Group psychotherapy holds unique benefits for individuals with developmental disabilities, just as it does for individuals without such impairments. In fact, meta-analyses of comparative research studies indicate that group psychotherapy is as effective or more effective than traditional individual forms of psychotherapy. Further, experts in the treatment of sexual offenders and of sexual abuse and non-sexual trauma survivors contend that group psychotherapy appears to be the treatment of choice for these patient groups. In the growing literature in the field of mental health and intellectual disabilities, group psychotherapy is receiving increasing amounts of attention and support for its efficacy. Its utility with offenders who have developmental disabilities, a group that has drawn much recent concern, has lead to considerable documentation.

Despite group therapy’s efficacy, the opportunity for in-depth training in group theory and technique has been quite limited in formal graduate programs. Clinical programs generally provide considerably less training and experience in group psychotherapy than in individual. Many clinicians learn to conduct group psychotherapy on the job, often in human service programs, hospitals, or outpatient clinics.

In this article we hope to provide support to the growing body of clinicians who are conducting psychotherapy groups for people with developmental disabilities. We will explore a number of dilemmas encountered by clinicians running psychotherapy groups. We have drawn these dilemmas from our own experiences in working with people with developmental disabilities, as well as from commonly reported problems from other clinicians with whom we have consulted.

**GROUP AS SOCIAL MICRO COSM**

Fortunately or unfortunately, individuals display their repertoire of interpersonal behaviors in group sessions. The good news is that we, as facilitators, are able to observe, in vivo, each member’s particular brand of interpersonal pathology. The bad news is, of course, the same thing. Each member’s psychopathology is presented, often in full force. The behavior of one member affects, and is affected by, each of the others, and can demand considerable clinical skill on our part to manage. Yet, we need to think of these interpersonal difficulties as more than management problems. They are samples of the very pathologies that caused the individual to need treatment in the first place. Some members talk over others, some take offense to any comments directed toward them, some shut down when questioned about recent problems, while others become antagonistic.

One clinician with whom we consulted had been providing individual psychotherapy to a young woman with mild intellectual disabilities for a few months. Ms. A was referred by staff at her sheltered workshop who had observed that she was frequently quite agitated and displayed verbally aggressive behavior. In individual sessions the young woman was cooperative and easy to work with. She reported on interactions...
with peers that distressed her, and described problems in her living situation with her sponsor, and her interest in staying in contact with her sister. When the clinician began a therapy group for people with developmental disabilities and psychiatric disorders, she invited the young woman to join. The clinician was hopeful about the new treatment plan. She had developed a good working relationship with the patient, and expected that group would enhance her progress even further. Ms. A expressed eager anticipation and entered the first session in good spirits. However, no sooner had the clinician begun initial introduction of the members than Ms. A pounced, verbally, on the member seated next to her.

“Your hair is dirty,” she scolded. “What’s the matter with you? You need to go wash your hair! It looks terrible!” She continued in this manner, talking over the clinician’s attempts to intervene.

The recipient of the attack said nothing. She shot a hurt look at the clinician, then began to inch her chair away from her accuser. During a consultation a few days later, the clinician commented, “I got a good look at what the workshop staff referred her for. What a disaster the first session was!”

Certainly, when one member makes a verbal attack on another, there is a problem to deal with. Yet, the old saying that everything is “grist for the mill” could not be truer than when it comes to psychotherapy. Out of this dilemma, in which we observe one member’s verbal aggression and another’s lack of assertiveness, we can create opportunities to help each modify their particular styles, and expand their set of prosocial skills. We will discuss at length the treatment of Ms. A and of the member at the receiving end of her attack in the next section. Briefly, however, a good general strategy to use in the moment is for the clinician to address her comments and attention to the member subjected to the inappropriate behavior, rather than to the member displaying it. The facilitator’s intervention is best kept to a quick and emphatic announcement of praise to the target of the aggression, telling her that she is doing a great job of staying calm and in control. She could also invite that member to move to another seat if she would like. The facilitator can then go on to acknowledge each of the other members for having stayed calm and in control during the disruption.

In keeping with the theoretical underpinnings of group psychotherapy, an individual’s limitations in assessing and participating in interpersonal interactions are directly related to his experience of distress, and his particular form of psychopathology. In the above example, Ms. A had reported distressing interpersonal incidents in individual therapy, yet she lacked awareness of her own role in her difficulties. For example, she was very interested in visiting her sister, and lamented that she did not go to her sister’s house as often as she would like. She also mentioned that sometimes she had difficult encounters with her sister’s two children. Perhaps her difficulties in dealing with others, especially those she considered competitors for valued attention (such as her sister’s children who drew some of her sister’s attention, and her co-workers who commanded some of her supervisor’s attention) played a role in the infrequency of her visits.

Another example is that of a young woman with moderate intellectual disabilities who is extremely passive, and tends not to assert herself or even to express her feelings for the most part. Such a style is often associated with depression. If this individual experiences abuse and remains unassertive, she is likely to become even more depressed. In this case, the young woman will have much work to do to recover from her abuse. She will also, however, need to develop new skills in verbal expression and assertiveness. Her passive style will become evident in the group setting, and can be addressed directly there. As she alters her style, and evolves a more adaptive repertoire of interpersonal skills, her sense of self-efficacy will grow as well, and her depression will diminish.

We will examine two cases that provide examples of pathological interpersonal styles often seen in group members with developmental disabilities. With each case, we will describe techniques for reworking the raw material presented through these styles, altering it into more productive and satisfying behavior.

**Case 1: Verbal Aggression: Ms. A**

Ms. A is the young woman who began her first group session by assailing another member about her hair care. She was initially referred because of hostile interpersonal behavior of this sort, which was typical of her interactions with her peers at her workshop, though not with authorities. She was often agitated, and easily flew into verbal diatribes directed at coworkers.
To address such behavior, it is helpful to use behavioral principles. Ms. A had already demonstrated that she valued the attention of authorities, including her therapist. With this in mind, the therapist made a plan to treat any of her “attack behavior” as a cue for other members to earn the therapist’s attention. In other words, when Ms. A began to “attack” another member, the therapist would immediately address the victim, and then the witnessing members. For example, after Ms. A again scolded a member for her dirty hair, the therapist turned to that member and said, “It’s great the way you are staying so calm. Good for you. You are not yelling or fighting.” She then turned to the other members, and carefully addressed each by name. “Each of you is doing a great job staying calm. I’m glad each of you can do the right thing, even with the yelling that happened in here.” Note that the therapist did not refer to Ms. A by name, or look at her, both of which might have been reinforcing to her.

Psychodramatic techniques can be employed to enhance the effect of reinforcing the others, as well as to teach the others increasingly adaptive responses. It is certainly a good thing that the victim, in this example, did not turn the attack into a fight. She could benefit from learning, however, that she could do more than sit passively. Simply being a submissive victim was likely to contribute to her poor sense of self and her depression.

We will describe a scene that incorporates psychodramatic techniques. In an effort to give the reader a feel for the group process in which these techniques were used, we will assign first names to each of the involved members.

The therapist began by employing a psychodramatic technique known as the “double,” a technique that is very easy for therapists as well as members to learn, and provides strong support to the involved members while running a very low risk of being threatening. In order for the therapist to double for the victimized member, named Patrice, the therapist got up from her chair and stood behind Patrice (after receiving her permission to do so). From this position of the “double,” the therapist restated and expanded upon Patrice’s feelings. Initially Patrice was able to say only that she felt “bad” when Angela (Ms. A) yelled at her. The therapist restated this, and then added, “It hurts my feelings.” She asked Patrice if this was accurate. Patrice said it was. Following this, the therapist coached Patrice to say this statement out loud herself. Next, Patrice was asked if she would like to have another member come up and double for her. The advantage in having a group member or members provide additional doubling is that the protagonist receives even more support, and other group members are able to practice empathic attunement. Moreover, the group as a whole becomes more cohesive and members perceive the group as increasingly supportive and safe.

Patrice chose Liz to provide the additional doubling for her. Liz got up and stood behind Patrice along with the therapist. The therapist asked Liz how she thought Patrice was feeling. Liz said, “Upset,” following which Patrice practiced saying this as a full statement in the first person, “I am upset.” Patrice then nodded her assent that this statement was indeed true for her. The therapist thanked Liz for her help.

Enactments of this sort were carried out over many sessions. The old behavioral adage, “It gets worse before it gets better” found no exception in Ms. A’s case, which took the form of her turning her comments away from her fellow members and, instead, speaking to the therapist. Early in her treatment, when the therapist first responded to her attacks on members by attending to those members, Ms. A would turn to the therapist to plead her case. As the therapist praised Patrice’s calmness, Ms. A veered from her attack on Patrice and appealed to the therapist, saying, “But look, her hair is really dirty. I’m not making it up. Look at her!” The therapist disregarded Ms. A’s argument, and maintained eye contact with Patrice. Over the weeks, Ms. A’s behavior became less frequent, and also would stop sooner when it occurred.

As Ms. A’s behavior improved, the therapist introduced two additional techniques, aimed at further improving the prosocial skills of each of the members. Patrice was encouraged, with a supportive double behind her, to speak to Ms. A directly. She was encouraged to tell Ms. A what she was feeling, and to look at her when saying it. The reason this tact was not taken earlier in the therapy is that Ms. A was still too volatile. She would not cooperate with letting another speak; she would attack again. This leg of the treatment was begun once Ms. A was able to stop herself from attacking, and demonstrated a positive response to affirmation for that effort. The therapist provided consistent positive affirmation.


Ms. A for each demonstration of three successive accomplishments: 1) being able to stop herself from “scolding” (a term she could identify with); 2) being able to listen while the target member stated her feelings to her, and 3) being able to restate the target member’s feelings.

This third step, having Ms. A repeat the message another directed to her, provided Ms. A with an opportunity for role training, thus expanding her social repertoire and her opportunity to create satisfying relationships.

Practicing each of these behavioral changes was a great deal of work for Ms. A and represented a great deal of growth. The next step, which the group will be addressing in coming sessions, will be to help Ms. A learn more prosocial ways of expressing her feelings. Statements beginning with “I feel” provide concrete models for members to utilize. The next time Ms. A attacks a member for being late by saying, for example, “Liz, you’re late! What’s the matter with you!” she will be asked to stop, and will be cued to make a statement beginning with “I feel.” The facilitator will quickly praise Liz and the others for their calm behavior. Ms. A will then be invited to state her feelings, such as, “I feel mad,” which will then be reinforced. In a group for which the norms for prosocial behavior have been fairly well established through consistent reinforcement, the groundwork is set for this level of intervention. Ms. A would be practicing behaviors for a new, prosocial role, known as role rehearsal in psychodrama.

CASE 2: CHRONIC UNDERASSERTIVENESS: MR. B

Unlike the underassertive abuse survivor described earlier in this paper, Mr. B was referred because of inappropriate behavior with children. He was fired from his job as a stock clerk at a large discount store, where he would frequently approach children, even with their parents present, and tickle them on the belly. He would stoop down in order to be at eye level with them, and tease them good-naturedly.

A number of customers had complained about Mr. B, and despite warnings that he should refrain from this behavior, he continued his interactions with children. When his mother brought him in for an evaluation, she reported, with considerable grief, that she had noticed that Mr. B often hugged his little nieces and nephews too hard and too long when they came to visit. She generally managed an effective “cease and desist” order, and was in the habit of keeping on the alert when young children visited. She had always felt Mr. B was harmless, and genuinely innocent in regard to his understanding of the meaning of his behavior. When Mr. B’s behavior finally cost him his job, she worried that there might be more wrong, and that perhaps she should have sought treatment sooner.

We have now worked with Mr. B for many years. While he has never touched a child’s genitalia, he has hugged and tickled children in ways that were unacceptable at work and in his neighborhood, and made children’s parents uncomfortable. Unlike many of the sexual offenders we see, Mr. B had little trouble telling us about his behaviors, and his reports agreed with those of his job coaches and his mother.

What took us a little longer to understand was that Mr. B was chronically underassertive, socialized to be “a nice boy.” In no way was Mr. B’s underassertiveness presented as a referral problem; it did not bother anyone else. At 31, Mr. B still felt very much like a boy. He was a polite and attentive group member, but wanted to raise his hand before speaking, even though this was contrary to group norms. Mr. B longed for the facilitators to “direct traffic” in order to create an opportunity for him to speak. He did not know how to interject himself into a discussion, and clearly felt inhibited in doing so.

In time, Mr. B began to complain about a woman who attended some of his recreational programs. She would continually tap on his shoulder to get his attention. He was completely at a loss as to how to stop her. At another point, another young woman began to call him at home. She would sometimes invite him to her house. He reported that he did not like this young woman, but had not been able to get her to stop calling, and had even gone along with visiting her because he could not say “No.”

When Mr. B was with children, however, he felt free. He was happy, and could really relax and have fun. Until he started group, he continued to play with children in his neighborhood. His face lit up when he demonstrated some of these interactions for us in the group, using a combination of dolls and other members seated on the floor to represent children.

Mr. B missed the kids in his neighborhood with whom he had grown up. Now he was being told it was not “safe” for him to play with neighborhood kids; he could get into trouble.
Mr. B was hurt, and he was lonely. His mother was good about bringing him to many recreational events for young adults with intellectual disabilities, but he had little fun at these events. He could not speak up, and someone, like the woman who incessantly tapped his shoulder, would always end up picking on him.

Mr. B's style in the group had many positive features: he was attentive, honest, and cooperative. He never interrupted. But somehow, Mr. B seemed to miss opportunities to talk. Others would go on, and interactions would take place, but Mr. B held back. He persisted in wanting to raise his hand, and would look pleadingly at one of the facilitators before giving up. When he did speak, which initially was only when he was chosen to do so by another member, his speech was faltering and hesitant, and he failed to sustain eye contact. He often spoke too softly to be heard, and so slowly that it was a trial to listen to.

We approached Mr. B's problem with psychodramatic techniques, using both behavioral enactments and doubling. We had Mr. B portray a scene in which he demonstrated how the woman taps on his shoulder. Mr. B initially had to alternate between playing his own role and then the woman's role to demonstrate her behavior. It is generally best to have the protagonist, in this case, Mr. B, portray the auxiliary role first, in order to train another member or a facilitator in the role. In this way, the portrayal of the role will be most like the way the protagonist sees it.

After demonstrating the role, Mr. B chose the co-facilitator to play the woman's role. She began tapping his shoulder, and hurling questions at him. Mr. B, for his part, then demonstrated his usual, futile efforts to stop her by moving away, yet saying nothing. She, of course, pursued him. We then froze the action and asked Mr. B if he felt anyone could double for him. Doubling for the protagonist in the scene, exactly at the point where he experiences distress and gets stuck, provides a demonstration of emotional support as well as clarification of his feelings. These are important pieces of groundwork to lay, before asking the protagonist to try a behavioral change. They greatly increase his readiness to make a change. Asking the protagonist to try out a new way of behaving should only be done after one or more members have successfully doubled for him.

To clearly delineate the group process for the reader, we will again assign first names to the members. Mr. B, whom we will call Ben, chose a member named William as his double. William stood behind Ben, in the typical position of the double, in the scene which had been “frozen”; the co-facilitator remained in the role of the pursuer. The facilitator asked William how he thought Ben felt in this scene, reiterating the dynamics to aid William's understanding. William thought and said, “Mad.” William was then coached to check the accuracy of this guess with Ben. Ben stammered. He denied feeling mad. William tried again and came up with, “Not happy,” to which Ben agreed. William, and then Ben, each expressed the feeling in the first person, saying, “I am not happy.” The facilitator, to enhance the doubling, then added, “I really annoyed.” Ben agreed with this, and repeated the statement.

Next, Ben was asked if he would like to try something new in response to the pursuer, and Ben agreed. He was asked if he had an idea of his own he would like to try, or if he would like to ask another member for an idea. Ben said he had his own idea. The facilitator then thanked William for his help and told him he could return to his seat. She then said that Ben should prepare to try his idea, and cued the co-facilitator to go back into action as the pursuer.

The co-facilitator immediately resumed tapping Ben's shoulder and pepperimg him with questions. Ben made a few muffled verbal statements for her to stop. The facilitator again froze the action. At this point, a “freeze” was called to highlight and augment Ben's attempt to try something different, that is, his attempt to speak up to the auxiliary.

The facilitator said, “Ben, you're starting to do some good talking. Now, while the scene is frozen and you have a chance to think, say out loud what you want to say. Say it right to her face, while she is "frozen," just for practice. And remember, any way you want to say it is OK for now; it doesn't have to be perfect.”

Ben regarded the “frozen” co-therapist-as-auxiliary. “Stop bugging me,” he said. “I don't like you poking me all the time.”

Ben said these words tentatively. The facilitator repeated each of them loudly and deliberately, standing behind Ben. She then asked Ben to say these statements again, and gave two specific suggestions: that he look directly into the auxiliary's eyes, and that he speak twice as loud.

“Stop bugging me,” Ben said, a little louder. “I don’t like it.”
“Good,” said the facilitator, affirming Ben’s effort with the “frozen” auxiliary. “Now, try it again when she starts up.” The facilitator cued the auxiliary to resume her act, and prompted Ben to restate his words. This time he spoke, fairly clearly, to the auxiliary while she was in action. The facilitator then quickly affirmed Ben for this work. The scene was again frozen, and, to draw the enactment to a close, the facilitator directed Ben to say “the last thing you want to say for now” to the auxiliary, a standard closing technique.

“Sit down and stop bugging me,” he said. The facilitator repeated this statement for emphasis. She then thanked Ben, and invited him back to his seat.

Variations on enactments of this sort were performed many times throughout the course of Mr. B’s therapy. In addition to these psychodramatic interventions, the facilitators also made ongoing note of Mr. B’s relative gains in asserting himself and interjecting comments during discussions. Each of these efforts was acknowledged with praise, either immediately or during the affirmation stage. Also, facilitators continued to resist, for the most part, responding to Mr. B’s pleading looks or occasional hand-raising.

Mr. B’s referral problem, inappropriate behavior with children, has not occurred at all in the last three years, and his overall assertiveness has improved, though continues to need work. For the past year, Mr. B has had a girlfriend his own age, and is learning how to negotiate a successful relationship with her, as well as how to manage his interpersonal behavior with her in the workplace.

**SUMMARY**

In this article we looked at two common examples of interpersonal dynamics that can be successfully modified in group. We described psychodramatic techniques, including role rehearsal, role training, and doubling, in conjunction with behavioral principles to achieve these changes.

It is our hope that increasing familiarity with group dynamics and techniques will encourage practitioners to employ group treatment with patients with developmental disabilities. As cliché as it may sound, each interpersonal problem a member presents is truly an opportunity for growth, for that individual and the other members, and provides the very material needed to turn a simple gathering of people into a catalyst for change.

**REFERENCES**


**Correspondence:** Nancy Razza, Ph.D., 723 N. Beers Street, 2B, Holmdel, NJ 07733; email: tomasulo@att.net.

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