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The ACTing cure: evidence-based group treatment for people with intellectual disabilities

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Current research using action methods and creative dramatics with people with intellectual and psychiatric disabilities is reviewed, with a focus on the uses and distinction between psychodrama and dramatherapy. The Interactive-Behavioral Therapy/Active Cognitive Treatment (IBT-ACT) model is introduced and suggestions for future research are explored.

Keywords: intellectual disabilities; group therapy; improvisation; dramatherapy; signature strengths; psychodrama; creative dramatics; spontaneity

Introduction

'You can discover more about a person in an hour of play than in a year of conversation.' – Plato

When seeing the world through someone else's eyes, one has the liberating experience of stepping outside of the self, taking a break from one's own beliefs, behaviours, and thoughts, and slipping into another reality. Story and performance are powerful tools – facilitating integration, broadening and building new roles, and shifting perspectives. For those whose capacity for language is often diminished, the ACTing cure through its use of playful creativity may provide an untapped resource for personal growth and healing. The distance and playfulness of 'what if' can bring a solution or new insight. The need for creative and adaptive measures to work with people who have limited verbal and literacy levels is a relatively untapped resource for therapeutic gains (Brown et al. 2011), yet two promising paths are emerging: psychodrama (Tomasulo 2014; Tomasulo and Razza 2006; Hurley, Tomasulo, and Pfadt 1998) and dramatherapy (Landy and Montgomery 2012; Banks, 2006; Stefańska 2006; Hackett and Bourne 2014).

What is psychodrama?

Conceived and developed by Jacob L. Moreno, MD, psychodrama employs guided dramatic action to examine problems or issues raised by an individual

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> (psychodrama) or a group (sociodrama). Using experiential methods, sociometry, role theory, and group dynamics, psychodrama facilitates insight, personal growth, and integration on cognitive, affective, and behavioral levels. It clarifies issues, increases physical and emotional well-being, enhances learning and develops new skills. (American Society of Group Psychotherapy and Psychodrama n.d.)

What is dramatherapy?

> Dramatherapy is an active, experiential approach to facilitating change. Through storytelling, projective play, purposeful improvisation, and performance, participants are invited to rehearse desired behaviors, practice being in relationship, expand and find flexibility between life roles, and perform the change they wish to be and see in the world. (North American Drama Therapy Association n.d.)

Psychodrama and dramatherapy are siblings, similar yet different – both use the embodied techniques of drama and the theatre, and can be used in individual or group settings. Kedem-Tahar and Felix-Kellermann (1996) write that 'drama has been used for centuries both within the theater and in various healing rituals to reflect on life. Today drama is a common source of inspiration for both psychodrama and dramatherapy'. They also point out that though the modalities are based on common principles, they are different in certain aspects. Psychodrama is under the umbrella of group psychotherapy founded by J.L. Moreno, based on sociometry, social psychology, and object relation theory. Its major aims are self-awareness, therapeutic gain and involvement in work with tele and catharsis, action insight, and the magic 'as-if'. In practice it has a clear structure, oriented towards experiential wisdom, focused on the individual and using specific techniques. The therapist functions as an analyst, director, therapist, and group leader. Dramatherapy is listed within the expressive art therapies, based on Jungian psychology, theatre theory, and ritual role and play theory. The process uses self-expression, aesthetic distancing through play and improvisation with a focus on the group process. Dramatherapy values the creative-expressive learning of roles and may have an unclear structure, as cognitive processing is less important than dramatic expression. Techniques employed by dramatherapy are more miscellaneous in an eclectic variety of exercises. The role of the therapist is the dramaturg, artist, teacher of drama, and leader of rituals.

Kedem-Tahar and Felix-Kellermann (1996) comment on the ever-changing, spontaneous nature of the two modalities, which can make comparison challenging and intermittent. Though one can argue while listing similarities and differences of psychodrama and dramatherapy, most might agree that the 'Once upon a time' indirect approach of dramatherapy may have a less personal slant but give a broader creative license to the participants to view issues.

Sally Bailey (2014) says that narrative transportation (engagement with story) invites us to use a different lens for looking at a particular story. It requires the ability and willingness to suspend disbelief, just as in a theatre when the curtain goes up and we accept the reality of the play and the characters in order to be

immersed in the story. Those who do so may experience changes in their attitudes and beliefs. The character might become a role model. When we identify with a character (especially when our goals are similar), empathy with the protagonist can create a positive change in us and a flexibility to look at events for a different viewpoint. This effect comes to play not only on stage, but in the therapy room as well (Tomasulo and Pawelski 2012). Performers and the audience can both benefit from the process by acting out the narrative or by witnessing it.

In a professional performance the focus is on the final product, not on the creative process. The audience employs the actor to go through the experience for them. The actor is a skilled professional and a vehicle for the story for the benefit of the audience. In a therapeutic setting we concentrate on the process of the creation, not on the final product. The primary goal is to serve the participants through their journey. The actor (protagonist) and the audience are actively 'on stage' together and collaborate to resolve issues, discover solutions, find new storylines, and alternate perspectives to write their stories. The experience can be therapeutic, educational, or recreational.

Through the aesthetic distance of the theatre and working through metaphors, the dramatherapist assists the client to discover a fictional role. According to Kirmayer (2004), the use of metaphor allows for transformative experiences to take place across multiple levels of sensory, affective, and conceptual understanding. The use of metaphor in role-play is the core of aesthetic distance and therapeutic transformation. The open and creative artfulness of drama allows the exploration of underlying issues of everyday life by improvising and playing the role of someone else. The experience can have illuminating, therapeutic, and transforming benefits to the actor (Landy and Montgomery 2012).

Landy (2008), in his book *The Couch and the Stage*, writes about the basic assumptions of role theory that since life is dramatic the 'central feature of existence is dramatic action'. He discusses the reciprocal nature between action and role: 'role emerges as much from action as action does from role'. He also highlights the duality of human existence, the presence of roles and counter-roles, and the 'taxonomy of roles' (102–105). Landy's role theory holds the *theatricum mundi* (world is a stage) metaphor of life.

> All the world's a stage,
>
> And all the men and women merely players;
>
> They have their exits and their entrances,
>
> And one man in his time plays many parts…
>
> (Shakespeare (1599), *As you Like It*, Act II, Scene VII)

In her foreword to Landy's book (2008), Zerka Moreno, J.L. Moreno's wife and psychodrama pioneer, adds to Shakespeare's notion by amplifying her husband's important view: 'None of us have been handed a complete script at birth; we have to improvise. We stumble, learn painfully as we go along. All the drama therapies help to make that learning less painful and often even joyous' (xi).

What is improvisation? 'The process and product of creativity occurring simultaneously' (Lewis and Lovatt 2013, 47), 'Improvisation is making it up as you go along' (Halpern, Close, and Johnson 1994, 2). Acting without a net, performance without a script, impromptu, or, as one of our clients once described it, 'off the cuff'. Improvisation is spontaneity in action. Life can be understood as a series of improvisations.

Bermant (2013) compares spontaneity to luck, in that it favours the well-prepared. Spontaneity, creativity, and flexibility are grounded in the skills of improvisation where only the process and form – not the content – is rehearsed. Bermant elaborates that improvisation and performance significantly relate to well-being in other life domains, and that improvisation is undeniably a social interaction. He discusses that the benefits of improvisation are significant in therapeutic fields, as well as in relational arenas, educational contents, and coaching models. Acting – pretending – allows the actor to step into someone else's shoes and try out new roles, looking at the world through a different lens. With correctly guided practice, the desired role may become easier to perform and can integrate as second nature, aiding in emotional conflicts and self-awareness, developing social skills, managing behaviours, reducing anxiety, increasing self-esteem, spotting strengths in self and in others, and stretching role flexibility (Bermant 2013; Stefańska 2006).

In her compelling pilot study, Stefańska (2006) examined how theatrical activities are effective in developing a sense of dignity amongst young people with slight intellectual disabilities. Data showed an enhanced level in the recognition of social situations, expressing systems and personal values – level of dignity is closely linked to the ability of noticing respectful behaviours in others. She found that dignity can be developed and shaped using dramatic improvisation. Participants improved their capacity for cooperation, creativity, attention, reduced anxiety, decision making, and problem solving in action. Research findings indicated a noticeable positive difference in planning actions, voicing opinions, building peer support, better interpersonal relationships, and taking responsibility for self and the team.

Hackett and Bourne's (2014) group study had similar conclusions to Stefańska (2006). In their study participants were people with learning disabilities and mental health problems who had been recently discharged from inpatient assessment and treatment units. Their 'Get Going Group', a 12-week pilot study, provided further benefits using creative drama, the magic of 'as if', and freedom of imagination. Findings showed reduced re-hospitalisation rates, improved leisure time, and richer relationships. Group members reported a general enhancement in satisfaction with quality of life. Staff members reported

'improved confidence and self-esteem' and 'developed social skills in a group situation'. The Get Going Group model is built on mutual peer support, as people of all abilities entered a safe play space of shared responsibility, imaginary narratives, and problem-solving scenes. Group members had the opportunity to continue as facilitators in later groups. The model incorporates an understanding of the universality of human experiences, the healing bond of mutual agreements, and the common goal of a final performance.

Performance and the creative process leading to it have equal value in the world of therapeutic theatre through exploring the dynamics of people with developmental disabilities in close relationships. *Rule Breaking* (by A. Silberblatt, dir. N. Brunner) was created and developed as an action-research performance by Hodemarska and collaborators, with a focus on the process and its therapeutic values (Hodemarska 2013). It was performed in November 2015 as part of New York University Drama Therapy Program's *As Performance* series in New York City.

This scripted play within the domain of therapeutic theatre concentrated on the processes and dynamics between collaborators in the rehearsal room over a period of 11 months. It explored the impact of developmental disabilities on relationships between caregivers and care receivers through true stories based on the real experiences of the actors and creative team. All cast members were individuals with disabilities, family members, loved ones and caregivers, who told their stories through a character they had built. Audiences were deeply transported into their world, with loves and challenges, obstacles and rights, pain and hope, family and community, and the balance between the yearning to be trusted and independent while still needing support.

One of the authors (AS) attended the performance as part of the research for writing this paper. The healing power of story and the impact of performance were palpable in the room, as audience members and actors shared their thoughts in the question-and-answer after the play on their connection to the stories and their newly gained insights.

The performance was similar, yet different, from the AHRC New York City presentation, titled *Dreams, Rights & Responsibilities – Words Through Our Eyes*, which was performed on 21 May 2015. Both performances were process oriented, focusing on stories of people with cognitive disabilities, and yet the process was different. In the NYU project collaborators were people with disabilities along with their friends or family members, the cast was invited and steady, a script was developed during the rehearsal process for a performance that was presented several times. At AHRC New York City the group was open and ever-changing, there were no rehearsals for the performance, which was improvised within a structure, focused on skill-building and problem-solving. The participants were self-selected and made up of adults with sub-average IQ and concomitant psychiatric disabilities. The one-off performance was facilitated as a large open group, interactive and improvised.

AHRC New York City participants requested the 'show' to demonstrate their work process and their newly acquired skills. The group had worked together for five months weekly in 3.5-hour sessions. Members decided on all details of structure, content, creative direction, title, and casting. The 90-minute multimedia presentation in May 2015 consisted of theatre games with audience participation, recordings of improvised scenes projected on a large TV screen, visual poetry written by a group member, discussion with the audience, and live role-playing to develop the taped scenes towards their desired outcomes. Sessions and the performance were taped. The videographer and co-editor was a member of the group. Sections of the show were peer-led. Currently the group is working on a documentary to be entered for the 2017 Disability Film Festival in Manhattan with the working title *The World Through Our Eyes*.

This group structure is a strengths-based dramatherapy-inspired adaptation of Tomasulo's psychodramatic and evidence-based IBT group model (described below). This hybrid model is referred to as *The ACTing Cure*, where ACT refers to Active Cognitive Treatment. The format follows the exact structure of the four-stage IBT model, while working with flexible content within the organised form, where cognitive processing, engagement, and dramatic expression are equally important. The work integrates the experiences of one of the authors (AS) as a trained actor and clinician. The similarities and differences between these professions are noticeable as being largely complementary yet with powerful differences in the weight and focus between the audience and the actor.

The model also incorporates findings of applied positive psychology, and tools of mindfulness and meta-practice. (Tomasulo 2014). The motto of this complex model comes from a quote of unknown origin: 'I adore spontaneity, providing it is carefully planned.'

Action-based group treatment: Interactive-Behavioral Therapy

Interactive-Behavioral Therapy (IBT) was developed in the 1980s as the first group format specifically designed for people with intellectual and psychiatric disorders using modified psychodramatic techniques (Razza and Tomasulo 2005). Tomasulo's IBT role-playing methodology and format has been the subject of a number of studies (Blaine 1993; Carlin 1998; Daniels 1998; Keller 1995; Lundrigan 2007; Oliver-Brannon 2000) and the emphasis of the American Psychological Association's first and only book on psychotherapy for people with intellectual disabilities (ID) (Razza and Tomasulo 2005).

IBT was fashioned around the activation of therapeutic factors originally identified by Yalom (Yalom and Leszcz 2005). The model trained therapists to look for the occurrence of these factors: acceptance/cohesion, universality, altruism, instillation of hope, guidance, vicarious learning/modelling, catharsis, imparting of information, self-disclosure, self-understanding, interpersonal learning, corrective recapitulation of the primary family, development of socialising techniques, and existential factors (Razza and Tomasulo 2005). The success of

this model has been written about extensively elsewhere (Razza and Tomasulo 2005), and limitations of space prohibit elaborating on each factor. The reader is directed to these sources for a more in-depth discussion.

Additionally, IBT emerged as a vehicle to strengthen prosocial behaviour (behaviour intended to benefit others while increasing one's social skills) within the group context (Weiner 1999). To optimise this cultivation, the IBT model uses a four-stage format that is process oriented. The engagement of the process involves facilitator(s) guiding the members through each of the stages, namely (1) orientation, (2) warm-up and sharing, (3) enactment, and (4) affirmation.

Each stage was designed to deepen the engagement of the members in the group process by allowing for safe methods of self-disclosure and acknowledging these therapeutic factors. More recently (Tomasulo 2014), facilitators have been coached to recognise their own character strengths and to spot strengths in other group members, using Peterson and Seligman's (2004) understanding and measurement of such strengths. In doing so, it was found that character strengths and therapeutic factors are remarkably similar. In fact, upon closer inspection, some of the terms used were identical or very closely overlapped. (For a more detailed discussion of this overlap the reader is referred to Tomasulo (2014).)

Flückiger and Grosse Holtforth (2008) and colleagues have developed a procedure, 'resource priming', where the facilitators of psychotherapeutic exercises take five minutes before their session to focus on the strengths of their individual clients. The result is that the priming leads to 'resource activation' whereby participants focus on the positive perspective of their behaviour, which in turn leads to better progress in therapy, as measured by greater reduction in symptoms and higher levels of well-being.

Such resource priming is now part of an IBT facilitator's therapeutic practice by a pre-group contemplation of each member's strengths. In augmenting IBT to use the findings from positive psychotherapy (Seligman, Rashid, and Parks 2006; Rashid 2015), the use of strength spotting during the four stages has been enhanced. During each of the stages the facilitators identify the occurrence of therapeutic factors and character strengths. This acts as a foundation for support and encouragement while accessing self-disclosure from the participants, before bringing the group to the central stage of enactment, where they shift toward group engagement.

(1) The *orientation* stage uses 'cognitive networking' as members get ready for the group process by listening and giving feedback, repeating what they have heard. The topic of discussion during this initial stage is less important than the process.
(2) The *warm-up and sharing* stage is designed to help members reveal more about their needs – something called vertical self-disclosure. This is usually more personal and emotional information.
(3) The *enactment* stage uses action methods from the field of psychodrama to role-play emotionally salient scenes from a chosen protagonist, which

then becomes the focus of the group's work for the day. The three techniques used are the 'empty chair', 'doubling', and 'role-reversal'. The empty chair is a classic version of the technique originally developed by Moreno (Moreno and Fox 1987) where the protagonist engages in talking to an empty chair that represents another person, or a future or past self. In the technique of doubling group members express the protagonist's unspoken feelings and thoughts. Typically multiple group members stand behind the protagonist taking turns to express what they think the protagonist is thinking and feeling. The accuracy or alignment of these expressions provides the protagonist with a feeling of being understood and supported, while drawing in the group's participation. Such an enactment can foster the therapeutic factors as listed above (Razza and Tomasulo 2005; Razza et al. 2014). The use of a 'multiple double' lessens the normal egocentric nature of individuals with ID and psychopathology, because the protagonist is listening for the accuracy of the double, and the doubles are attempting empathic understanding of the protagonist (Tomasulo 2014).The 'role-reversal' technique provides role clarification, reality testing, and, most important, empathic development and spontaneity as the protagonist is asked to 'step into the other's shoes'. The insight, understanding, or perspective development is acknowledged when they return to their original chair – and role.
Throughout the first three stages, the facilitators recognise and acknowledge the therapeutic factors that have occurred, or been demonstrated, by the group. For a complete discussion of examples of research on the emergence of therapeutic factors, see Tomasulo (2014).

(4) The *affirmation* stage allows for a review of each participant's display of therapeutic factors and character strengths throughout the group by both facilitators and group members. Over time, the members are taught to give feedback to one another during this phase, which also allows for positive emotional closure of each session.

Adaptations of IBT using dramatherapy

Dramatherapy approaches are slightly, but importantly, different than the approach of psychodrama mentioned above. However, when working with people who have intellectual disabilities and have experienced trauma or other difficult emotions such direct approaches may not always be appropriate or effective. One reason is that the activator threshold for triggering a traumatic reaction is typically less for individuals with cognitive limitations – and the traumatic response may often manifest differently (Razza and Tomasulo 2005). Such variations in the triggering and display of trauma for people with intellectual and developmental disabilities (IDD) demand broader and potentially less intrusive means of accessing therapeutic gain. Dramatherapy offers this potential.

The value of dramatherapy in this regard is inherent in its indirect approach. Through the aesthetic distance of the theatre and working through metaphors, the dramatherapist assists the client to discover a fictional role. According to Kirmayer (2004), the use of metaphor allows for transformative experiences to take place across multiple levels of sensory, affective, and conceptual understanding. The use of metaphor in role-play is the core of aesthetic distance and therapeutic transformation. The open and creative artfulness of drama allows exploration of underlying issues of everyday life by improvising and playing the role of someone else. The experience can have illuminating, therapeutic, and transforming benefits to the actor (Landy and Montgomery 2012).

ACT focuses on the importance of spontaneity and improvisation, resource priming and activation, and how therapeutic factors (Yalom and Leszcz 2005) and signature strengths (Peterson and Seligman 2004) emerge and overlap during sessions (Tomasulo 2014). Both IBT and ACT were designed so that each session is a complete experience. Yet there is added value in continued participation.

The four-stage process can be compared metaphorically to taking a flight: Stage 1. Orientation = The Runway; Stage 2. Warm-up = The Take-Off; Stage 3. Enactment = The Flight; and Stage 4. Affirmation = The Destination. In the ACT model the objectives of Tomasulo's IBT model remain the same. However, the core difference in the ACT modification is the use of the indirect approach of dramatherapy and spontaneity building improvisational theatre techniques. ACT inserts an adjustable aesthetic distance by using metaphors, story-building, and creative dramatic enactments.

The IBT orientation stage uses 'cognitive networking' to allow members to get ready for the group process. In the ACT adaptation, cognitive networking is reached through improvisational theatre exercises. Rather than only listening and repeating feedback on what has been heard, ACT uses modified interactive theatre games designed to enhance focus on the surroundings, self, and other group members using all senses – to listen, reflect, pay attention, establish trust and safety, and be open to giving and receiving. The interested reader can find the origin of these modifications in Spolin (1999) and Bailey (2010) and Cattanach (1992).

The warm-up and sharing stage continues cognitive networking, but helps engage members more deeply. In the ACT modification the exercises help to create a universality by highlighting the collective of human experiences. This stage also has skill-building aspects to enhance short-term memory, decision-making, creativity, story-building, and recognising and expressing emotions. Members learn basic improvisational rules, such as building on agreement, integration and coordination of verbal and non-verbal communication, and expressing and recognising emotions, which aid integration into daily living.

To the enactment stage's use of action methods from the field of psychodrama, such as empty chair, doubling, and role-reversal, is added the dramatic techniques of the ACT modification – the liberating and adjustable aesthetic distance of metaphor through fictional stories and characters, which may be close

to or different from our own reality. This process allows for more flexibility of engagement with the group and its therapeutic advantages. By using collective and fictional metaphors, stories and characters, participants can enter the process with a higher sense of safety, as self-disclosure is less necessary for therapeutic gain.

The affirmation stage allows for the review of the therapeutic factors and character strengths as they have emerged throughout the group. At this stage, both the facilitator(s) and members affirm the incidence of therapeutic factors and signature strengths. In the ACT modification the goals are the same, yet the feedback is given at three levels: first, on how the actor portrayed the character; second, how their individual character strengths came forward; and finally, how therapeutic factors relevant to the group process surfaced through interaction with other members.

People with intellectual disabilities are arguably the most marginalised and stigmatised disabilities subgroup. In their research, Nezu, Nezu, and Gill-Weiss (1992) identified a number of factors accounting for the higher than average rates of mental health problems among people with ID. Those factors – which include low levels of social support, poorly developed social skills, a sense of learned helplessness, low socioeconomic levels, increased presence of physical disabilities, heightened family stress, increased likelihood of central nervous system damage, and decreased inhibitions to responding to stressful events – affect all people adversely, yet occur more frequently to people with ID. Research also indicates a lack of training in this area for clinicians and other mental health professionals (Costello et al., 2007; Cumella, 2007).

Olkin and Pledger (2003) declare that the field of psychology has viewed individuals with disabilities as belonging to the separate domain of rehabilitation psychology, and that it 'thus has conveyed that most psychologists do not need to be trained and skilled in working with people with disabilities and their families' (296). This segregation of responsibilities has created a splintered sector for disabilities in general, and for intellectual disabilities specifically.

Disability studies, thus, have been fractured off from mainstream treatment. There are gaps in current research, outcome studies, training innovations, education, and professional development to effectively assist the intellectually disabled and developmentally disabled (ID/DD) population (Razza et al. 2014). This is true not only for psychologists but for other professionals, who are not being adequately prepared. Social workers, psychiatrists, psychiatric nurses, and licensed professional counsellors typically have even less training and preparation when it comes to therapeutic interventions for people with intellectual disabilities. This dearth seems to be reinforcing bio-psychosocial factors. The isolating stigma and lack of community inclusion may prevent people with intellectual and developmental disabilities from flourishing and living fulfilled lives in society.

The need for creative and adaptive measures to work with people who have limited verbal and literacy levels is a relatively untapped resource for therapeutic gains (Brown et al. 2011), yet two promising paths are emerging: psychodrama

(Tomasulo 2014; Tomasulo and Razza 2006; Hurley, Tomasulo, and Pfadt 1998) and dramatherapy (Landy and Montgomery 2012; Banks, 2006; Stefańska 2006; Hackett and Bourne 2014).

Summary of research on IBT

Blaine (1993) tested the efficacy of an IBT group treating both intellectually disabled and non-disabled participants over 17 sessions. Using a number of measures, she concluded that both types of patients showed significant positive change from the therapy, and interestingly, those subjects with ID demonstrated higher frequencies of most therapeutic factors (as identified by Razza and Tomasulo 2005; Tomasulo 2010; Yalom and Leszcz 2005). Daniels (1998) tested the 16 weekly sessions of the IBT model compared with a group of chronically mentally ill adults carrying the diagnoses of schizophrenia or schizoaffective disorder. Multiple clinical rating scales were administered to measure changes in social functioning and negative symptomatology. Three hypotheses were tested, and each was supported by the ensuing data. Specifically, it was found that IBT: (1) increases the overall social competence of people with chronic schizophrenia or schizoaffective disorders; (2) improves the negative symptoms that are often associated with poor treatment outcomes for people diagnosed with schizophrenia or schizoaffective disorders; and (3) facilitates the emergence of those therapeutic factors found to enhance social competence in people with chronic schizophrenia and schizoaffective disorders. What is of particular interest is that in 16 weeks of treatment with the IBT model, the Global Assessment of Functioning (GAF) Scale – a 90-item scale used to assess overall psychosocial functioning and symptom level – was significantly improved for the treatment groups. This suggests that the IBT format, in addition to facilitating therapeutic factors, supports the evolution of global social competence. Rather than strengthening specific behavioural components alone, as would be the goal of an applied behaviour analysis approach, the IBT model is aimed at broader development of interpersonal socialisation.

The IBT group, compared with the behaviour modification controls evidenced greater reduction in target behaviours, increased problem-solving skills, and earlier returns to the community, further supporting the emphasis on global social competence (Oliver-Brannon 2000).

The IBT model uses a format that prepares the facilitators to notice traits that emerge naturally within a group. These traits are known to have positive therapeutic value with other populations, and the work of the IBT group facilitation is to acknowledge and facilitate their activation for the purpose of improving the global social competence of the membership. The specific role-playing techniques are used to engage members in an encounter where they can both give and receive. The accumulated result of these efforts results in greater well-being for the members, as indicated in the studies reviewed.

Pilot studies and future directions

In an intriguing pilot study, Lundrigan (2007) designed a questionnaire based upon Seligman's Consumer Reports survey of client satisfaction with mental health services (Seligman 1995). The results are informative about how therapy helps ID participants and how it is perceived. Because most of the participants could not read, Lundrigan administered the survey via a semi-structured interview to 40 IBT participants, all of whom were dually diagnosed with IQs between 50 and 70. Participants reported feeling helped by their participation in IBT groups, as evidenced by their responses to these questionnaires, and a few selected participants were chosen for in-depth clinical interviews. Of the 40 clients who were surveyed, 34 (85%) felt that they had been helped by participation in IBT. It is of note that this figure corresponds closely to the 87% satisfaction rate found in the Consumer Reports study. The high degree of satisfaction reported in the questionnaire lends further support to the presence of the therapeutic factors in the IBT groups identified by Razza and Tomasulo (2005).

The participants entering this study also identified their reasons for treatment. In descending order, the symptoms bringing them to therapy are noted as: depression, grief, generalised anxiety, family problems, marital or sex issues, problems at work, desire for weight loss, drug and alcohol issues, and eating disorders. In other words, they appeared for therapy for the same reasons as those in the Consumer Reports study. In the Lundrigan study, the satisfaction level of all the participants ranged from being 'satisfied' to being 'completely satisfied' with their therapist and 97% ranked the competence level of the therapist as 'fair' to 'excellent'. In a similar vein, respondents of the Consumer Reports study were equally pleased irrespective of whether they were seen by a psychiatrist, a psychologist, or a social worker.

Of particular importance are the *quantitative* measures of improvement resulting from taking part in the IBT groups. In total, 90% of the participants felt that therapy improved their ability to get along with others, while 82.5% believed that the therapy helped them become more productive at work. Additionally, 80% felt it was helpful in coping with everyday stress, and 85% felt IBT helped them enjoy life more. In addition, 92.5% thought that therapy was responsible for personal growth and insight, while 95% noted their confidence and self-esteem had been bettered. With regard to combating the symptoms of depression, the most commonly sought-after reason for treatment, 85% felt IBT helped them alleviate low moods. What is most striking about these numbers is that of the 40 participants, none reported that the therapy made them worse, even though this option was clearly given to them during the semi-structured interview.

Lundrigan's study shows the power of action methods in a specifically therapeutic environment. However, other researchers have been able to demonstrate how dramatic techniques can have a therapeutic effect on performers in

more social or performance-based environments (Fenech 2009; Hackett and Bourne 2014).

Conclusion

Freud made popular the term 'talking cure' (Freud 1910). When Moreno attended one of Freud's lectures in 1912, he recalled the experience:

> As the students filed out, he singled me out from the crowd and asked me what I was doing. I responded, 'Well, Dr. Freud, I start where you leave off. You analyze their dreams. I give them the courage to dream again. You analyze and tear them apart. I let them act out their conflicting roles and help them to put the parts back together again'. (Holmes 2014)

Their powerful methods took different paths to a common destination – Freud's through talking, Moreno's through action. Dramatic methods may provide the best of both worlds.

We propose that the ACTing cure is an extension to treatment options for people with intellectual disabilities. Future research should focus on the specifics of how performance-based treatment models and processes can alleviate emotional distress and enhance well-being.

According to Shakespeare, we are 'merely players' in the drama of life – yet he also wrote that we 'play many parts'. The ACTing cure can provide participants with more than just being an actor – to become whole by being the writer, director, and the dramaturg of their life.

Notes on contributors

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