

# A New Beginning

## – A dramatherapy group for participants with co-occurring mental illness and substance abuse in a mental health setting

by Joanna Jaaniste

### Abstract

Rehabilitation for people with dual diagnosis (co-existing mental illness and substance dependence) has existed in many forms over the past thirty years and has become more urgently needed over time. Treatment for this population inevitably requires a team effort (Schwartz & Lehman, 1998). These people are difficult to engage in treatment and it takes time to unravel the interacting effects of substance abuse and their mental illness. Social relationships may also be problematic, particularly once the person has decided to discontinue drug or alcohol abuse. Often such clients find it easier to communicate socially with people who have similar problems (Hatfield, 1993).

Improvements in self-esteem and reduced intake of drugs and alcohol are rarely monitored in the one community psychiatric facility, as in this study. The method of treatment in this case was to run a small group for participants over an extended period with support from multidisciplinary teams, using a Dutch model for drug and alcohol rehabilitation. By targeting psychiatric relapse prevention and people's life stories, using a biographical developmental framework and dramatherapy interventions, the intention was to achieve outcomes of higher self esteem and reduced intake of recreational drugs. In fact the pre and post measures chosen did not show significant variance. For all participants, including those who were already abstinent, changes in lifestyle and achievement of life goals were sought. As a result, there was reported enjoyment of mutual support, sharing and understanding of individual life stories, together with strategies to increase resilience. Further research is needed to identify how best to measure outcomes.

Hatfield, A. (1993) 'Dual Diagnosis and Mental Illness', *Journal of National Alliance for the Mentally Ill*, (Online), retrieved 11.1.08

Schwartz, R. & Lehman, A. (1995) in 'Overview of Treatment Principles' in Lehman, A. & Dixon, L. (eds.) *Double Jeopardy*, Harwood Academic Publishers, Chur, Switzerland, p.77

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### Introduction and Background

The lifetime prevalence rates of people with co-morbid substance misuse and mental health disorders are higher (Todd et al., 2004) and the current rate of substance misuse, is higher (Green et al., 2007) than that of people in the general population. Co-morbid substance use is associated with a range of poor outcomes, including homelessness, aggression, physical health complications and incarceration (Cleary et al., 2008), thus highlighting the need for effective interventions. Recent research suggests that treatment appears to be more efficacious when mental health and substance use services function as an integrated system of care (Drake et al., 2004).

The contribution of creative therapies to the treatment of people experiencing substance misuse and mental health problems is soundly under-researched and under-reported. This article will describe eleven group sessions for people with co-morbid mental health problems and substance misuse that were based on dramatherapy, and undertaken in the Therapy & Recovery Service (TARS), Fairfield/Liverpool Mental Health Service, within the Sydney South West Area Health Service.

The project was based on a Dutch model of substance abuse rehabilitation at a service called ARTA, which specialises in biographical work based on seven-year periods of human development (Lievegoed, 1988). Artistic activities and therapies offered during recovery at ARTA include dramatherapy. At ARTA, mentors are allocated to accompany clients through a self-awareness process. This enables participants to own a more conscious picture of their lives (ARTA Prospectus, 2000).

Participants are followed up by ARTA after seven years once recovery is completed. On average, between 1985 and 1991, most people followed up self-identified as being addiction-free (van der Haar, 2004). This result is identified as more efficacious than at 'regular' addiction treatment clinics in Holland, and may be accounted for by

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the cohesion and structure, positivity and continuity of care provided at ARTA (Tjaden et al., 2005).

For this project, representatives from ARTA and Regenesi (the Australian branch of ARTA) consulted with members of the multi-disciplinary mental health rehabilitation team to develop and implement the intervention. It was designed using the ARTA framework to facilitate greater self-awareness of substance use patterns and foster hope for recovery, using dramatherapy strategies of embodiment, projection, improvisation and role-reversal.

## **Method and Group Members**

Participants were referred from the local case management team for support in dealing with co-morbid mental health and substance use issues. Exclusion criteria included current florid psychosis and/or lack of motivation to be abstinent. Of twelve referrals, only five participants were appropriate for the group, based on their stated desire for abstinence or interest in becoming substance-free. Psychosis did not impact on any referred individual's capacity to participate. One participant was diagnosed with bipolar affective disorder and four with schizophrenia. Their mean age was forty-two years, and four out of the five individuals spoke English as a first language.

## **Evaluation**

The programme was evaluated under the rubric of a quality activity and performed within existing budget. For the purposes of this paper, names have been changed. Improvements in self-esteem and reduced intake of drugs and alcohol are not consistently evaluated in community mental health services. Low self-esteem is considered to be more pronounced in patients with substance abuse (Silverstone & Mahnaz, 2003). Four assessment and evaluation tools were used to guide programme acceptance, structure interventions, and as pre- and post test measures. We used the Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965) to rate changes in participants' self-esteem. The RSES contains ten items which assess a person's overall sense of worth as a human being. Originally designed to measure self-worth in adolescents, it has been used with people with a severe mental illness (Torrey et al. 2000). Scores range from 10 to 40, with higher scores indicating better self-esteem. Generally, ratings of between 15-25 are within normal limits (Rosenberg, 1979).

We also used three clinician rated scales for alcohol and substance intake from the Dartmouth Psychiatric Research Centre (Drake et al., 1995) to track changes in patterns of use. The Substance Abuse Treatment Scale (SATS) identifies which stage of substance abuse treatment – ranging from 'pre-engagement' to 'remission or recovery' – the participant is in. The Clinician Rating of Alcohol Use Disorder (CRAUD) and the Clinician rating of Drug Use Disorder (CRDUD) both rate the participants' use of either drugs or alcohol on a scale ranging from 'Abstinence' to 'Severe Dependence'.

Finally, participants set individual goals they hoped to achieve by attending the group. At the programme's completion, the percentage of participants goals met was calculated.

## **Efficacy**

It is important to try to define efficacy and success, in the dramatherapist's own terms as well as in the participant's terms. For the dramatherapist, it was essential to work with the person to assist them to find meaning in the work they were doing in the group. Often, there is a sense that something has changed, but it is difficult to identify what has changed. If this work was to be successful in our terms, the participants would need to have a mental picture of what was happening in the therapeutic transactions and to explore areas of their lives which gave them a more explicit understanding of themselves, and to find the words to express this understanding. It is part of the therapist's role to assist the client to find meaning in what is happening in the therapy and to empower them to make decisions and choices about the direction and goals of the therapeutic process (Jones, 2005).

Participants' opinions about their experience of each session were also a part of this evaluation, as they commented in writing before (expectations) and after (achievements) each session. These notes, together with the dramatherapist's own, and the supervision of the work, enabled a picture to be built of client process and progress.

During early sessions, it became obvious that clients had long-term expectations they hoped to achieve eventually through becoming or remaining abstinent. Examples of these long-term goals included gaining access to children, weight reduction and re-entry into the workforce.

## **Preparation and Structure of Intervention**

Participants were engaged through fliers sent to the local mental health teams; referrals were through ordinary pathways to TARS. An eleven-session group was designed around dramatherapy techniques and psychoeducation strategies, and co-facilitated by a clinician from the local ambulatory care service. Dramatherapy interventions were based on the biographical model (Lievegoed, 1988), which is described in greater detail later in the paper. Within this framework interventions included improvisation and roleplay, together with role reversal. Improvisation was used enabling participants to distinguish between fantasy and reality (Jennings & Gersie, 1987), work which can be extremely helpful in mental health settings. Designed for at-risk adolescents, this is a useful tool for people whose adolescent lifestage has been interrupted by drug-taking or illness, precluding a healthy developmental transition to adulthood. A psychiatrist was engaged to co-facilitate one of the sessions. As already mentioned, clients noted down expectations at the start and achievements at the end of each session. Sessions began with reflection on the participants' week and review of the last meeting, to

confirm what participants had understood and what might require further clarification. In general, groups consisted of drama warm-ups, a psychoeducational element and dramatherapy.

Group sessions covered the sharing of stories, preceded by symbolic and metaphorical work using objects and coloured scarves. The first occasion when substances were used was identified, as well as the original episode of mental illness. Stigma was dealt with in the group, and the dual effect of co-morbid difficulties where stigma is involved. In the writer's experience, people with substance abuse issues can have greater experiences of stigma than people with mental health problems within mental health services and in the community.

Habit-hiding and its impact on mental health came up in sessions, as well as triggers to substance abuse and family patterns imitated from the participants' families of origin or early care-givers. Towards the end of the intervention, future goals were considered, together with changing patterns and re-learning, as well as grief and loss issues.

For the therapists, it was important that participants understood the dangers of mixing recreational drugs and psychiatric medication. It was hoped that, through this educational element of the intervention, participants would become more proactive in asking questions of their psychiatrist.

## Dramatherapy Interventions and Process

*As creative arts therapists, we... do not directly treat the primary illnesses presented to us, such as schizophrenia... No, we treat people's morale, self-esteem and courage in facing these life challenges, and help them ward off the depression, the hopelessness, and the anger that such conditions give rise to (D. Johnson, 1991).*

Using the biographical model, it is important to treat participants' morale, self-esteem and courage, to help them *understand* rather than 'ward off' or deny the negative symptoms of illness. This understanding lays the foundation for further work. Greta Schnee expresses this well:

*By the very act of sharing one's personal suffering, in creative and expressive forms, each member is engaged in meaning making. Thus, by the end of the group, the mood is often more hopeful and patients are more open and available to positive aspects of experience (G. Schnee, 1996).*

Initially, concrete objects were used as projective material, placed and grouped through client choice in order to achieve gradual cohesion in the group. Clients were asked to choose an object which reminded them how they started to use alcohol or substance; this facilitated identification with common feelings (Jones, 1996). Gradually, people began to disclose experiences, and they were introduced to the idea of developmental seven-year

periods. It was interesting that, with the exception of one member, they were all in mid-life. It was therefore important for them to understand Lievegoed's paradigm from mid-life onwards, where the physical body begins to deteriorate, the life of the spirit needs to flourish. This is particularly important for people with alcoholism, where there is a physical deterioration, particularly in the liver, and at the same time a kind of 'false self' is being created by the alcohol each day, which shrouds depression and masks difficulties (Dunselman, 1993).

After the initial familiarisation period, the dramatherapy took the form of eliciting group and individual aims, using body sculpting and fantasy/reality work. Linking aims with real life is essential for this client group. Aims sometimes tend to be grandiose and unreachable for people who are likely to be unemployed, such as: 'I want to have a sports car and go fast' or 'I'd like to win the lottery'. The reality was that one needed to move out of the home of his alcoholic father and find his own accommodation and another lived on takeaway food which was not helping his physical, let alone his mental health. By comparing the sculptures and drawings of their fantasy and reality, they came to see that first steps needed to be more simple without losing the future possibility of fulfilling their goals (Jennings & Gersie, 1987).

Participants were then introduced to Lievegoed's developmental schema of seven-year periods – 0–7; 7–14, etc. Warmups were focused on embodiment of events and memories from the seven year periods, moving backwards from the present to the past, and improvisation which gradually accompanied participants through their stages of development. This activity gives them an understanding of the seven year periods and how they relate to each individual. Even though several group members were taking psychiatric medications, which can dull bodily responses, the embodiment work tended to pinpoint the actual time when they started taking recreational drugs or alcohol or the mental illness began to affect them. Then the embodied role of an imagined object (not linked to the objects chosen earlier, but more personal this time) created a link between the concrete and the symbolic. One member became the coffee table where he had sat with his teenage friends and their bongos, and the oppressive body position brought back many of the feelings he had experienced in 'coming down' and withdrawal, even though he had been abstinent of cannabis for some years. For him it was the 7–14 lifestage that was important here, since it was adolescent experimentation that introduced him to smoking. In supervision it was considered that although the exercise can bring back a feeling of resolve never to relive the actual experience, it can be overwhelming for some participants to take the role of an object with such a close association to using substance, and this strategy has been altered in later groups run on these lines.

This group's experience progressed to the exploration of generational patterns, and to the circumstances which

had led to using in the first place. For several participants, what had always seemed to be idle curiosity now appeared to be a search for love, friendship or affection in the face of abuse in the 0–7 period. John Casson writes of the large number of clients in his sample of voice-hearers who were survivors of abuse (Casson, 2004). He began his research with:

*an intuition that people who hear voices have, at some time in their lives, been unable to voice what they have experienced.*

*Unable to speak of it, their experience has become unspeakable. The voices they hear are testimony to that experience and therefore are meaningful (Casson, 2004).*

He goes on to describe the abuser as the silencer of the victim. Two of the men in our group confirmed this. There was a general consensus that recreational drugs or alcohol had been an escape from a difficult reality, be it targeted abuse, domestic violence or the ravings of an alcoholic parent. Clive's work with his neighbour, described below, is an example of the boundary-awareness necessary in these cases.

Through playback theatre methods and role reversal, participants were able to relive some of those early experiences, and then go on to identify what they had learned through their addiction – the qualities which had unconsciously helped them through the dark times, assisting them withstand the losses and discomforts. By developing a deeper understanding of their lives through the prism of the developmental paradigm, which suggests there is a 'second chance' or a new opportunity for radical change in mid-life, there was a sense of hope that the generational patterning could be changed. Anecdotally, this can lead to a considerable reduction in the amount of shame people feel; shame which hinders the recovering addict. Understanding the causes of using, and in most cases the reason for the onset of mental illness, encouraged participants to lower their intake of the addictive substance.

One client whom I shall call Mike wanted to change and step out of the self-fulfilling prophecies that had accompanied him since childhood. Abuse from his 'old man' who was still sending him out to buy liquor for him was a real stumbling block. He said of his expectations in this regard: *'I expect to be able to change the patterns in my life that have always led me astray.'* He learned from a second client's improvisation, where he had always given in to authority figures, that he needed to be stronger. This man – I shall call him Clive – said the following after an improvisation where a demanding neighbour would tell him to jump, and he would ask: 'how high?':

*I realised during role play my aversion to confrontation is a pattern I need to avoid: eg. with the neighbour as I feel initially threatened, then frustrated when I am too agreeable and don't speak openly.*

Instead of locking the screen door against his neighbour and blocking his ears when they yelled out to him from below, he was able to tell them in role how he felt about their intrusive behaviour. He went on to be more assertive in practice with this person.

Clive realised that he had been able to address his lack of boundaries through this experience. On many occasions as a small child he had witnessed domestic violence, been made responsible for bringing medication to his mother which he had sometimes sampled, and been yelled at and emotionally abused. This awareness gave him the opportunity to integrate early experiences and move forward with greater insight.

## Outcomes

All participants completed the eleven session group series and reported enjoying the group process. Results of the standardised measures will be described. The mean pre-test ratings of the RSES was 15.4, and mean post-test rating was 15.2. This indicates a non-significant change, and is within limits for 'normal' self-esteem (Norton, 2003–2008). These results may indicate the group sessions impacted little on self-esteem, or that changes in self-esteem were not related to changes in substance use patterns. Alternatively, this may indicate that the RSES was the wrong choice of instrument to evaluate this group, or that self-esteem is an embedded phenomenon that cannot realistically change over eleven sessions.

Two participants maintained stable Substance Abuse Treatment Scale (SATS) ratings at pre and post testing; one rated 'In Remission or Recovery', which indicates no use for the past year, the second rated as being in 'Early Persuasion' at both time points, indicating maintaining contact with a case manager and stable or slightly decreased substance use. The other three participants moved from either the 'Engagement' or 'Early Persuasion' phase, to the 'Late persuasion' or 'Early Active Treatment' phase, indicating participants displayed a decrease in substance use and are engaging in ongoing treatment by the end of the programme.

Three participants rated as being in 'Abstinence' from alcohol use on the CRUAD at pre and post testing. The other two participants rated as 'Dependent' at pre testing. At the group's conclusion both participants rated as having decreased their Alcohol use to either 'Abuse' or 'Use without Impairment'. This may suggest the group had some impact on alcohol use. Ratings on the CRUAD for four participants showed no change between pre and post testing. One participant rated 'Abstinence'; others rated 'Use without Impairment' or 'Abuse'. One participant, abstinent of alcohol, binged on cannabis and ended up in a mental health unit in the last week of the group. He opted to join the next group, three months later. This participant's rating increased from 'Abstinence' to 'Abuse'. With the obvious exception, these results suggest the majority of the group maintained their substance use over the course of the group.

As far as patterns of addictions are concerned, one man mapped the local suburb where he drank at a particular hotel. This man then walked in a direction away from the pub to a less friendly one, where he would only have one standard drink instead of six.

The aim of helping participants be more proactive in asking questions of their doctor about the effects of mixing psychiatric and recreational drugs was not achieved. The group was reviewed and this issue addressed in the next group, by asking a resident psychiatrist to instruct the group on how to show concern, and be more proactive with their doctors about taking medication. This was an education for the psychiatrist as much as the clients!

*By the end of the eleventh session, clients had achieved more than 50% of their expectations.* The most significant aspect of the final meeting was a unanimous decision to meet every so often for mutual support.

## Conclusion

Schwartz and Lehman write of the importance of group therapy with this population:

*This modality is particularly useful to reduce social isolation, denial, manipulation, projection, and overdependence on the therapist* (Schwartz & Lehman, 1995).

More importantly, dramatherapy enabled the participants to express their difficulties with the dual burden of substance abuse and mental illness. Awareness of the biographical lifestages gave them a structure in which to make meaning of the difficulties and pain they had undergone in the past, and this enabled them to see themselves as more whole human beings in the future. The small sample size of this group makes it difficult to make definitive statements about the interpretation of these results. It may be that standard measures of substance use and self esteem are not the most appropriate measures to understand the efficacy of a group based on dramatherapy principles. Perhaps future groups would benefit from qualitative analysis that would more readily describe the development of awareness and personal meaning that participants gained from group involvement.

This article demonstrates the feasibility and participant acceptability of a dramatherapy group for people experiencing co-morbid mental health and substance use problems. The group was easily implemented in a busy mental health service. Participants reported enjoying the process, and requested further contact and support to develop and maintain abstinence at the group's conclusion. However, clearly further research on the efficacy of dramatherapy for people experiencing both mental health and substance use problems is needed. Increased numbers of participants could intensify the dynamic in the group; alternatively an investigation of individual therapy before the group, enabling participants to make use of the sessions once they do join (Casson, 2004) could be

valuable for future investigations. Importantly, further research should focus on identifying how best to measure outcomes from dramatherapy interventions with a dual diagnosis population.

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Joanna welcomes any feedback on her article to:  
dramatherapy@ozemail.com.au

*The address for article submission is:*

**Bea Scott**  
**Flat 5, 77 Clapham Common South Side**  
**London SW4 9DG**  
**beascott@ymail.com**