

How to Trick 'Angry': Narrative Therapy For People With An Intellectual Disability Who Have Been Referred For 'Anger Management'

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Narratives surrounding intellectual disability are largely disempowering, focussing on 'impairment' and 'defect'. Therapeutic approaches are dominated by behavioural theories, which construct the problem as residing 'within' the individual. Systemic theories have started to be applied to therapy with people with intellectual disabilities. These have proved useful in helping to deconstruct the stories that people tell about themselves.

This study is of a narrative therapy group, which ran for eight sessions, in a community setting. The theoretical justification for the therapy is described. We then explain the assessment of potential participants for the group. We outline the three group phases of 'externalising conversations', 'exploring exceptions and unique outcomes' and 'developing and anchoring the alternative narratives'. Evaluation by feedback and questionnaire is discussed.

Reflection on what has been learned is considered: how 'anger' is construed by people with intellectual disabilities, how those narratives can change and what might be the implications of constructing alternative narratives around 'anger'.

THE CONTEXT OF THIS WORK

This work was carried out in a specialist challenging needs department for people with learning disabilities, accepting referrals from two Community Learning Disability Services. 'Learning disability' is in itself a social construction, and the terminology to describe these difficulties varies across settings and empirical research, for example being described as 'intellectual disability' or 'learning difficulty'. As the inclusion criteria for these services necessitated a diagnosed 'learning disability' as defined by the British Psychological Society (2000) we use this terminology throughout.

The service had received a high number of referrals requesting 'anger management', a significant number of which had been referred in the past with limited success. Referrals for aggressive behaviour are common in learning disability services, and Rose *et al* (2005) note that such behaviours are the primary reason why people with learning disability are admitted to institutional settings.

WHY CHOOSE NARRATIVE THERAPY?

A guiding principle behind any intervention for challenging behaviour is that

“Interventions should be delivered in a person-centred context and a framework of positive behavioural support. They should include proactive and reactive strategies.” (Royal College of Psychiatrists, 2007, p. 10)

Traditionally, therapeutic interventions to such behaviours have privileged a behavioural approach (eg. Beail, 2003; Royal College of Psychiatrists, 2007; Sturmey, 2005). Behavioural therapies have the widest evidence base in this area, given the limited research that has been conducted with other therapeutic approaches (Beail, 2003). Sturmey (2005) claims that psychotherapy in particular for people with learning disability has a poor evidence base and should be “avoided whenever possible” in favour of behavioural interventions. However, it was clear to us that we needed to take a contextual focus on what was happening in people’s lives, which traditional behavioural models could not provide. For example, we noted that the service-context often necessitates extensive reliance on others to meet personal care needs, which could give rise to feelings of resentment and hostility. A woman assessed for the group (who gave permission for her story to be shared) spoke of how angry she felt when her care-staff asked her if she had been for “wee-wee or a poo-poo”, despite being in her forties. She often expressed her anger through hitting them as her physical disability precluded her walking away.

Furthermore, Rose *et al* (2005) observe that behavioural interventions do not explicitly encourage self-regulation of behaviour; there appears to be an underlying assumption that people with learning disability are not *able* to self-regulate their behaviour. In addition, these methods, by virtue of their underlying theoretical basis of behaviourism cannot attend to underlying emotional experiences. Whilst Taylor *et al* (2004) observe that anger is not a necessary or sufficient precursor to the occurrence of aggressive behaviours, all of those assessed in our study described feelings of anger they experienced, suggesting that an approach that explicitly attends to these underpinning emotions could be beneficial.

Whilst there has been little research focussing on other theoretical approaches, clinicians have increasingly employed cognitive-behavioural therapy (CBT) techniques; the small evidence-base has indicated that CBT can significantly reduce self-reported anger in people with learning disability (eg. Benson *et al*, 1986; Rose *et al*, 2000; Taylor *et al*, 2002; Willner *et al*, 2002). Whilst it could be supposed that CBT privileges a self-actualising approach (Taylor *et al*, 2004), Rose (1996) suggests that the behavioural elements are more effective for people with learning disability than the cognitive elements. In addition, Pilgrim and Bentall (1999) observe that CBT is prone to psychological reductionism, as its singular focus on individual cognitive processes can imply that our construction of reality is the ‘problem’, rather than the reality itself. In that sense, many interventions *inadvertently* contribute to the problem by using prescribed methods to ‘fix’ the person. Given that people with learning disability are already embedded within stories of ‘damage’, such interventions could increase stigmatisation.

For these reasons, we were keen to utilise a theoretical and therapeutic framework that attended to the wider systemic influences on feelings and behaviour, acknowledged underlying emotional experiences and encouraged self-regulation of behaviour, without reinforcing stories of 'damage'. Therefore, despite both authors having a strong background in behavioural theory and therapy, it seemed that a new approach was needed here.

A narrative approach appeared suited to deconstructing the discourses of 'problem' and 'damage', that have the effect of "... specifying truths and narrow ways of being for people" (Zimmerman and Beaudoin, 2002). There has been little research exploring the use of narrative ways of working with people with learning disability; most evidence in this area is based primarily on case-study examples (eg. Clare & Grant, 1994; Fidell, 1997; Lynggaard & Scior, 2002; Perry & Gentle, 1997; Robbins, 2004). One case-study supported use of narrative work for an individual referred for 'anger management' (Leaning, 2007), so this represented a novel approach.

THEORETICAL UNDERPINNINGS OF NARRATIVE THERAPY

Narrative theory draws strongly on social constructionist approaches. These propose that thinking about self and others, and consequently action, is socially and culturally embedded (Zimmerman and Beaudoin, 2002), and thus identities are "fluid and changeable" according to context (Scior & Lynggaard, 2006). This builds on Mead's (1934) ideas that "... the development of a self involves 'taking on the attitude of the other'; if other's attitude tells us we are 'bad', then we are 'bad'." It also incorporates Korzybski's ideas about abstractions not being the same as the thing itself, famously summed up in the phrase "the map is not the territory" (Korzybski, 1933). A particularly important influence is Foucault's theories of power and knowledge (eg. Faubion, 1994). Given that people with learning disability are often so marginalised through professional discourses and practices, an approach that invites people to separate 'self' from 'problem' and highlights competencies and abilities could be empowering.

The social construction of 'learning disability' is somewhat at odds with the ideology of 'normalisation' (Wolfensberger, 1972) that has shaped the service-development and policy (Valuing People; Department of Health, 2001), with its focus on reducing difference and working towards inclusion. Therefore, people are being normalised into a culture largely influenced by north American and European conceptions of when anger is legitimate and illegitimate, and in expectations as to appropriate expression (Howells & Day, 2003), which usually emphasise self-control. However, as stated previously, traditional approaches to challenging behaviour may assume that people with learning disability *cannot* self-regulate their behaviour. We were curious about how people with learning disability might integrate these conflicting messages into their lives.

An important maxim of narrative therapy is that "the problem is the problem, the person is not the problem" (White & Epston, 1990). White and Epston (1990) consider that the experts in a problem are the people who experience that problem, and propose helping people by separating the problem from the person

by using “externalising conversations”. Baum and Lynggaard (2006) have described the general principles of applying this approach to people with learning disability.

RESEARCH INTO PRACTICE

The planned intervention consisted of an assessment, eight sessions of 50 minutes each and an outcome evaluation, described in more detail below.

Assessment

Assessments were conducted by at least one of the authors, accompanied by an assistant psychologist, using a semi-structured interview. Ten referrals were received for the group: 7 men and 3 women aged between 20 and 57. Two could not be contacted and three expressed a preference for individual work. Assessments were conducted with the remaining five. There has been little attention paid to variables that might be influential in helping people manage anger (Rose *et al*, 2005), so we were not selecting participants on the basis of pre-established factors.

Referrals to psychology services are often made on behalf of people with learning disability, so their goals and understanding of the implications of the referral might differ from those of the referrer (Rose *et al*, 2005). This is particularly true when the presenting problem is ‘anger management’ since others’ concern about risk can mean people are pressurised into seeking help (Howells & Day, 2003). We therefore wanted to ascertain clients’ own views of the ‘problem’ and how it affected their lives to provide information for assessment and a means of evaluating outcome. This also created a space in which participants could ask questions and discuss any concerns. France and Uhlin (2006) discuss the potential for narrative to be utilised as a measure of clinical outcome; we did not formally assess changes in narrative form and content but thought it important to stay mindful of subjective shifts in clients’ stories, and recorded their words verbatim.

Three standardised questionnaires were administered over two further sessions by two assistant psychologists, not involved with the planning or running of the group: the Novaco Anger Scale and Provocation Inventory (NAS-PI; Novaco, 2003) and the Rosenberg Self-Esteem Scale (Rosenberg, 1965). There were administered verbally, with visuals prompts to support understanding of the Likert scales involved. The NAS-PI self-report questionnaires were used to assess the relationship between anger and aggressive behaviours, employing Northgate modifications (Novaco & Taylor, 2004) which enabled them to be used more effectively with people with learning disability by simplifying the language and providing examples and clarifications where required. The NAS is a 60-item questionnaire on which a higher score represents a positive relationship between anger and aggressive behaviours. The PI is a 25-item measure identifying situations that can invoke anger, a higher score representing a higher tendency towards provocation. The Rosenberg Self-Esteem Scale is a ten-item self-report questionnaire used to assess global sense of self-worth, a higher score

representing higher self-esteem. This measure was chosen as previous studies (e.g. King *et al*, 1999) have found a link between anger control and self-esteem¹.

Sessions

Sessions were held weekly in a community location identified as being easily accessible by public transport, and wheelchair accessible. Sessions were structured around a consistent framework, which included confirmation of the planned agenda, a recap on the previous session, phased intervention as described below, summary and collaborative agenda setting for the following week. Some integral aspects of the intervention are described in more detail here.

Phase One: Externalising conversations

The process of externalisation is seen as a linguistic process, enabling clients to separate themselves from the problem, and from the problem-saturated descriptions that have encompassed or become their identities. This shifts focus to the relationship between the person and the problem, creating a context in which people work together to 'defeat' problems, reducing guilt and blame. Harper and Spellman (2006) suggest that externalising anger might invite people to move away from a sense of responsibility for the effects of their actions, and we attended carefully to this. However, we felt that externalising anger was not synonymous with admonishing responsibility, since the essential tenet of the group was about finding ways to 'keep control' or 'beat' anger. We felt that externalising anger could help to mutually develop an understanding of how it affected clients.

In the first session, we invited members to share their stories. One member recalled an incident at their day-centre in which they hit a member of staff and pulled their hair. This participant became distressed when describing this event, and clearly felt ashamed. In summarising and reflecting clients' stories back to them, we modelled use of externalising language by reflecting back our participants descriptions, but making changes such as not describing participants as '*being* angry', rather as having an *external* 'temper' or 'angry' who can 'trick us'. To support this work we created a visual summary of the aims of the group, in which we identified an external 'angry' that we hoped to notice, question and overcome.

In the second session, we invited group members to give their own label or name to anger; in narrative approaches, clients' own experience and the way it is language is privileged in deciding what the 'problem' is (Zimmerman & Beaudoin, 2002). Chosen names included 'temper' and 'angry'. Lynggaard and Scior (2002) discuss the value of illustrations in assisting people with learning

¹ It might be noted that the extensive use of objective outcome measures is somewhat incompatible with a social constructionist approach. Indeed, some systemic authors (eg. Larnar, 2004) are critical of the "politics of evidence" critiquing the use of the devices of strictly controlled trials using well-defined issues. The authors do not seek to reconcile this tension, rather we would like to point out that this is a recognised aspect of working within the narrow definition of what constitutes an evidence base within the National Health Service, with its emphasis upon accountability, and commissioners' requirements for "systematic evidence reviews" to determine whether procedures should be paid for (Spring, 2007).

disability to concretise externalised language and from which to construct new accounts of the problem. We invited group members to draw this (e.g. Figure 1),



Figure 1. What does 'angry' look like?

thus providing a visualisation of the externalised concept. The illustrations in this document are the ones drawn by the authors in the sessions, but are illustrative of participants' drawings. We also started to develop an understanding of people's relationship to 'angry'; for example, one member described how it made them feel scared and anxious and "wasn't very nice" to them.

Phase Two: Exploring exceptions and unique outcomes

The aim of this second stage in the group was to help people begin to see themselves as authors in their own stories, and to develop a greater sense of agency. Through noticing unique outcomes to the problem, people are enabled to identify features that could establish a preferred alternative story and preferred identity. This is helped by employing a "grammar of agency" (Epston & White, 1992).

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Figure 2. "'Angry' doesn't like getting wet"

We invited group members to describe any times that they had noticed 'angry' "creeping up on them" but "beaten it just in time". This enabled us to celebrate 'unique outcomes' and express curiosity as to how people had managed to "trick" 'angry' instead. In many instances, we felt this gave meaning to moments of 'victory' that would otherwise have remained invisible. We linked these discussions to the externalised concepts, by illustrating the aspects of the 'exceptions' that had led to the 'unique outcomes'. For example, one member recounted that when they had a bath or went swimming, "'angry' went away", creating an alternative narrative of "'angry' doesn't like getting wet" (figure 2).

In line with the emerging alternative narratives, we started to think about the role of support networks in helping to beat 'angry', identifying allies and considering the ways in which the actions of others might either help or hinder 'angry' (e.g. Figure 3).

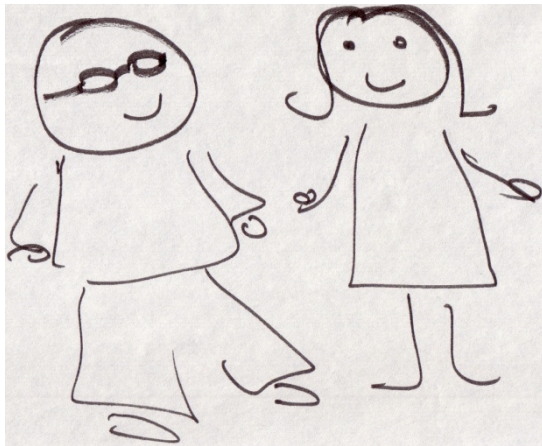


Figure 3. “‘Angry’ doesn’t like me talking to staff”

Phase three: Developing and anchoring the alternative narratives

Harper and Spellman (2006) discuss the use of therapeutic documents to summarise the effects of the problem and outlining the “emerging traces of an alternative story”, using clients’ own language and actual examples. We compiled the work from the sessions, using the participants’ words and pictures, into a book charting the development of the new story.



Figure 4. “I win! I beat ‘angry!’”

Epston and White (1992) describe the importance of circulation of emerging narratives and inclusion of others to anchor and continue the development of the alternative story. In the last session, we invited support workers and other staff to act as an audience as participants shared their new narratives. We also encouraged participants to shift their role to that of ‘consultant’ (Epston & White, 1990), recommending ways of beating ‘angry’ to staff. This created a context for the participant to extend their audience beyond the therapy room, to include their wider care circle, and to enlist their support as allies in the future.

The reconstructed narratives at the end of the group were extremely empowering, privileging self-actualisation and mastery (figures 4 and 5).

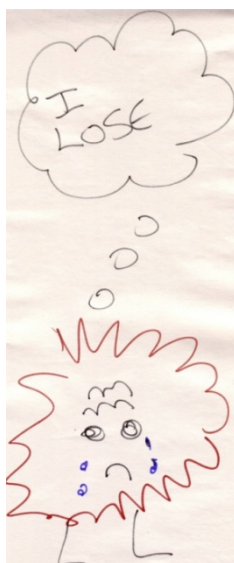


Figure 5. ‘Angry’ loses!

Outcomes

Outcome was assessed in part through monitoring subjective changes in participants’ narratives about themselves and ‘angry’. At the start of the intervention, ‘angry’ was always in control and there were “never” any occasions otherwise. By the end of the group, participants had recognised a number of unique outcomes and identified their own very real strengths and resources that helped them to beat ‘angry’, summarised in the remark by one participant that “I win, anger loses”. This created new self-narratives of people determined to ‘beat angry’ in extremely creative and resourceful ways. This change was noted and remarked upon by several professionals within the wider system; for example, one participant was pleased that his improved mastery over ‘angry’ was being demonstrated by having fewer recorded outbursts on his behavioural chart,

and that he was receiving positive comments on his behaviour.

The standardised measures were re-completed at the end of the intervention by two assistant psychologists, and were less conclusive, in that there were slight, but probably insignificant, gains in the scores that measured anger. These standardised outcomes were inconsistent with verbal self-reports and those of support staff. They also failed to agree with behavioural measures of aggressive behaviours being used in some settings, which showed a marked reduction. This may be a limitation of using questionnaires with this client group, although there is another intriguing possibility that, by feeling more in control of 'anger' people might have felt more able to own up to angry feelings. It is also likely that these measures are not sensitive to short-term changes, so a greater interval between assessment and evaluation would help to clarify this.

CONCLUSIONS

We feel that, despite the limitations of this being a small-scale piece of work, with inconclusive quantitative results, the qualitative reports from both participants and their wider care circle are extremely encouraging. Given the lack of any previous case studies in this area we feel that the outcomes of this group are promising and suggestive of the utility of narrative therapy for this client group. As already discussed the research in this area is limited, and further research to extend the evidence base available would be invaluable.

We had not set out to explicitly capture care staff evaluations of the group, but given the enthusiasm of the staff to share their thoughts, as well as the positive effect this had on participants, we would want to pay more attention to the systemic aspects of this style of therapy in future. Robbins (2004) suggests that the wider influences on self-perception and interactions are particularly important given the extensive numbers of people involved in a client's care in this group of people. The potential role of narrative therapy in examining and deconstructing professional discourses seems exciting, and suggests that an improvement for this style of group would be to build in an examination of these wider narratives from the start. We were also struck by narrative therapy's applicability to a client-group for whom such a narrow range of therapeutic techniques have been historically viewed useful.

We consider that the discourses around disability, and learning disability in particular, can be disempowering. The role of services and therapeutic approaches in maintaining a status quo where the individual is deprived of meaningful choice and agency should be more openly acknowledged and challenged. However a welcome finding from this limited study is that the same system can provide the basis for recognising, validating, and hopefully maintaining positive change.

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