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Anger Management: A Group Treatment Program for People with Mental Retardation

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This paper describes the development of anger management groups for people with moderate to severe mental retardation. The group was based on work developed by Novaco (1976) and extended to people with mild mental retardation. Modifications to group techniques, such as participants being accompanied by a support worker in the group and more effort to help participants label emotions, were required for this more disabled group. An evaluation of the group is described and it was found that a reduction in aggressive behavior occurred after group treatment. Suggestions are made for future efforts in this area.

KEY WORDS: mental retardation; anger; group therapy; cognitive therapy.

INTRODUCTION

Several surveys have shown that a large number of people with mental retardation have severe challenging behavior. For example, Kushlick and Cox (1973) found that 10% of children and 12% of adults in one district demonstrated "severely disruptive behaviors," that is, they may have been self-injurious, aggressive to others, destructive toward the environment, non-compliant, or generally disruptive. A more recent study (Kiernan, 1991) has placed the incidence of "challenging behavior" in a range from 7 to 17% of individuals in the population they surveyed. However, the frequency of such behaviors is probably not the main issue. Rather, it is the physical and psychological consequences of what may be relatively rare incidents that can persist long after an event and that can have a major impact on the individuals concerned. Other reports also suggest that people with mental retardation are more likely to have emotional difficulties than non-disabled people (Reiss *et al.*, 1982; Rutter *et al.*, 1970).

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Traditionally, much of the help offered to people with mental retardation has been in terms of management by others (e.g., the provision of medication or the manipulation of environmental variables). Many of the methodologies applied by psychologists have been based on the work of operant psychologists. This has tended to minimize the importance of the subjective awareness of the individual, making it at best irrelevant or another piece of information to be collected (Bender, 1993). Even though these approaches often achieve the desired outcome, they do not necessarily encourage appropriate self regulation by the individual. Consequently, when environments change, or it becomes impossible to continue medication, problems may recur.

The principal reasons that have been advocated for the denial of talking therapies to people with mental retardation is the belief by some therapists in the inability of people with mental retardation to comprehend therapeutic processes and techniques. This belief has its origins in the work of Freud (1953). Subsequent therapeutic developments have tended to ignore people with mental retardation as potential beneficiaries of treatment (Bender, 1993).

There is evidence that difficulties with anger control in people with mental retardation can be exaggerated by a number of factors. This is likely, for example, when it is combined with other difficulties such as poor communication (e.g., Durand, 1990), and when it interacts with an individual's living arrangements and ability to live as independently as possible such that it can lead to even more restricted opportunities (e.g., LaVigna and Donnellan, 1986). Additionally, people with mental retardation have been shown to be poorer at recognizing emotions (including anger) and situations that can influence emotions (Gray *et al.*, 1983; Maurer and Newbrough, 1987; McAlpine *et al.*, 1991). However, these special considerations do not seen adequate in themselves to restrict the further development and use of talking therapies with people with mental retardation.

THERAPEUTIC APPROACHES

In recent years, there has been a growing interest in a wider range of therapeutic approaches for people with mental retardation. This has been confirmed by a number of reviews of treatment strategies, particularly those involving self-management (e.g., Harchik *et al.*, 1992; Hurley, 1989). Support for the development of cognitive approaches with people who have mental retardation has come from cognitive therapists (Williams and

Moorey, 1989). One particular approach that has received attention is anger management. Most of this work is based on a model developed by Novaco (1976, 1978) in the United States. In this model, anger is seen as an emotional state with three principle components: physiological, cognitive and behavioral. These three components are all inter-related with both anger and the environment.

He also emphasized the importance of separating anger as an emotional state from aggressive behavior. Novaco contends that anger can be a problem when it is too frequent, too intense, lasts too long or if it results in aggression. Novaco's (1976, 1978, 1985) treatment approach consists of three stages: (1) Education — including emotion identification, determining the functions of anger, examining personal patterns of anger, devising provocation inventory, and developing a hierarchy of triggers; (2) Skill acquisition — developing skills such as interpersonal problem solving, arousal reduction, increased assertiveness, and improved communication. These are taught using structured role plays, self talk, relaxation etc.; (3) Combining 1 and 2 — evaluating whether the client will be able to cope with provoking situations using role plays and in vivo exposure.

This treatment approach has been shown to be effective with a number of groups. Some of these include people with mental health problems and particular at-risk occupational groups (e.g., police officers) (Novaco, 1979). Some studies have shown that these techniques are useful for people with mild mental retardation (Benson 1986; Black *et al.*, 1988).

The purpose of this study was to extend this basic treatment approach to individuals with more severe disabilities. A number of clients were treated by the author with some degree of success. However, individual work required a considerable amount of time. There were also issues about the difficulties of inclusion of staff in individual work. Suggestions have also been made previously that group therapy may be particularly suitable to people whose central problem is a damaged identity (Bender and Tombs, 1992; Hollins, 1992; Szivos and Griffiths, 1992). It was therefore decided to conduct a group which would use the trained therapist's time more economically. Further, it would provide a defined role for residential staff and care providers and offer opportunities for learning those therapeutic techniques more difficult to provide in individual therapy. Referrals were invited for a group with a focus on the reduction of aggressive behavior in people with mental retardation.

METHOD

Participants

Referrals were clients using the local learning disability service who were eligible if they met the following criteria: (1) they were experiencing problems with anger which had led to physical assault on other people and/or repeated damage to property; (2) they had a degree of receptive language such that they could understand simple directions and had a developmental age of 2 years 6 months or more on the BPVS (Dunn *et al.*, 1982); (3) they were able to sit with one of the group leaders on an individual basis for 10 min or more during an initial interview; (4) they could attend the group *with* a member of staff from their place of work or residence, who could also accompany them to and from home.

Assessment

On referral, a number of assessments were carried out which meant one or more therapists from the group went to see each person referred on at least one occasion prior to treatments. The house leader and keyworker involved would also receive one or more visits to explain the nature of and requirements of the group. Assessments were generally designed to facilitate a closer understanding of the individual's difficulties and were intended to help determine who the groups would be suitable for in the future. Assessments included: (1) structured interview, adapted from Benson (1992); (2) a test of emotional perception from faces (see Spence, 1980); (3) the British Picture Vocabulary Scale (BPVS), a test of Receptive Hearing Vocabulary (Dunn *et al.*, 1982); (4) a record of aggressive incidents that was maintained throughout the group treatment period and up to 3 months follow-up.

Aggression was initially defined as physical assault on others that may or may not have led to bodily harm; also included were incidents that led to actual damage to property of any kind. However, this definition was subsequently broadened to include verbal abuse which consisted of shouting loudly and/or swearing, and/or threats of physical violence to others.

It was deemed necessary to include incidents of verbal abuse, even though there are known difficulties with the reliability of recording such incidents (Reed, 1990). However, for some individuals, these incidents were viewed as major difficulties which needed to be reduced.

Incidents were recorded as a narrative, both in a separate log of incidents kept by staff, and in a diary kept by the participants with the assistance of staff. Incidents were recorded by residential or day service staff who were on duty when they occurred; they were generally unqualified care workers. However, discussions were always held between the head of the home and the care workers to define the recordings required. These recordings were collected from the homes and reviewed by two of the group leaders prior to inclusion in the results. Individuals concerned with data collection were aware of the intervention.

People were also asked if they wanted to decrease their aggressive behavior. All of the participants who agreed to attend the groups indicated that they would like to try and reduce their difficulties with aggression. Staff agreed to actively support the participants by providing transport, attending sessions, helping participants keep diaries, and regularly reminding participants about the work they were doing in the group while at home.

Research Design

Records of incidents were kept on each individual for at least 3 months prior to the group, during the group, and for at least 3 months after the group.

Procedure

Group sessions lasted one and a half hours, including a tea break. There were 16 sessions: ten weekly sessions, a 3-week break followed by six more weekly sessions.

Each participant was accompanied by a care worker from their residential home or place of work. In two cases, this was usually the head of the home; in the others, it was their keyworker. There were also two group leaders: one was a qualified and experienced clinical psychologist, the other an assistant psychologist with a degree in psychology. This resulted in a high staff ratio, generally seven staff to five clients, ensuring that most difficulties that arose could be dealt with. However, it was always made clear to both staff and participants that if they wanted to, they could leave the room with a staff member and go outside or to another quiet room that was left empty during the group. It was possible for two or more members of staff to accompany people if there were major difficulties.

Warming up

Sessions always included a warming up exercise, usually involving throwing a ball to each other, with the individual identifying themselves or the person to whom they were throwing the ball. This was of course very important in the early groups, and remained quite important throughout the group as it became seen as a focus which clearly identified the start of the group.

Winding Down

In a similar way, groups were always concluded with a relaxation exercise. This was based on behavioral relaxation training (Lindsay and Batty, 1986).

Initial Therapeutic Input

This concentrated on defining individual difficulties with anger and the importance of anger in their lives. Considerable effort was also directed toward working on identifying emotions and factors that influenced emotions.

Defining individual problems was accomplished via self-monitoring diary. Individuals who could not write themselves were expected to sit down with someone else either at their place of work or home at the end of each day and review what had gone on. Initially they were particularly encouraged to mention positive events and things that had made them happy. It was only after the group had been going for several weeks that they were encouraged to discuss things that made them sad and angry.

By monitoring individual emotions and responses in the form of a diary, it was possible for the participants, staff who accompanied them, and group therapists to develop a functional analysis of the participants' behavior. By examining a variety of situations, it became possible for everyone involved in the group to develop an understanding of the behavior of the participants, both in terms of what was likely to please them, and to trigger and maintain aggressive patterns of responding.

A number of techniques were used to examine emotions. These included photographs from newspapers, pictures inviting people to add why they felt happy/sad/angry (Picture my Feelings, 1989), and a video which had been previously used in social work training exercises (Understanding and Controlling Violent Situations, undated). This demonstrated people who

had become angry for a variety of reasons. Emotions were identified and attempts were made to associate emotions with events by referring to both participants' and others' experiences. Early sessions were, therefore, used to: (1) identify and assess individual problems, (2) examine factors that were triggering and maintaining various behaviors, and (3) teach some of the terminology and concepts required for developing the work in greater detail.

Later Therapeutic Input

As the sessions progressed, we moved onto step 2 of Novaco's program. For this group, we role played situations that may cause problems, including both inappropriate (aggressive) and appropriate (nonaggressive) responses. A variety of responses were role played and discussed, emphasizing the inappropriateness of the range of possible responses. A video was used for immediate feedback and group discussion. This procedure enabled the therapist to provide a problem-solving framework for participants.

Role-plays gradually became more challenging, incorporating situations that were difficult for participants, and also using members of staff who worked with them where appropriate. Again, a range of responses was provided and the advantages of a nonaggressive response were emphasized.

Since a staff member accompanied each group member, it was possible for them to explain to other workers how to develop and encourage appropriate responses at home. Using staff in the home situation to remind individuals about the anger management group and its purpose, could also reduce aggressive behavior, thus, gradually introducing step 3 of Novaco's treatment.

A number of other cognitive approaches were carried out in the group. These included: (1) improving self-awareness of cognitions using self-statements to moderate anger, and (2) thought-stopping techniques.

RESULTS

Six people were selected for the group, four men and two women, with an age range from 21 to 43 years (mean 35 years). Sessions were well attended by both staff and participants. One person dropped out of the group after four sessions. Staff failed to continue collecting his data and, consequently, he is not included in the analysis. Of the other individuals, two attended every session, two missed two of the sessions and one missed four sessions (primarily due to insufficient staff to bring him).

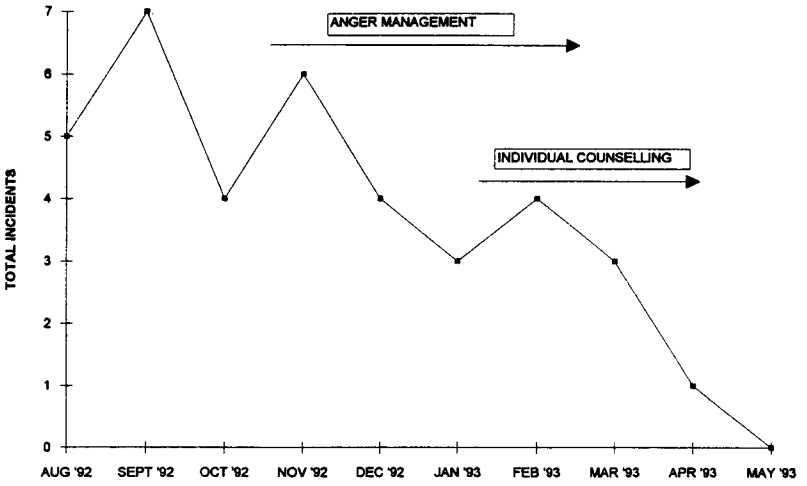

Fig. 1. Participant 1.

Participant 1

This participant was a 33-year-old woman who lived in a small group home with three other residents and attended a day center 5 days per week. Staff were available at any time to assist her. However, she was independent in many self-help skills and locally in the community. Her score on the BPVS was 76, equivalent to a receptive vocabulary of approximately 8 years 2 months. Her difficulties were mainly confined to verbal abuse and property damage, with occasional assaults on others. Difficulties were most likely to occur in situations where considerable social demands were placed on her and at times when changes were required, such as in her day center routine. She enjoyed participation in the group, but it was unclear that what she learned was fully implemented, as the staff who accompanied her did not work closely with her at home. She had some difficulties in accepting group termination, which required considerable discussion both in and out of the group. While recognizing some of these problems, it was possible to provide six individual sessions of counseling aimed at introducing the work of the group to her immediate care providers and at helping her develop the techniques in her home environment.

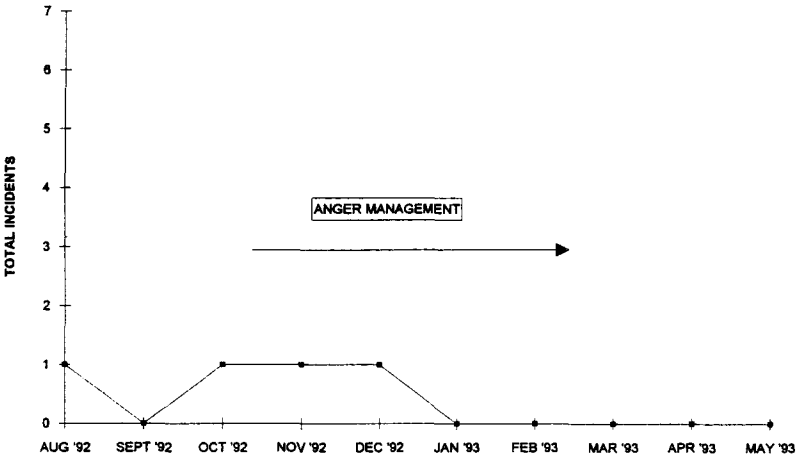

Fig. 2. Participant 2.

Data collected by her carers are shown in Fig. 1. All of the figures were generated using software developed by Groves *et al.* (1992).

Participant 2

Participant 2 was a 38-year-old man who lived in another small group home with four other people. He also attended a day center and staff were available to assist him at all times. He had significant difficulties with his hearing and restricted movement in his hands. He was also quite limited with his verbal expression and only scored 22 on the BPVS (equivalent to receptive vocabulary of 2 years 9 months).

His aggressive outbursts were relatively infrequent; however, when they did occur, they would usually result in physical assault on other people. Incidents would often occur at busy times, and may have resulted from his inability to express views or understand other people. He was a keen and active participant in the group, as were staff from his residence. He seemed to make active use of the techniques he acquired in the group at home and in the day center. Staff who worked with him commented that, after the group, he was much more willing to both try and understand what others were saying to him and make himself understood (see Fig. 2).

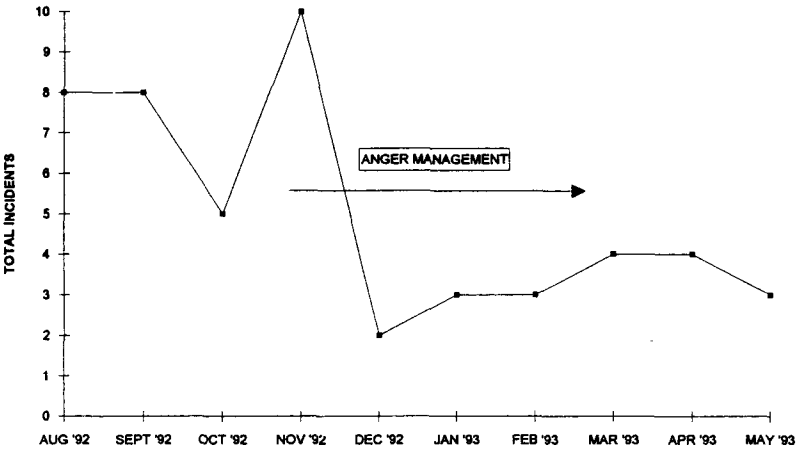

Fig. 3. Participant 3.

Participant 3

Participant 3 was a 43-year-old man who lived with two other residents in a small home that was part of a larger residential campus. He had a range of self-help skills in the home, but needed to be escorted outside. His BPVS score was 32 (3 years 8 months). His day service was provided by an occupational therapy department. The accommodation was fully staffed. He had been institutionalized for many years. He frequently physically assaulted other people and also damaged property. Incidents would often occur during periods of inactivity or when events that he had expected to occur did not, such as people visiting him and going out, even if the events were not planned to happen.

This man participated in many of the social aspects of the group and adapted the relaxation techniques to his home setting. However, his attendance was less regular than other participants due to staff shortages in his residential setting (12/16 sessions), but there was still a decline in the number of incidents over the course of the group (Fig. 3).

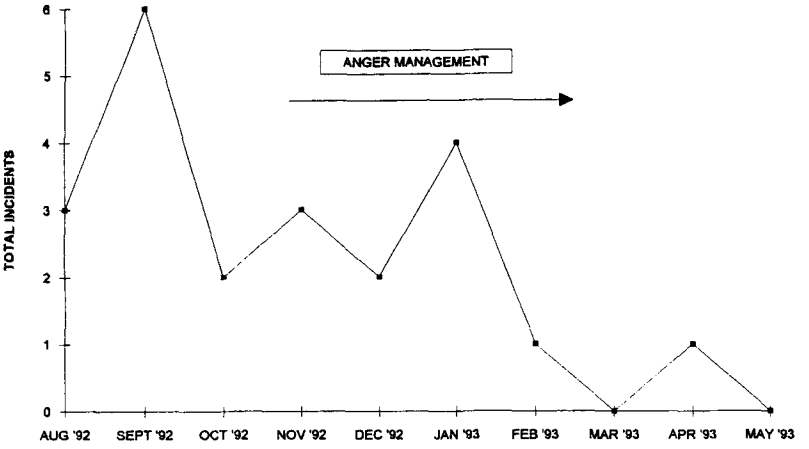

Fig. 4. Participant 4.

Participant 4

This person was a 28-year-old man who lived at home with his parents and attended a day center. He had all the necessary basic self-help and some academic skills, and may have been more independent. However, his parents did not want him to leave home or the day center unescorted. His BPVS score was 85 (9 years 3 months). He came to the group with day center staff, but also had difficulties at home.

He had long-standing outbursts of aggression that had recently increased in frequency. These included physical assault on staff in the center, his parents and other service users. However, incidents usually involved property damage and verbal abuse. Incidents were often related to demands being made of him and changes in routine. He was initially reluctant to participate, but agreed to take part on condition that he did not appear on video. Close links were also maintained between his parents and one of the group therapists, but care was taken to include the participant in these discussions. Reductions in assaults were recorded both at home and in the day center (see Fig. 4).

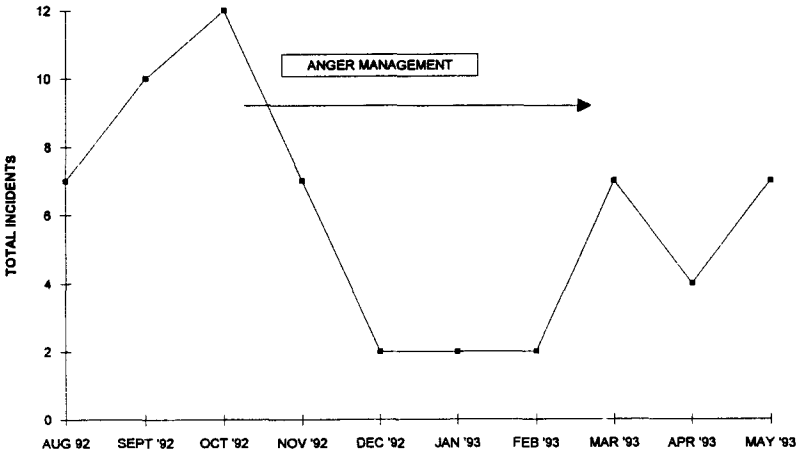

Fig. 5. Participant 5.

Participant 5

Participant 5 was a 21-year-old woman who lived with eight other people in a community home and intermittently attended a day center. Staff were always available to assist. She was relatively immature and needed considerable assistance outside of the home. Her BPVS score was 73 (7 years 10 months).

She was frequently verbally abusive, more rarely damaging property and/or other people. She had only moved to her new home a few months before and there were clearly some issues about her settling into her new accommodation. However, incidents were also clearly related to requests being made for her to participate in new and routine activities.

She was relatively quiet in the group and had to be encouraged to participate. However, she was well supported by staff from the community home who encouraged her to apply the techniques she learned at home. Yet, she tended to become more withdrawn as the group progressed. Incidents of verbal abuse were replaced by passive noncooperation with staff. Even though it was agreed that this could be a rather more adaptive response, it made life very difficult for residential staff. After considerable discussion and consultation, it was decided to look for another residential placement some time after the group finished. Her results are shown in Fig. 5.

General Considerations

All of the individuals who attended the majority of sessions showed fewer incidents at follow up than in the 3-month baseline period. Another general characteristic of the participants was that, prior to the group, the amount of time which elapsed between a trigger and an aggressive response was generally very short, at most a few seconds. One important feature of the therapy reported by staff was a general increase in time between trigger and response, thus providing an opportunity to develop more appropriate responses. However, an accurate measurement of this period of time was not obtained.

In general, it was found that role play was the most useful technique employed in the group. This was used to enact incidents that had led to both nonaggressive (constructive) and aggressive outcomes. A range of alternatives to an aggressive response was developed through brainstorming and role play. Initially, incidents leading to aggression were only role-played by accompanying members of staff and therapists. However, clients were encouraged to both role-play themselves coping with incidents in a nonaggressive way, and to role-play staff members who might be working with them. All of the group participants were able to take part in role plays as either themselves or members of staff.

Other cognitive techniques were introduced. These included using positive self statements. Unfortunately, none of the group were able to remember complex statements. A therapist attempted to work with participants by whispering positive statements in their ear during the role play, but this resulted in some considerable confusion. However, asking individuals to pair simple relaxation techniques (deep breathing, concentrating on the word "relax") with various individual triggers during role plays seemed to have an effect. Three of the participants reportedly used this technique on a number of occasions outside of the group.

Participants only achieved very low scores on the Spence (1980) test for perception of facial expression, both before and after the group. In future groups, it may be more useful to use simpler tests of emotional expression specifically designed for people with mental retardation (e.g., Benson and Ivins, 1992; Reed and Clements, 1989).

DISCUSSION

The results suggested that this therapeutic approach can be successful with people who have more severe mental retardation. Involving people

with mental retardation in their own treatment in an active way seemed to provide them with ownership of the problem and motivation to change their own behavior. If the groups are not successful by themselves, they can help in the diagnosis of problems and lead to additional therapeutic interventions. These can come from the individuals running the group, but can also involve other accompanying members of staff who work more closely with the participants and can develop skills by attending the group. It appeared that the most significant results were achieved when both clients and staff attending the groups showed commitment to the group and the procedures used.

All of the people attending the group seemed to have improved in that the number of incidents of aggressive behavior decreased. Even though problems were considerably reduced only one person showed a complete absence of incidents in the three month follow up period (the person with the lowest BPVS score). Hopefully, improvements would be maintained, but this indicates that a longer period of treatment may be beneficial.

The success of the group treatment may have been attributable to some overlap in the types of antecedents that would often trigger incidents in the individuals who attended, with changes in routine and demand avoidance being important antecedents for three individuals. They may have been able to learn from each other and from others' role-plays more effectively. The possible increase in time between antecedents and behavior reported by staff is also potentially important, as this is a feature of Novaco's therapy which increases the time available for appraisal of a situation to produce a more adaptive response. In this case, however, it may be that staff are now able to manage the situation more skillfully using the information they have gained from the group.

In future evaluations, it will be important to develop record keeping procedures, possibly introducing blind raters to assess the records kept by care staff, and to introduce a system of inter-rater reliability. It will also be important to try and develop a controlled trial to determine the effectiveness of these groups, possibly keeping a waiting list of people who need similar treatment. Unfortunately, this will be very difficult to do as the people in the group showed problems of such severity that they could have been removed from their homes or day services if problems had persisted, necessitating the use of other therapeutic interventions if anger management had not been available. It would also have been useful to keep records of additional interventions, such as medication and the provision of additional staff support, to see if the group reduced the need for these types of services.

Another important question that arises from this work is what is the mechanism of change for the individuals in the group? Is it a cognitive (therapeutic) process? Even though I have been trying to apply Novaco's model, the full range of therapeutic approaches used by Novaco is difficult to apply with people who have more severe disabilities (they may be useful with further adaptation). The techniques which seemed to be most effective were behavioral or educational in nature (e.g., teaching emotional recognition, role play and relaxation). However, using these techniques in a problem-solving framework ensured a greater emphasis on self-regulation and ownership by group participants than many other forms of therapy. A reformulation of the theoretical conceptualization of this approach may be useful, possibly in terms of rule-governed behavior and self regulation (Catania *et al.*, 1990; Whitman, 1990; Zettle and Hayes, 1982). Clearly, further work on integrating clinical and theoretical approaches in this area would be interesting and potentially valuable.

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