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Carer reports of the efficacy of cognitive behavioral interventions for anger

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ABSTRACT

Anger resulting in Aggression can be a significant problem for some people with Intellectual Disabilities. Carers were asked to complete a provocation inventory and an attribution scale before and after a group cognitive behavioral intervention aimed for anger and at similar points in time for a waiting list control. When compared using an analysis of variance results suggest that staff perceive a significant reduction in aggressive responses for participants who took part in the intervention. A regression analysis of factors that may influence the amount of change observed suggests that greater change was achieved if participants were accompanied by carers and had been attributed by carers as having an emotional cause for their behavior.

1. Introduction

Aggressive behavior can have a significant impact on quality of life of an individual and can also have an impact on the psychological well-being of their carers (e.g. Hassall, Rose, & McDonald, 2005; Jenkins, Rose, & Lovell, 1997). It can also impact on the quality of care provided by staff (Rose, Jones, & Fletcher, 1998). Aggression is relatively common in people with Intellectual Disabilities with a range of estimates of prevalence varying from 10 to over 50% (Benson & Brooks, 2008). Aggression in adults can have multiple functions (Benson & Brooks, 2008) and has been traditionally been treated within a psychopharmacological or within a behavioral framework. Reviews suggest that there is evidence to support the use of behavioral treatment methods (e.g. Didden, Duker, & Korzilius, 1999; Emerson, 2001; McClean, Grey, & McCracken, 2007) but less conclusive evidence for psychopharmacological methods (e.g. Brylewski & Duggan, 1999; Edwards, Lennox, & White, 2007).

While a behavioral approach may remain the most appropriate treatment option for some people with Intellectual Disabilities over recent years there has been a greater emphasis on using cognitive behavioral approaches (Lindsay & Hastings, 2004). Cognitively based anger control packages of treatment for people with learning disabilities have been the subject of a number of studies evaluating their efficacy from the participants perspective (e.g. Benson, Rice, & Miranti, 1986; Burns, Bird, Leach, & Higgins, 2003; Lindsay et al., 2004; Rose, Loftus, Flint, & Carey, 2005; Rose, Dodd, & Rose, 2008; Taylor, Novaco, Gillmer, & Thorne, 2002). Other studies have found reductions in expressed anger of participants by evaluating the groups from a carer perspective (King et al., 1999; Willner & Tomlinson, 2007; Willner, Jones, Tams, & Green, 2002). More recently a study has shown that the skills and strategies learned by individuals in a day service setting can generalize to residential settings using staff ratings across different contexts (Willner & Tomlinson, 2007). While many of these studies

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suffer from significant weaknesses in design such as small numbers and the lack of an effective control group, all of them demonstrate reductions in either measures of aggression or expressed anger as a result of intervention. The conclusion of reviews (Hassiotis & Hall, 2008; Taylor, 2002; Whitaker, 2001) are that while methodological difficulties exist the evidence suggests that these treatments show some promise.

The mechanism for change remains unclear with some authors suggesting that only the behavioral elements of these interventions are effective in changing the behavior of people with Intellectual Disabilities (Sturmey, 2004). However, whatever the psychological mechanism is for change, therapeutic interventions based on cognitive behavioral models provide a methodology that values the individual and includes them at the centre of the change process. Some studies have used direct care staff within the therapy and there has been a suggestion that involving carers in anger interventions could enhances treatment-outcomes. Rose et al. (2005) also found that individuals with a greater receptive vocabulary tended to assess themselves as reducing their expressed anger more than others. This finding is supported by Willner et al. (2002) who found a positive correlation between general intelligence and improved outcome.

Weiner's (1980) model of helping behavior suggests that if staff perceive challenging behavior to be under the personal control of an individual, then this is more likely to provoke negative emotions, such as anger, and results in them offering less help. In contrast, if the cause of challenging behavior is not judged to be under the individual's control it is more likely to provoke a greater willingness to help. Evidence exists for the application of Weiner's (1980) model to ID services (e.g. Dagnan, Trower, & Smith, 1998; Wanless & Jahoda, 2002) although some researchers have argued that it needs to be adapted (Bailey, Hare, Hatton, & Limb, 2006; Jones & Hastings, 2003). Phillips and Rose (2010) have found that staff attributions of challenging behavior are related to placement breakdown. That is, when staff perceive clients to be in control of their challenging behavior their residential placement is more likely to break down even if reported levels of challenging behavior are similar. Other methods of assessing attributions also exist for example, Hastings (1997) developed the Challenging Behavior Attribution Scale that asks care staff why individuals with Intellectual Disability might engage in challenging behavior. The CHABA has six subscales and Grey, McClean, and Barnes-Holmes (2002) found that the learned positive and emotional subscales were most likely to be endorsed by staff as attributions for challenging behavior. That is, the staff would attribute the behavior to either positive reinforcement processes or emotional reasons. This suggests an association between staff attributions and the expression of aggression in people with Intellectual Disability that would be interesting to explore in relation to cognitive behavioral intervention programs.

This paper aims to examine changes in carer ratings and attributions of individuals they care for over the course of a therapeutic group based on a cognitive behavioral model that aimed to help them manage their anger more appropriately and to reduce inappropriate aggression. It was hypothesized that greater change would result if clients were accompanied by staff and if they were more able. It was also suggested that carer attributions of client behavior may influence outcome however no specific hypotheses were made in respect of what attributions may be important.

2. Method

2.1. Participants

Referrals were invited by three community clinical psychology departments, all within the British National Health Service, for a group with a focus on the reduction of aggressive behavior in people with Intellectual Disabilities. One of the departments served an urban borough, another a large city and the other a mixed rural and urban population. Participants were all registered clients of community Intellectual Disability services. All participants were experiencing problems with anger leading to aggression and were referred to specialist psychology departments for people with Intellectual Disabilities.

The problems being experienced by participants included: aggressive physical contact – aggressive physical contact from a service user towards another individual irrespective of whether or not this resulted in injury, for instance, hitting, slapping, scratching, biting, throwing objects at you, hair pulling, spitting, or grabbing at clothing. Threats of violence – threats of violence, including, verbal threats of violence, physically threatening violence, either with gesture, or by physically threatening with overt behavior, e.g. punching the wall or overturning furniture. Verbal Aggression – Incidents where the service user was verbally abusive including, swearing, shouting, screaming, calling names, or being personally insulting towards another person.

Everyone had to attend willingly and express an interest in controlling their anger. The study was reviewed and approved by the appropriate review committees.

Forty-three people were included within six groups however six people dropped out during the course of therapy. Unfortunately, it was not possible to collect further data on individuals who dropped out. This left 37 people included within the groups, 26 men and 12 women. Sessions were very well attended by participants. Nineteen people were included in a waiting list control, 16 men and 3 women. Characteristics of individuals on the waiting list were similar to the intervention group. For example, the mean age of the intervention group was 38.0 years (range: 18–66) and that of the control group was 38.5 years (range: 17–66). They were also assessed using the British Picture Vocabulary Scale (BPVS), a test of Receptive Hearing Vocabulary (Dunn, Dunn, Whetton, & Burley, 1997) mean scores on this measure for the intervention group on this measure were 70.45 (range: 24–112) and 68.00 (range: 28–100) for the control group. This was consistent with participants having a moderate to mild degree of Intellectual Disability. No differences were found between groups when these data were compared using a MANOVA.