerations regarding the use of humor in counseling settings are equally critical. Maples et al. (2001) provided a summary of existing literature and guidance on the appropriate use of humor in counseling within multicultural populations. The authors wisely advised, “As in any counseling relationship, but perhaps magnified with ethnically diverse clients, the element of mutual trust and respect should clearly be present before humor is used” (p. 59). Lastly, group leaders must possess awareness that humor and laughter can sometimes be employed as unhealthy defense mechanisms. Conrad Hyers (1969), an American writer and theologian, reminded us: “It is possible to laugh at oneself as a way of excusing oneself, as a technique for not looking candidly at oneself” (p. 26). Group leaders sensitive to these limitations are better able to select appropriate individuals for the group and implement CIT in the treatment of SAD.
Conclusion

Individuals with SAD are frequently denied the simple pleasure and profound meaning that deep human connections provide. Given the high percentage of nonresponders to GCBT alone (Eng et al., 2001) and the dearth of treatment options emphasizing “appetitive goals and activities and positive emotion” (Kashdan & Steger, 2006, p. 126), CIT warrants further exploration for the treatment of SAD and other mental health issues. Given the stigma associated with mental health treatment, an improv comedy wellness group may also attract more individuals suffering silently with SAD. For clients and mental health professionals interested in a creative alternative that harnesses multiple therapeutic elements, CIT may provide a novel pathway to recovery.

Note

This article includes discussion of the program Improv for Anxiety and The Second City Training Center. The authors Mark Pfeffer and Becca Barish, in partnership with The Second City Training Center, currently facilitate the comedic improv therapy portion of the program Improv for Anxiety. Becca Barish is also a faculty member at The Second City Training Center where she teaches traditional improv comedy classes. This article does not necessarily reflect the views of The Second City Training Center.

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