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Peer with intellectual disabilities as a mindfulness-based anger and aggression management therapist

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ABSTRACT

A young man with intellectual disabilities (ID) and mental illness, who had previously been taught to successfully manage his aggressive behavior by using *Meditation on the Soles of the Feet*, reported that he shared his mindfulness practice with his peers with ID. When requested by his peers, and without any training as a therapist, he began to teach this procedure to his peers for controlling their anger and aggressive behavior. We tracked the anger and aggressive behavior of three of the individuals he taught and the fidelity of his teaching of the procedure. According to self and staff reports, anger and aggressive behavior of the three individuals decreased to very low levels within five months of initiating training and remained at very low levels for the two years during which informal data were collected. The fidelity of his teaching the procedure was high, if one allows for his idiosyncratic teaching methods. These findings suggest that individuals with mild ID, who have mastered an effective mindfulness-based strategy to control their aggressive behavior, may be able to teach their peers the same strategy to successfully control their anger and aggressive behavior to a level that is acceptable for community living.

1. Introduction

Individuals with and without intellectual disabilities (ID) exhibit anger and aggression (Potegal, Stemmler, & Spielberger, 2010). Anger is an emotional arousal state that has response-activating functions and often leads to aggression as a behavioral outcome (Bandura, 1973, 1983; Del Vecchio & O'Leary, 2004). Anger is often linked to a broad range of psychopathology in both institutionalized and community settings (Novaco, 2010). Although research is typically silent on the extent of anger evidenced in individuals with ID, prevalence surveys indicate aggression levels between 35% and 38.2% in institutions and 9.7% and 17% in the community (Novaco & Taylor, 2004; Taylor, 2002). Individuals with ID typically have restricted opportunity for community involvement and socialization (Kampert & Goreczny, 2007), and even this low level of participation is at risk when they exhibit anger and aggression in social contexts. Furthermore, the frequent expression of anger and aggression often has negative health outcomes that may affect their long-term wellness (Suinn, 2001).

Reviews of current treatment literature suggest that psychopharmacological and psychosocial interventions are the mainstay of anger and aggression management in individuals with ID (Brosnan & Healy, 2011; Matson, 2009; Matson &

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Neale, 2009; Singh, Lancioni, Winton, & Singh, 2011). Although the new generation antipsychotics (e.g., risperidone, aripiprazole, and olanzapine) are used fairly frequently, especially in institutions, the evidence that they may be useful in reducing aggression in this population is limited. Also, while there is a hint in the literature of beneficial effects on aggression with some antidepressants (e.g., fluvoxamine, fluoxetine, and sertraline), the data are too sparse for drawing any general conclusions about the effectiveness of antidepressants for controlling aggression in this population (Singh, Lancioni, Winton, et al., 2011). In general, however, clinicians have been advised to be cautious in using psychopharmacological agents to treat aggression in individuals with ID because the evidence base for their effectiveness is limited, and the risks associated with the drugs may outweigh their effectiveness (Matson & Wilkins, 2008; Tyrer et al., 2008).

In contrast to psychopharmacological interventions, behavioral interventions have a much stronger evidence base for their efficacy in treating aggression exhibited by individuals with ID (Brosnan & Healy, 2011; Singh, Lancioni, Winton, et al., 2011). Typically, effective behavioral interventions are based on assessed functions of the aggressive behavior in specific contexts. Behavioral interventions focus not only on reducing or eliminating the aggressive behavior, but also on teaching the individual alternative means of achieving the same ends as those produced by the aggressive behavior. In general, the majority of effective behavioral interventions have used three kinds of strategies: antecedent, instructional, and contingency management (Brosnan & Healy, 2011; Singh, Lancioni, Winton, et al., 2011).

Both behavioral and psychopharmacological interventions for challenging behaviors, such as anger and aggression, rely on external agents (e.g., parents, caregivers, and teachers) to administer the programmed contingencies or medications. However, the zeitgeist is to encourage individuals with ID to learn self-management skills that will enable them to regulate their own behaviors and to achieve self-selected goals (Singh et al., in press), and researchers have been exploring the effectiveness of self-management skills in treating anger and aggression (e.g., Taylor, Novaco, Gillmer, Robertson, & Thorne, 2005). Self-management procedures avoid problems of generalization and maintenance because individuals are able to use the procedures in multiple settings, provide immediate self-reinforcement, and apply them to covert behaviors, thoughts, and feelings. Thus, these procedures appear to be ideal for community living.

In a series of studies, we have tried to demonstrate the effectiveness of *Meditation on the Soles of the Feet* (SoF), a mindfulness-based procedure, in assisting individuals with ID to self-manage their challenging behaviors (Singh et al., in press). For example, it has been shown to be reasonably effective for the self-management of aggression, disruption, and property destruction by individuals with ID, including those with autism (Singh, Lancioni, Manikam, et al., 2011) and Asperger syndrome (Singh, Lancioni, Singh, et al. 2011). This procedure requires an individual to divert attention from an emotionally arousing thought, event, or situation that may lead to aggressive behavior, to an emotionally neutral part of the body – the soles of the feet. The individual learns to stop, focus the mind back on the body, calm down, and then make a choice about how to react to the thought, event, or situation that triggered the aggressive behavior. This procedure provides the individual with an internalized response that is portable, easy to master and can be accessed in almost any situation.

In the original study, we taught a 27-year-old man (James) with mild ID and mental illness to use SoF to control his aggressive behavior so that he could be discharged from a psychiatric hospital to community living (Singh, Wahler, Adkins, & Myers, 2003). Once he mastered the procedure, he used it fairly consistently in situations that would normally have elicited an aggressive response from him. In time, he was able to manage his aggressive behaviors, meet the community provider's requirement for six months of aggression-free behavior in the psychiatric hospital before being transitioned to the community, and then successfully live in the community without re-admission to the hospital. A 12-month follow-up showed he did not engage in aggressive behavior once he transitioned to the community.

We kept in touch with James informally following the termination of the study. After he had been living in the community for some time, he informed us that when asked by his peers how he managed his aggression and if he would teach them the same procedure, he did so with great enthusiasm. Apparently, he had taught two of his peers with ID the SoF procedure before he told us about it. When asked why he had not informed us earlier, he said that he was uncertain as to what we would think about him passing on what we had taught him. When we told him we were delighted he was passing forward what he had learned, he quietly mentioned that he was uncertain if he was teaching the procedure correctly. Furthermore, he asked if we could assess his teaching of the SoF procedure to his peers and assist him to become a better "therapist." In this study, we report on the efforts and outcomes of James as a therapist, in teaching SoF for anger and aggression management to three new peers.

2. Method

2.1. Participants

Three adults with mild ID participated at their own request. All three were friends of the therapist, had noticed how he was able to control his anger and aggression and had requested he teach them the coping skills that he used. Each one had anger and aggression issues at work, although to varying degrees. None was on any psychopharmacological, behavioral, or any other treatment program for aggressive behavior. All participants and the therapist lived in the community and, to protect their privacy, we have given them pseudonyms below.

Joshua was a 29-year-old man who had never been institutionalized, lived with his parents for most of his life and had transitioned to a supported living placement at the age of 26. He received special education for 10 years and was subsequently placed in supported employment in a fast food restaurant where he was employed as a busboy (i.e., he was