

Group therapy for adults with a learning disability: use of active techniques

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We describe our experience of running a group using active therapy techniques for adults with a learning disability, and briefly explore cognitive developmental theory in an attempt to understand some of our observations.

Despite positive accounts of psychotherapeutic groups for adults with a learning disability (Pantlin, 1985; Hollins & Evered, 1990; Gravestock & McCauley, 1994), most therapies offered to these individuals are based on behavioural or social-skills training (Matson, 1984), supportive counselling or medication. Only in recent years have active methods including use of psychodrama, dramatherapy and role-play been described (Brudenell, 1987; Sprague, 1991). Active methods are appropriate for individuals with a learning disability since they encourage participation by all group members and facilitate the development of self expression. In addition, through the use of role-play, gaming and improvisation, new and old encounters can be experienced and rehearsed, and lessons learnt (Brudenell, 1987).

While working as a registrar (G.S.) and a consultant (S.A.) within a community team caring mainly for adults with a moderate learning disability, we set up and ran a seven-week closed group using active therapy techniques.

Setting up the group

The group arose out of a wish to provide an opportunity for those adults with a learning disability who were experiencing change in their lives, to meet new faces outside of the work or home environment and share experiences.

We hoped that regular attendance would result in the identification of: feelings brought up by being in the group and exploration of whether or not these were familiar to previous situations; recognition of feelings existing within others; and an increased level of confidence and social skills.

The names of eight adults, all female, and all with a moderate learning disability, whom it was

thought might benefit from the group, were put forward by members of the community team. Seven agreed to attend. We had not set out to run a single gender group but, in fact, only received referrals for women. Exclusion criteria included challenging behaviours that were likely to disrupt the group on a regular basis, inability to get to the venue and communication difficulties of such a degree that were likely to make participation difficult. The duration of the group was time-limited to seven weeks, mainly on account of our other commitments.

Running the group

The sessions were timed to last an hour in total. This included a 15-minute coffee break before the group dispersed. Our previous experience with a similar group had shown that it would be difficult to sustain members' concentration for any longer period of time. Before each session we met to review our plans for the group and make sure that we had all necessary materials. One of us would start the group off with a warming-up exercise, before handing it over to the other organiser to facilitate the main piece of work and to bring the session to a close. We were supervised by a qualified psychodrama therapist who also had experience working as a nurse within the field of learning disability. Supervision time was used to review the last session and think about the next.

Over the seven weeks, a variety of exercises were used to facilitate group members' recognition and exploration of emotions engendered by past social situations and to allow for new coping strategies to be developed and rehearsed. The hope was that these would then be put into practice outside of the group. Exercises included making face and name badges to promote discussion about the anxieties associated with meeting new people and role-playing social situations which individuals in the group found difficult. The use of empty chairs to represent the emotions of happiness, sadness, anger and

loneliness provided an opportunity for members to express their feelings about the impending termination of the group in the penultimate session. In the last session members gave and received feedback by identifying positive qualities in each other using sticky labels. Transferring the labels on paper provided something concrete for them to take away.

There was evidence that Yalom's (1985) therapeutic factors could be applied to the group. Feelings of belonging to and acceptance within the group were shown for example when one member who found it difficult to join in insisted on supplying biscuits for the coffee break one week. Perhaps this was her way of letting the group know how important merely attending was to her. Members showed great generosity in helping those less able than themselves in some of the exercises, e.g. those who could write helping those who could not when making name badges. Concern was shown for absent members as was a desire to include them in activities, e.g. by using an empty chair. Members exhibited a greater capacity for empathy than we had expected and were able to understand the difficulties of others in the group and thus share common experiences. The group setting promoted learning of new social skills while role-play provided an opportunity to observe and imitate the behaviour of others.

Use of role-play was not without its difficulties however. On two occasions members appeared to have difficulty in distinguishing fantasy from reality. This was apparent after one session in which members were asked to move around the room pretending to be the animal which could best represent how they were feeling that day. A few days later, a member of staff from one of the community houses rang in, asking if we had any idea why one of our group members was writhing around the carpet in a rather strange manner. She had been pretending to be a snake while in the group earlier that week and clearly still saw herself in this role! On another occasion, the registrar had been pretending to be upset as part of a role-play. Group members were anxious to try to comfort her, even after the session had ended and enquired after her well-being the following week. Additional difficulties in role-play were found when members participated in emotionally charged situations, e.g. those involving anger or arguments, when they took the role of someone whom they perceived to be in authority or when they attempted to reverse roles with each other or someone they knew.

In the final session, one of the members feedback how she had been able to put a coping strategy learnt into practice, and had thus conquered her fears of discothèques. It was generally agreed that the most valuable aspects of the group were the role-plays ('acting') followed

by the socialising and coffee breaks. The members were unanimous in their wish to attend a similar group in the future.

Comment

In an attempt to make sense of our observations. We found it helpful to review some of the theories existing about cognitive development in individuals with a learning disability. It has been suggested that cognitive development proceeds through the same sequential stages but at a slower pace than usual, and that the manifest disability relates to the stage of development reached. Another theory is that individuals with a learning disability follow a different cognitive developmental sequence, and as adults think and perceive the world differently. Our experience, which stems mainly from the use of role-play, seems to favour this second theory. In addition, Stokes & Sinason (1992) have distinguished between emotional and cognitive intelligence, stating that individuals with limited cognitive ability may be capable of greater emotional understanding and knowledge than was previously thought.

The use of role-play is dependent on an ability to pretend. Pretence is a special kind of 'acting as if', where the pretender correctly perceives the actual situation (McCune-Nicolich, 1981). Pretence can be seen as a precursor of a theory of mind and develops in the second year of life. Having a theory of mind is synonymous with empathy and enables an individual to read between the lines, as opposed to taking utterances literally. It occurs in normal four-year-olds as does the concept of false belief.

Given that our members appeared to possess empathy, one might expect they should also have an understanding or pretence since this developmental process is thought to occur at an earlier stage. This did not however appear to be the case. In addition, group members found it difficult and distressing to try to reverse roles with each other. To pretend to be someone else who is reversing roles with a third person may involve some degree of third order belief attribution (an ability thought to be acquired at the age of seven years in normal individuals) and is probably beyond the capabilities of many adults with a learning disability.

Use of action techniques increases the opportunities for individuals with a learning disability to think in the abstract and problem solve if they are able, while still allowing those who function on a more concrete level or have focal neurological deficits, e.g. parietal or frontal lobe dysfunction, to participate. Participation by all group members is encouraged despite differing abilities. The variety of techniques available facilitate the

development of self expression and allow for new learning through experience and rehearsal.

We offer the following advice to others who may wish to set up a similar group:

- (1) use language that is likely to be understood by everyone in the group and avoid abstract concepts, since formal operational thinking may not be present;
- (2) when role-playing, make the pretence obvious and de-role all group members, including the facilitators in a scrupulous fashion;
- (3) restrict role-play to the acting out of certain situations by group members acting as themselves and avoid the use of reversing roles with others in the group;
- (4) when role-playing emotionally charged situations, e.g. those which involve anger or arguments, these roles should be taken by the facilitators or represented by empty chairs.

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