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Research article

A dramatherapy case study with a young man who has dual diagnosis of intellectual disability and mental health problems

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ABSTRACT

The high prevalence of coexistence of intellectual disability (ID) and mental health problems points to the strong need for socioemotional therapy for people with intellectual disability. However, the publications regarding clinical practice or research on therapeutic work with people with intellectual disability, in general, and dual diagnosis of ID and mental health problems, more specifically, are sparse. This may be due to the fact that most research and clinical work with ID focus on the intellectual impairment rather than on the socio-emotional needs of this population. This paper illustrates a detailed case study of dramatherapy work with an adult with dual diagnosis of ID and anxiety disorder. The therapeutic work was done using story-making and storytelling as ways of helping to access and to organize inner reality. Following the description of the case study, concepts from developmental psychology and dramatherapy are used to conceptualize the case, highlighting the special characteristic of clinical work with this population.

1. Introduction

This paper reports work undertaken to explore the use of dramatherapy with an adult male client who has intellectual disability along with a co-diagnosis of anxiety disorder. The report explores and presents the ways in which therapy can take place with few verbalisations to meet the emotional needs of a person with intellectual disability. Concepts such as insight, creativity, and using projective means are interrogated in the context of working with this specific client group, and in relation to the work described with the client.

Zigler (Zigler, 2001; Zigler & Burack, 1989) argued that greater attention should be given to the social and emotional experiences of people with intellectual disability (rather than to the cognitive impairment), as these may play an important role in their adjustment to the everyday world. Stressing the opportunity to work therapeutically with this client group might encourage a greater emphasis on these aspects Zigler points out.

The present paper explores a case that illustrates the clinical significance of using dramatherapy with a client with dual diagnosis of intellectual disability and mental health problems. This case suggests that dramatherapy, using stories, images, metaphors, and non-direct projective work, can offer an important vehicle for psychological change for individuals with intellectual disability. In order to understand the therapeutic work of this case, I will use conceptualizations from developmental psychology and dramatherapy literature.

In the arts therapies profession, we often believe that we can provide effective therapy to people with disabled cognitive abilities, as our platform for change does not necessarily rely on words or intellectual abilities. The high prevalence of co-existence of intellectual disability and mental health problems (Morgan, Leonard, Bourke, & Jablensky, 2008) may point to the strong need for socioemotional therapy for people with intellectual disability. However, the publications regarding clinical practice or research on therapeutic work with people with intellectual disability (ID) in general, and dual diagnosis of ID and mental health problems, more specifically, are sparse (Mohamed & Mkabile, 2015). While music therapy offers relatively more contribution to this field (see for example Hoyle & McKinney, 2015; Hooper, Wigram, Carson, & Lindsay, 2008; Toolan & Coleman, 1994), there are only a few published studies in other arts therapy fields (Bowen & Rosal, 1989; Chesner, 1995; Lister, Tanguay, Snow, & D'Amico, 2009; Trzaska, 2012). However, there is hardly any literature documenting dramatherapy with people with ID and mental health problems. In this paper, I will describe the clinical work using dramatherapy with a client with dual diagnosis of ID and anxiety disorder of Obsessive Compulsive Disorder (OCD).

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2. Definition of key terms

Dual diagnosis is a term applied to the coexistence of the symptoms of both intellectual or developmental disabilities and mental health problems. Intellectual disability is defined by the American Association of Intellectual Disability (AAID) as characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, practical and adaptive skills. This disability originates before the age of 18 (Luckasson et al., 2002). General intellectual functioning is measured by an individually administered standardized test of intelligence that results in an overall intelligence quotient (IQ); an IQ score of 70 or below is defined as significantly sub-average functioning. Adaptive behavior refers to the effectiveness with which an individual meets society's demands of daily living for individuals of his or her age and cultural group. The measurement of adaptive behavior may include an evaluation of an individual's skills in such areas as eating and dressing, communication, socialization and responsibility. Intellectual Disability can be located within the broader field of developmental disabilities; hence ID is one kind of developmental disability.

The types of psychiatric disorders that persons with intellectual or developmental disabilities experience are the same as those seen in the general population, although the individual's life circumstances or level of intellectual functioning may alter the appearance of the symptoms (Morgan et al., 2008). In addition persons with a dual diagnosis can be found at all ages and levels of intellectual and adaptive functioning. Estimates of the frequency of dual diagnosis vary widely; however, the American National Association for the Dually Diagnosed (NADD) reports the estimation of 30–35% prevalence of psychiatric disorders among people with intellectual and developmental disabilities (Fletcher et al., 2009). Studies on the prevalence of psychiatric disorders among individuals with intellectual disability have shown, almost without exception, rates that are much higher than those found in the general population (Borthwick-Duffy, 1994; Moss, 2001; Whitaker & Read, 2006). As mentioned above, despite the indications that those with intellectual disability may be vulnerable to psychopathology, there is limited investigation into psychotherapy with this client group (Bhaumik, Gangadharan, Hiremath, & Russell, 2011).

The relatively lack of literature (clinical and research) about dramatherapy and dual diagnosis of ID and mental health raise questions like: Is dramatherapy relevant to this population; Can dramatherapy contribute to this field in any way? Next follows a detailed description of the therapeutic work with a client with id and mental health problems. This case aims to present the complexity and the richness of such work, bringing focus to this client group, thus enhancing the need for further studies and documentation of clinical work with people with id and mental health problems.

3. The case of David

3.1. Referral and assessment

David[1] (a pseudo name) was referred to therapy when he was 22, not long after he had moved from his parents' home to a village for people with various developmental psychopathologies. He had been previously hospitalized, for a short time, in a psychiatric unit. David was diagnosed with moderate ID, schizophrenia, and OCD. David comes from middle-class Caucasian Jewish family. The information documenting David's history and current situation pointed that he was lonely and isolated. David was referred to me by his social worker in the village when I was working as part of the multidisciplinary team that includes arts therapists, physiotherapist, speech therapist and more. I gained some experience in working with dual diagnosis and this was the reason David was referred to me. Therefore we begin meeting once a week for a 50-min session.

In the first meetings, David seemed helpless, anxious and lost. It felt like he had no "skin" (Bick, 1968) so that every movement I made or word I said seemed to have been experienced as invasive. He was extremely bothered by unseen dirt on the chair or on his pants and was constantly trying to get rid of the dirt. He presented very clearly his anxiety and OCD behavior, and his passiveness presented a typical helplessness behavior (Stamatelos & Mott, 1984). I was not sure we would be able to communicate, as he seemed so preoccupied in his own world. Based on our first encounters and on the information I got from his social worker I defined the aims of therapy accordingly: To help David find a way to express his inner world; To improve David's functioning (work, friends, etc); To reduce his anxiety symptoms and hopefully to improve his general wellbeing.

3.2. What does dramatherapy offer?

Dramatherapy is an eclectic form of techniques, models and methods (Emunah & Johnson, 2009). In the case presented, the technique that was chosen was using stories, based on the extensive work of Alida Gersie, of storytelling and story-making (Gersie, 1997, 2002) that will be detailed further below.

The daramatherapist Landy (1994) presented the concept of *aesthetic distance* to explain the therapeutic work. This concept describes a balance point where the client is both engaged emotionally ("feel") and cognitively ("think about") with his material. Hence, the client is able to play the role of the *actor* who feels and identifies, and that of the *audience*, which observes and gets perspective (Landy, 1994). Therefore Landy sees the aim of therapy to help the client reach a point of aesthetic distance.

Using this conceptualization, anxiety disorders can be viewed as being in a state of *underdistance* (Landy, 1994). Hence, there is a lack of emotional control, feeling flooded with emotions, a difficulty in getting perspective, and very little sense of boundaries. From this point of view, the aim in working with clients with anxiety disorders is to help them get to the midpoint of aesthetic distance, by enhancing the role of the observer and by using more distancing techniques that allow perspective-taking rather than a flood of emotions. The use of non-direct stories can offer a sense of control (being the "director" or the narrator, rather than the actor), while giving the opportunity to organize and get perspective on one's own material. Therefore I decided to try to work with David by focusing on non-direct, distant techniques, such as story-making.

3.3. The therapeutic process

3.3.1. First stage

The aim of the first stage of therapy is to look for a common language, considering that words are not necessary the main channel of communication. As a dramatherapist, I offer objects, pictures, puppets and others projective means to search for ways of expression. The idea of establishing a therapeutic relationship with clients with ID and mental health problems can feel very challenging at first (Chesner, 1995). Anna Chesner, in her book, *Dramatherapy for people with learning disabilities* (1995), described her extensive work with people with ID. She wrote: "The first principle is patience. ...Change is possible" (Chesner, 1995, p. 36). In the first stage of our therapeutic work I offered David pictures of different images and asked him to choose some that he liked or did not like. David cooperated and chose a picture of a tiger that he liked and a picture of a young man with music player that he did not like.

[1] David and his legal guardian gave their full consent to the publication of his case study.