'I don’t wanna be mad and sad’: Using individual systemic therapy to help manage anger and low mood in an adult with a learning disability

Accessible summary

- People with learning disabilities may find it useful to speak to a therapist if they struggle with difficulties like anger and low mood.
- Instead of seeing problems as being within the individual, some therapists think about how other people and wider relationships impact on a person’s well-being. This is called ‘systemic therapy’ as it thinks about the wider systems (like family, work, and social care teams) and how they can make difficulties better or worse.
- There is limited research that looks at systemic therapy with people with learning disabilities, which is surprising because individuals may have many different relationships with friends, relatives and people in different services.
- Some of the techniques that help things to change include: the therapist being curious, asking specific questions to help the individual think about their situation, and working with the individual to find a different way of looking at problems.

Abstract

People with learning disabilities have historically been overlooked in research investigating the efficacy of therapeutic interventions, despite the increased prevalence of mental health difficulties among this population. As it is not uncommon for individuals with learning disabilities to be part of different relational systems (including access to a range of services), it seems logical to consider wider systems when seeking to understand

difficulties that individuals may experience. Whilst it is encouraging that there is growing interest in the use of systemic interventions for people with learning disabilities, there is limited peer-reviewed research exploring psychological difficulties from a systemic lens. This paper seeks to address the gap in literature by presenting a case where individual systemic therapy is used to help an adult with a learning disability to manage low mood and anger. The paper documents the therapist's clinical decision-making and learning from this case, with the hope that it encourages others to consider systemic interventions for people with learning disabilities in future.

Key words: Individual systemic therapy, learning disability, anger, low mood

Theoretical/Research basis

People with learning disabilities (LD) face an increased risk of developing serious mental health issues (White, Chant, Edwards, Townsend & Waghorn, 2005). NICE (2020) recognise that mental health problems are common among individuals with learning disabilities, yet the therapeutic needs of this population are frequently overlooked, with NICE guidance rarely including considerations for working therapeutically with this population. Those with comorbid learning disabilities and mental ill health are identified as a population with both high unmet need (Torr, 2013) and experience of unacceptable health inequalities (Turner, 2011). It is widely recognised that those who belong to marginalised groups, such as individuals with learning disabilities, face overt and covert discrimination in their interactions with institutions (Atkins, 2016). The process of receiving a clinical mental health diagnosis for those with learning disabilities can, for example, be hampered by (i) issues relating to an individual's capacity to participate in

clinical assessments (White et al., 2005), (ii) their capacity to provide informed consent to participate in therapeutic interventions (Goldsmith, Skirton & Webb, 2008) and (iii) professionals' concern about acquiescence (Finlay & Lyons, 2002).

Individuals with learning disabilities often encounter multiple relationships with health and social care professionals or 'experts', who seek to guide families from dysfunction to healthy stability (Fredman, 2006). Although some argue that learning disabilities are socially constructed (e.g. Haydon-Laurelut & Jones, 2019), the disabling discourse that has arisen from the medical model promulgates the learning disability as the defining characteristic of individuals (Haegele & Hodge, 2016), thus implying that impairments within the individual need to be 'fixed'. The language used by professionals' influences both their expectations of and interactions with people with learning disabilities (Barton, 2009). This can, if not attended to, increase power differentials between individuals with learning disabilities and professionals delivering support for mental health difficulties.

Historically, clinicians have questioned the applicability of mainstream models of individual or group therapy for individuals with learning disabilities (Mason, 2007). While there is an expectation for clinicians to offer evidence-based interventions (BPS, 2019), the sparse evidence base subsequently places responsibility on clinicians to adapt interventions to best meet the needs of people with learning disabilities. NICE (2018a) generally recommend that specialist support should be provided by community learning disability teams to meet the mental health, social and communication needs of individuals who have 'behaviour that challenges' (p.1). However, to date, there are only three specific

interventions that NICE (2018b) recommend, including adapted CBT for depression if the person has a mild learning disability, relaxation therapy for the treatment of anxiety, and graded exposure to treat phobias or anxiety symptoms. Yet each of these recommendations places the onus on the individual to change their thinking or behaviour to manage *their* difficulties rather than understand any difficulties in the context of relationships with others. Given that people with learning disabilities may require support from wider systems, including health, education and social care, it seems cogent to consider therapeutic interventions for mental health difficulties that understand individuals' relationships with the wider system (Bronfenbrenner, 1979).

There is growing interest in the application of systemic therapy for individuals with learning disabilities (see Kaur, Scior & Wilson, 2009 for an overview of systemic work with this client group), with studies demonstrating the effectiveness of systemic work with families where a member has a learning disability (Baum, 2006), particularly in relation to stress and coping. However, research is still in its infancy (Johnson, 2016), and it comprises a range of non-peer reviewed studies that are critiqued for being overly descriptive and focused on single case examples (Johnson, 2016). In the absence of a strong body of LD-specific systemic research, it is necessary to examine the systemic evidence for treatment of low mood and anger in the wider adult population.

Stratton's (2016) evidence base of family and systemic practice identified that systemic therapy is effective in multiple domains of functioning, including improvements in mental health difficulties and family outcomes, with long-lasting positive effects (Sawyer &

Borduin, 2011). Carr (2014) also advocates the use of systemic therapy for people with depression, which is endorsed by NICE, who also recommends family therapy for adults with depression (AFT, 2016). Further support for systemic therapy for low mood is provided by von Sydow, Beher, Schweitzer & Retzlaff's (2010) meta-content analysis of 38 randomised controlled trials (RCTs), which found 34 of 38 studies to be efficacious for mood disorders, with positive changes remaining stable during the 5-year follow-up.

Greater attention appears to be paid to systemic interventions for mood than anger, which has traditionally been defined as a problem located *within* the individual with little reference to the context, relationships or wider systems (Lynggaard, 2017). It has been more than 25 years since Novaco (1993) invited clinicians to view anger contextually, but, until relatively recently, surprisingly little has been written about anger in adults from a systemic perspective, with even less focus on anger in adults with a learning disability. As Taylor & Novaco (2005) denote, emotions such as anger are often overlooked in people with learning disabilities, with greater emphasis paid to aspects of challenging behaviour that impacts on others. Bertrando & Arcelloni (2018) suggest that anger may have an essential protective systemic effect, i.e. feeling anger makes it difficult to perceive other emotions that increase feelings of vulnerability.

Despite the scant literature on systemic therapy interventions for people with learning disabilities who experience low mood and anger, Baum (2018) argues that systemic approaches could be effective *if* adapted to meet the needs of this client group. NICE (2019) stipulate that psychological interventions should be tailored to meet the preferences, level

of understanding, needs, and strengths of individuals with learning disabilities. This is particularly important in reducing issues of power and difference (AFT, 2019). Reductions in power differentials in therapy can be achieved through the co-creation of meaning, by offering choice and by including multiple perspectives, which can be achieved with systemic approaches.

Systemic literature has predominantly focused on work with couples and families, with Tramonti & Fanali (2015) suggesting that the field of systemic therapy with individuals has largely been neglected. Some may question the compatibility of systemic interventions with individuals, particularly as systemic thinking offered a shift in perspective from individuals to relational systems, with 'the primary concerns of systemic therapists (being) with patterns of relationships in human systems, and understanding problems in context' (Jenkins & Asen, 1992, p.2). However, even in the early days, the Milan school of systemic practitioners recognised the need to work with individuals when it was not possible to convene the family (Boscolo & Bertrando, 1996). In such instances, Bateson's notion of systemic wisdom can be used to bring the voices of other important members of the network into the room (Hedges, 2005), by utilising the principles of neutrality, circularity and hypothesising in individual settings (Tramonti & Fanali, 2015). Unlike other therapeutic modalities, which place responsibility for change with the person seeking therapy, systemic work with individuals recognises that 'problems develop through a process of mutual communication: (where) nobody is to blame' (Hedges, 2005, p.20). To date, there is a dearth of literature of individual systemic work with people with learning disabilities. This case study seeks to add to the literature by presenting the case of Polly

(pseudonym), who engaged in 11 individual systemic therapy sessions and one family meeting.

Introduction to the case

Polly is a White British female in her 20s, with a mild learning disability. She lives with her Mum, Step-Dad and one sibling, the sibling's partner and their children. Polly's Dad lives with 'his other family' in a different country but he visits occasionally to see Polly and her siblings. Polly's other siblings live a substantial distance from Polly, and each sibling has a long-term partner and children. Polly enjoys being an auntie to her nieces and nephews. Despite the geographical distance, Polly describes her family as very close.

Presenting issues

Polly's social worker made a referral for psychology support because she was concerned about Polly's low mood and anger, which had significantly deteriorated since her latest contact with her Dad and, according to the referral, Polly's 'mood and anger issues' were putting a strain on her relationships at home.

Relevant background information

Polly has an on-off relationship with her boyfriend, whom she was not in contact with when referred for therapy but reconnected with him later in the therapy process. When not with her boyfriend, Polly enjoys listening to music and drawing. Polly attended a mainstream school but required 1:1 support from specialist staff. Polly successfully completed a vocational qualification but had many years of unsuccessful attempts to secure paid

employment, which impacted on her mood and self-esteem. With support from her social worker and a job coach, Polly eventually gained employment, which she loves. Polly describes being very happy in her workplace.

Polly receives support from a local Community Learning Disability Team (CLDT), comprising specialist health care professionals, including Nurses, Psychologists, Social Workers, Occupational Therapists and Physiotherapists who provide assessment, advice, therapeutic intervention and support to adults with learning disabilities. Polly primarily receives social care support and does not require input from other health professionals. Polly has a good relationship with her social worker, with whom she communicates fairly regularly, either in face-to-face meetings or via frequent calls or text messages. Polly often turns to her social worker when experiencing relationship issues that she finds difficult to manage.

Systemic case conceptualisation

Systemic therapy was initially considered as a suitable intervention as it has promising evidence in the treatment of mood disorders (von Sydow et al., 2010) and because Polly's difficulties appeared to be relational in nature. It was originally anticipated that Polly and her family would engage in family therapy sessions. With Polly's informed consent, family members were invited to attend sessions as this would have permitted multiple perspectives to be heard (McGoldrick, Gerson & Petry, 2008) and because therapeutic gains are strengthened when family members participate in the therapeutic process (Stratton, 2016). However, Polly's family were reluctant to attend because they had 'tried family therapy

before' and they indicated a preference for Polly to engage in 1:1 therapy to help with '*her* difficulties'. Polly's Mum did, however, agree to a phone consultation (at the request of Polly) following the initial assessment, and Polly also consented to her social worker being contacted to provide background information that Polly did not want to 'go over' in the initial assessment. Despite the absence of key members in Polly's family system, systemic therapy was chosen because Polly had requested it, following a positive experience of systemic family work in the past, and it was important to give Polly agency in collaboratively deciding the most suitable mode of therapy. The therapist was in the process of undertaking an intermediate systemic therapy qualification (accredited by the Association of Family Therapy – AFT) and was able to offer this mode of therapy under supervision from a qualified and experienced Systemic Practitioner.

Initial hypotheses

Initial hypotheses were generated as part of the process of initiating change within a system (Tickle & Rennoldson, 2016), while considering multiple perspectives from a range of sources, including: (i) reading historic case notes documenting systemic family therapy sessions with a previous therapist, (ii) written referral information from the social worker, (iii) a follow-up telephone consultation with the social worker, (iv) a telephone consultation with Polly's Mum, (v) the initial session with Polly, and (vi) discussions with the clinical supervisor. Four initial hypotheses were developed to try and make sense of what was happening in the therapeutic encounter with Polly (Bertrando & Arcelloni, 2006).

Hypothesis one: Does the family identify and reinforce the message that Polly is the one person in the family who 'has problems'. Polly's script appears to be that 'I need to get

myself sorted'. What do family members think about this? Is this reinforced by members of the family system, who were not willing to participate in therapy? They shared that Polly needs professional help with *her* anger and mood problems. Does Polly see herself as different from her 'perfect siblings' who all have 'sorted lives'? What is the family script regarding being successful, or even acceptable, in life?

Hypothesis two: Polly yearns for the relationship she used to have with Dad in the 'happy times' before he left. What relationship does Polly's Dad want with her? What is Polly's understanding of the reasons for the family break-up? How is Polly managing disparate feelings of anger towards Dad for leaving and breaking up the family unit versus a strong desire for him to be closer and be there for her? Given Polly's need for more concrete explanations of difficult concepts, is Dad's physical absence preventing Polly from being able to address this?

Hypothesis three: Has it been a struggle for Polly to adapt to an adjusted family? How have the family adapted to changing family dynamics? Does the family script reinforce the message that everyone else has managed to adjust to the change in family structure, but Polly has not been co-operative in adjusting? Polly wants a better relationship with her step-Dad, but does she feel that forming a good relationship with him would be disloyal to her Dad? What type of relationship is Polly's step-Dad seeking with Polly?

Hypothesis four: Polly has recently transitioned from being very dependent and reliant on her family to meet her financial, social and emotional needs to working and earning her

own money and developing a good social network with work colleagues. She is reaching towards a new stage of the family life cycle (Carter & McGoldrick, 1988) and seems to crave more independence. What is the change in the family life cycle like for other members of the family? Has there been a change in Polly's Mum's role as key advocate and protector to afford increased independence to Polly? If so, what is that like for Polly, her Mum and other members of the family? Polly is the last of the children to depend on her Mum and Step-Dad. Could some of Polly's frustration at home be around changes in relationships?

The therapist's revision of hypothesis / Formulation

The first hypothesis was taken forward in order to make sense of the information gained from multiple voices in Polly's support network. This hypothesis was selected over the others because it was the most prevailing theme; Polly appeared stuck in not being able to manage 'her anger', and although other members of the family system were not physically present in the therapy sessions, the therapist believed it was important to explore the difficulties Polly was experiencing in the context of her relationships with others. While seeking neutrality, in terms of maintaining a curious state of mind (Ceccin, 1987), the therapist was keen to explore the family narrative that Polly needs to be 'fixed', as is often the case with people with learning disabilities (Haegele & Hodge, 2016). The initial working hypothesis increased curiosity about where Polly sees her value within the family, but it was not until interventive questions were asked that it became apparent that Polly's benchmark of a perfect life is having a successful and happy romantic relationship; this is the one thing that everyone in Polly's family has, except her. The hypothesis was

subsequently revised to explore whether being in a long-term, stable relationship is an indicator of success for Polly and her family.

As a professional joining Polly's support system, the therapist was curious about how Polly would react to working with yet another new professional, particularly as Polly had formed such a good working relationship with the previous systemic therapist who had left the team. The therapist felt a little nervous about whether or not she would meet Polly's expectations and succeed in forming a similarly positive therapeutic alliance. Polly shared that she was nervous about meeting someone new but gave feedback that she liked the therapist (which was a relief) and believed that she and the therapist could 'work well together'. The therapist wondered what Polly would feel about needing more support, e.g. would this reinforce that Polly has problems that need professional help? Polly explained that she was pleased to have someone to talk to and was ready for further therapy to help mange her issues. The therapist was curious to explore alternative perspectives that might externalise the problem and, in doing so, give greater agency to Polly (White, 1988; Tomm, 2019).

The Social GGRRAAACCEEESSS framework (often referred to as social graces) developed by Burnham (1992, 1993) and Roper-Hall (1998) was used to consider aspects of visible and invisible elements of identity that might impact on the therapy process. These include gender, geography, race, religion, age, ability, appearance, class, culture, ethnicity, education, employment, sexuality, sexual orientation and spirituality (Burnham, 2012). Although Polly and the therapist shared some similarities, in terms of gender, race,

ethnicity and sexuality, which may have been helpful in the formation of a therapeutic relationship, there were notably more differences, including dissimilarities in geography (i.e. living in a rural location compared with a city), age (the therapist was a decade older than Polly), ability, education (in terms of type and experiences of school) and economics, all of which create difference and power inequality. In addition to the aforementioned graces, agency was a notable area of difference between the therapist and Polly. While the therapist had lived independently and had experienced freedom in making choices about living accommodation, paid employment, socializing and travel since leaving home for university at 18 years of age, Polly had limited experience in independent decision-making without the involvement of others (either family or social workers), and experience of others challenging decisions that were deemed to be unwise, such as seeing unsuitable boyfriends, for example. Moreover, the therapist was aware that Polly viewed her as a professional; this was important to consider as Polly had a long-history of working with professionals who have made decisions with and without consulting Polly that she has not always agreed with. The therapist was mindful that this contributed further toward a power-imbalance that needed to be held in mind during the therapeutic work, as stipulated by the Association of Family Therapy (AFT, 2015).

Account of the therapeutic work

The following section delineates the process of assessment, collaborative goal setting, the measure used to explore family functioning and identification of client strengths.

Assessment

Prior to completing the assessment, limits of confidentiality were explained, and Polly

provided informed consent as she was deemed by the CLDT service to have capacity (AFT, 2019; DoH, 2001). In acknowledging an inherent power differential, the therapist was aware of Stalker's (1998) assertion that individuals with learning disabilities can, through their experiences of others making decisions for them, be socialised into compliance (Hollomotz, 2018). Thus, the following steps were taken: clear explanations were provided to maximise opportunities for Polly's voice to be heard; the therapist explained that Polly can stop the session if needed; it was explained that sometimes people need to ask for things to be explained differently if the therapist has not been clear; and the therapist said she welcomed it when people question and disagree, thereby hoping to reduce potential acquiescence.

Polly's assessment involved: (i) exploring the presenting problem in relation to family relationships, by completing a genogram[1] (ii) identifying the systemic context of being a millennial with a learning disability, (iii) completing the SCORE-15 Index of family function and change (Carr & Stratton, 2017), (iv) exploring significant family events (i.e. parental divorce, absent Dad), (v) understanding wider socio-cultural factors, and (vi) identifying different perspectives and meanings held in relation to the problem. First, a genogram was completed to map Polly's family relations (Nicholls, 2011) and explore family strengths and resilience (Walsh, 1998). Polly included her parents, step-parents, siblings (and their partners and children), work colleagues, social worker, job coach and friends from a local charity that supports individuals with learning disabilities.

Goals

[1] The genogram is not included in this paper to preserve the anonymity of Polly and her family.

Polly identified her goal as 'I don't wanna feel mad and sad'. Through collaborative discussion, the therapist and Polly agreed that the therapy would focus on finding ways to improve her mood and to find ways to manage feelings of anger. As requested by Polly, others in her support network were invited to speak to the therapist as part of the assessment process. It became evident that others had different goals, as evidenced via the referral and consultation information. For example, a telephone consultation with Polly's Mum, when declining to attend sessions, revealed that family members wanted Polly to improve family relationships and to learn to take responsibility for her actions, whilst Polly's social worker wanted Polly to manage her low mood, tell the truth and not blame others, as well as improve family relationships. The onus appeared to be placed on Polly to make changes. Although the individual systemic intervention focused on Polly's goals, the family and social worker's goals were acknowledged and held in mind.

Measures

First, idiographic ratings were taken, where Polly was verbally asked to rate her anger (8/10) and her mood (4/10) over the past week, with 10 being the highest emotion. Polly was able to reflect on her mood (assessed through discussion regarding fluctuations in mood in relation to different situations during the past week), with Polly confirming her ratings after the discussion, which had not changed. The SCORE-15 was also completed during Polly's assessment, which revealed a total score of 37, (M=2.47) and identified issues with disrupted communication (Total=18, M= 3.6), being overwhelmed by difficulties (Total=13, M= 2.6), and strengths and adaptability (Total=6, M= 1.2). Although Polly's individual responses on the SCORE-15 revealed that she felt listened to in her

family, and she described her family as loving and caring, she also reported that people in the family ignore one another on purpose and blame one another when things go wrong. In a busy family system, where all adults work full-time, and all other family members have partners to confide in and offload to, it was not clear who was really there to listen to Polly. It was also not clear what the respective needs of the family members were, and how those in the family system communicated their needs to one another. Although the therapist had planned to repeat the SCORE-15 in the final session, unfortunately there was not time to do so as Polly had to leave early for another commitment; the therapist therefore took the decision to prioritise the therapy review and focus on Polly's reflections of her therapy experience. It was unfortunate that it was not possible to formally assess therapeutic change during the course of the intervention.

Client strengths

In the context of Polly assuming responsibility for being the one in the family with all the problems, it was important to identify and strengthen Polly's positive attributes. This is especially pertinent in a (LD) population that has historically been defined by limitations (Scior & Lynggaard, 2006). Through collaborative discussion, Polly was able to acknowledge that she has a number of positive qualities, including being kind, caring, nice, funny, good at word searches and being a great auntie.

Ethical issues

All material has been anonymised to protect client confidentiality. Written consent for publication was sought (via an accessible consent from outlining what it means for work

to be written anonymously and asking permission for the case report to be published in a journal). The therapist was mindful of potential acquiescence (Finlay & Lyons, 2002) and encouraged Polly to say if she was unsure or if she did not wish to consent. Polly said she would like her work to be shared with other people.

Intervention

The intervention comprised 12 weekly sessions, including 11 individual sessions with Polly and one family meeting in week 10 (requested by Polly and attended by Polly's Mum, sibling and social worker). There was an additional face-to-face consultation with Polly's social worker (immediately prior to the family meeting) and a telephone conversation with Polly's Mum and her social worker (all with Polly's consent), who contacted the service in advance of the family meeting to share concerns about Polly's relationship with her boyfriend.

John Burnham's (1992) Approach-Method-Technique model was employed as a framework to delineate Polly's systemic intervention (as illustrated in Fig. 1). In accordance with Haydon-Laurelut & Jones (2019) and Nunkoosing (2019), who assert that 'learning disability' is a socially constructed term, the intervention was broadly approached from a social constructionist perspective. Akin to the therapist's personal beliefs, this approach challenges assumptions that problems are inherent with individuals and, instead, explores how the description of a problem arises, which may be a problem itself (Davis, 2000). In order to remain person-centred, a range of methods and techniques were borrowed from different systemic approaches.

[INSERT FIGURE 1]

The intervention involved:

1) 11 individual sessions with Polly

- To assess family system and functioning – using the SCORE-15 measure of family function and change
- To externalise the 'problem' and understand it from a social constructionist perspective
- To help Polly recognise how the beliefs, meanings and understanding of others within the system impacts on current difficulties
- To provide a positive therapeutic experience that promotes resilience and improves family relationships

2) A consultation with Polly's Social Worker and a separate consultation with Polly's Mum (with Polly's consent)

- To develop a working alliance with those in the wider system (Friedlander, Escudero, Heatherington & Diamond, 2011)
- To gain multiple perspectives
- To facilitate therapeutic understanding
- To support Polly in strengthening her resources

3) Organising a family meeting toward the end of the therapeutic process (at Polly's request)

- To gain multiple perspectives
- To include family members in the therapy process
- To facilitate shared understanding of the socially constructed difficulties
- To explore Polly's strengths and highlight Polly's achievements
- It felt important here to reiterate how Polly has been brave and worked hard

to make tough decisions and take steps to focus on her own wellbeing

- To help the family support Polly in strengthening her resources

The family meeting was requested by Polly to share the 'good work' she had done in her sessions and to talk about some of the difficulties that Polly had talked about in the sessions. The intention of the family meeting was to explore relationships and curiously reflect on patterns of communication within the family system, and explore ways that family members' resources could be strengthened. The therapist was seen by Polly as an ally, but positioned as a facilitator, with different members of the system each wanting their voice to be heard and their respective goals accomplished. The therapist knew from having read Polly's care assessment that she needed quite concrete questions, so subsequently used a simple pattern of questioning, which explored simple positive feedback loops for different members of Polly's family. The therapist was conscious from other work in the LD Service that she needed to think carefully about the content and phrasing of questions to pitch them at a level that neither assumed understanding nor unnecessarily simplified content when individuals could process more challenging questions.

Systemic questioning

The type of systemic questions asked during the intervention are presented in Table 1. The choice of questioning was influenced by different factors, including the therapist's knowledge of suitable systemic questions to ask (as covered on the Intermediate Systemic course), awareness of Polly's ability to answer different types of questions, and confidence in trying out more complex circular questions at the time it felt most appropriate and therapeutically beneficial to consider the perspectives of others in the system.

[INSERT TABLE 1]

Change techniques

A variety of change techniques were utilised during the intervention to instigate therapeutic change. First, engagement was central to developing a positive therapeutic alliance with Polly, her social worker and her Mum. While Polly was familiar and comfortable in engaging with professionals from the CLDT, her Mum warmed to the idea of meeting with the therapist only after rapport had been built via telephone conversations. Despite undertaking individual systemic work, the therapist tried to maintain a neutral curious stance to include the voices of those not involved in the therapeutic process (Nichols, 2011), including Polly's past boyfriends, her siblings, her Dad who lived abroad and her step-parents, with whom she had historically had a tumultuous relationship.

Perhaps the most important change techniques were those that enabled Polly to gain new perspectives. For example, *externalising* anger (White, 1988) as something that sometimes gets the better of Polly but seeing it as something that is not within her, and *scaling* (Yu, 2018) how different members feel in relation to externalised frustration and how others might see the size of the problem (e.g. Polly realised that others recognise her positive qualities before any 'problem behaviours'). *Curiosity* (Ceccin, 1987) was effective in exploring patterns of communication and behaviour within the family (e.g. where Polly realised that everyone experiences a range of good mood, low mood, calm periods and times of frustration and anger. Meanwhile, p*ositively connoting behaviour* (Kraemer,

1983) and *reframing* (Nichols, 1984) were helpful in challenging the family narrative about Polly having difficulties with anger and her mood. As Polly identified feeling angry about the difficult relationships with her Dad and step-Dad, *hypothesising* (Tickle & Rennoldson, 2016) was efficacious in exploring what it means to have a good relationship with each of them, without worrying about what the other might think.

In addition, *reflection* was used to explore the role of helpful and unhelpful coping strategies (e.g. avoidance) on family relationships – this enabled Polly to gain insight into what she and other family members might need from each other. For example, during the family meeting, the therapist reflected the attributes she heard Polly identify as helpful ways of interacting with her at home, including people being calm, gentle, kind, available to listen and having 1:1 time with Polly. The therapist also wondered what needs the family members had and how they communicated their thoughts and emotions with one another. Polly also seemed to benefit from discussions around *unique outcomes* (White & Epston, 1990)*;* for example, when exploring what her step-Dad did differently in a recent interaction that prevented anger from getting the better of Polly. Polly recognised that on one occasion he gave her a nickname, which helped her to feel more included as a member of the family, this in turn encouraged her to be nicer to him and, consequently, they had a good chat whereby he opened up about his own difficulties. Polly felt that this was a turning point in their relationship.

Finally, *questioning* was fundamental to change in both the individual work with Polly and in the family meeting. Circular ranking questions, such as '*Who was most worried about*

your relationship with your ex-boyfriend?' helped Polly to understand how worried her Mum had been about his reactive and controlling behaviour. Circular questions, such as '*who has seen the most positive change*?' helped Polly hear positive affirmations from her Mum and social worker, which she said she needed to hear, and was a boost to her mood. Lineal defining questions were asked to clarify what Polly may need from others in order to feel as though she has had a positive social interaction with them. Meanwhile, asking reflexive future oriented questions, such as '*what would you like your relationships to look like*?' enabled Polly to reflect on the values and attributes she feels she deserves in future relationships. Interventive questioning (Tomm, 1988) was especially helpful at the family meeting in exploring communication patterns between family members. Polly's Mum seemed to have a moment of realisation when talking about Polly being anti-social in the evening. She described Polly isolating herself in her room and being rude when she does not join the family at the dinner table. When asked '*What do you think Polly is thinking when the family talk quickly to one another at the dinner table*?' and '*Why do you think Polly finds it difficult to sit with two couples*?' her Mum said she had not realised it was so hard for Polly.

Outcomes

The outcome of the family meeting was that Polly's Mum agreed to spend more 1:1 time with Polly, which is exactly what Polly said she wanted but did not feel bold enough to tell her. After 12 sessions, Polly said she was more content and calmer at home. Her self-rated

mood had increased from 4/10 to 10/10 (refer to Fig.2) and self-rated anger levels had reduced from 8/10 to 2/10 (see Fig.3).

[INSERT FIGURE 2]

[INSERT FIGURE 3]

Polly attributed the improvements to feeling listened to in the family meeting and feeling happy that Mum agreed to spend more 1:1 time with Polly. One might wonder how it would have been for Polly and those in her family system if the intervention had begun with a family meeting. When reviewing the differences that Polly had noticed at the end of the intervention, she identified improved relationships with family members and friends. She described herself as being like a happy sun, which she drew on a piece of paper before drawing rays for family members and friends. As changes in interactions were discussed, Polly identified that the happier and nicer she is to others, the nicer they are to her, which makes her happier. Together, this was mapped out and Polly said it looked like a happy flower, with interactions with people like petals (as depicted in Fig. 4). Although this image occurred organically in the session, it is noteworthy that the flower in Fig. 4 is similar to the virtuous flower used in cognitive behavioural therapy to depict positive functional cycles (Kennerley, Kirk & Westbrook, 2016).

[INSERT FIGURE 4]

It was jointly agreed that Polly had made good progress and had developed sufficient skills that further therapy was not required. The intervention had reached a natural end at this point, with the therapist feeling as though the ending was a positive experience for Polly (based on the positive feedback she provided) and the therapist, who was relieved that the individual systemic intervention appeared to have been helpful. It was, however, agreed that a CLDT psychologist would be available if ever required in future. There was no follow-up as the therapist left the service shortly after completing the work with Polly.

Implications/contributions to the field

Historically, there has been a tentativeness in using systemic interventions in learning disability services (Kaur et al., 2009), but this case highlights the value of systemic work, even when working with individual clients because others in the system are not able to engage in the therapy process. Although this single case contributes to a field that is critiqued for its reliance on single case examples (Johnson, 2016), it demonstrates the value in curiously keeping other members of the system in mind and giving a voice to those not in the therapy room (Nichols, 2011). This case illustrates how individual systemic therapy tailored to Polly's needs (NICE, 2019) was both acceptable and was perceived to be helpful by the client, who engaged well during the therapeutic process. As indicated by von Sydow et al (2010), low mood improved during the systemic therapy intervention, while anger decreased. This case reinforces Novaco's (1993) perspective that it is advantageous to view anger contextually. Externalising the problem (White, 1988), which occurred during the family meeting, enabled a shift from viewing anger as an issue within the client to locating it in the wider system (Lynggaard, 2017). Interventive and circular questioning was useful

(Tomm, 1988) in achieving this. This paper documents how it was important to challenge assumptions about client capabilities; in this case more complex triadic circular questions could have been asked, but it took time as an inexperienced systemic practitioner to learn how to adapt systemic approaches to best meet the needs of the client, as advocated by Baum (2019). As people with learning disabilities are a heterogeneous group, it would be advantageous for further research investigating systemic interventions with this population, as other therapists may encounter different experiences than those encountered here. It is, nonetheless, hoped that this case encourages others to use systemic approaches with individuals with learning disabilities.

Self-reflexivity

The therapist's response to working with Polly was initially one of disappointment; not with Polly but due to the reluctance to engage in the therapy process of others in Polly's system. The therapist felt disappointment for Polly, who was keen for key members of her system to attend her sessions. It is unknown how much more effective therapy would have been had the therapist been able to facilitate family discussions earlier in the process. This case did, however, highlight the value of working systemically with one individual alongside on-going consultation work with professionals and phone calls with a family member, which facilitated the development of sufficient therapeutic alliances to engage Polly's support network in a fruitful family meeting later in the process.

This case taught the therapist that she was overly tentative in the early sessions with Polly. With an initial focus on ensuring that questions were clear and jargon-free, the therapist

underestimated Polly's ability to respond to more complex circular questions that would have permitted consideration of how family members' interactions would have affected others in the family (Evans & Whitcomb, 2015), for example, which could have provided greater richness and insight into relational difficulties in Polly's family. Like others who report feeling de-skilled during their systemic training (Nel, 2008), the therapist lacked confidence in the early sessions in knowing how to pitch such questions, but Polly proved she was more than capable of answering such questions when asked later in the process. The therapist is now more aware how (unfounded) assumptions impacted on the therapy process and will be more mindful of this in future. On reflection, there was a reluctance to ask strategic questions that would, in hindsight, have opened up discussion about the controlling behaviour of Polly's boyfriends – perhaps due to the therapist's own family script regarding optimism and looking for people's strengths, which is central to her family narrative. In hindsight, the initial discomfort in discussing Polly's boyfriend's flaws resulted in rather verbose questioning and a shift away from the initial discussion. This highlights the control and power held by the therapist to influence the direction of the dialogue (Larner, 1995). Exploring this in supervision was helpful and has enabled the therapist to sit with discomfort during sessions and have more reflective discussions in supervision.

Supervision was helpful from the outset, particularly in exploring assumptions held about Polly's difficulties, relationships, and her world. Supervision helped to explore how the therapist's own family script (about the importance of being independent) may influence appraisal of others' relationships, but maintaining curiosity, practising self-reflexivity and

exploring this further in supervision was beneficial. Supervision also helped question how the therapist positions herself in relation to labels of disability. Although some labels are used to understand the problem, e.g. when written on a referral form to gain access to services, this may strengthen the narrative that the problem is located within the individual who is assigned a learning disability or mental health label yet it fails to question 'for whom it is a problem?' and 'what role does the system play?' Whilst learning disability terminology may be helpful in providing families with a shared vocabulary understood by different professionals, blind acceptance of labels can make it difficult to challenge disabling cultures (McElwee, 2008; Haydon-Laurelut, 2011).

Table 1. Overview of systemic questions used

Question type	*Description*
Interventive questions	These are questions as an intervention as opposed to questions merely to elicit an answer (Tomm, 1988). These were asked in order to (i) deconstruct the problem (Dallos & Draper, 2010), which Polly identified as feeling mad and sad, (ii) understand Polly's world and her position within her family, (iii) identify feedback loops that maintain difficulties (Smith & Karam, 2018) and (iv) explore feelings arising in the context of family difficulties.
Circular questions (Tomm, 1988)	Circular questions were asked to explore relationships and patterns of communication within Polly's family, to establish whom else struggled with mood and frustration. Polly identified that each family member struggled on different occasions, which normalised emotions that everyone feels. For example, '*when you are feeling sad, what does your family member do in response? What does this make you think/feel/behave'* etc.
Circular ranking questions	Circular ranking questions, such as '*Who was most worried about your relationship with your ex-boyfriend*?' were asked to explore the perspectives of people in the family system who were not in the room. These questions helped Polly to understand how worried her Mum had been about her boyfriend's reactive and controlling behaviour.
Solution-focused questions (Trepper, 2012)	Solution focused questions were asked to ascertain what 'perfect' or 'sorted lives' entail. For example, '*what would need to happen for your life to be perfect?'*
Information-gathering questions, including linear (investigative) questions	Information-gathering questions about past relationships revealed that Polly's two experiences of relationships have been with abusive and controlling partners and Polly has repeatedly returned to them following break-ups. The therapist was curious to explore what value Polly placed on forming and maintaining relationships at any cost, what it might mean to Polly to not be in a relationship, and to explore both where Polly sees her value and what value others see in Polly. These questions revealed that Polly expressed such a strong desire to be like the siblings she so admired that she accepted behaviour from boyfriends that her family did not consider to be acceptable. This, in turn, caused conflict with family members who struggled to comprehend why Polly was tolerating behaviours they considered to be detrimental to her. Subsequently, Polly described increased conflict and frustration at home and reduced mood, as Polly withdrew and isolated herself at home.
Lineal defining questions	Lineal defining questions have investigative intent and were asked to clarify what Polly needs from others to feel as though she has had a positive social interaction with them, e.g. 'what do you need your Mum to say to show she is pleased with you?'
Future oriented questions	This included questions such as '*what would you like your relationships to look like*?'. This was asked to explore the values and attributes Polly feels she deserves in future relationships.

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