Learning From a Person's Biography: An Introduction to the Biographical Timeline Process

by Beth I. Barol, PhD

Definition

The biographical timeline process, sometimes called "biography," "timeline," or "life line," is a facilitated process through which a team of people, having researched the events, passages, and interventions in a person's life, lay out those facts in a linear fashion, to enable a group to correlate information in a meaningful manner. Events and personal experiences (often thought of as "insignificant" in other contexts) that were previously stored in compartmentalized reports and files, are grouped according to their occurrence along a linear life-timeline.

Introduction

I have put off writing this article on the biographical timeline approach for over two years. Today, thinking once again about buckling down to write this piece, I thought that introducing it with both the reasons why I find this an important subject, as well as why I have resisted writing it, may be helpful to my readers.

First, my resistance to writing the article. For me, the biographical timeline process is a living event that occurs among the group present for the biography, the person we are seeking to understand better, and myself, as the facilitator and scribe. Every experience is unique, in that the dance of facilitation changes with each group's chemistry and with each individual's story. Setting pen to paper to attempt to capture this process, to me, runs the risk of deadening a living event and of appearing to provide a "cookbook" to be followed. Such a regimented approach would ensure that the person and the group would be lost in the name of this process tool. The quest would become more about a perfect biographical timeline than about the search for a deeper and more meaningful understanding of a human being who is struggling, and with whom we need to transform our relationship.

With that said, why then write on this subject? First, I feel called to do so because, after using and evolving the process for many years, I feel that it affords us some special opportunities to support people in a truly holistic manner. Secondly, I have seen evidence that many people have been minimizing the process to the point where, although important information is gleaned, the full potential is not realized.

The following discussion is meant to offer an understanding of the "what" and "why's" of the biography process, rather than the "how to's." A comparison could be made to a teacher instructing on how to sauté, steam, and fry, along with the benefits of each approach, while leaving the new cook the freedom to experiment with her own tastes, rather than follow specific recipes.

Influences

My influences regarding this tool are many, and like a biography, my perspective flows from the work of my predecessors. Looking at a person in the context of her or his biography and the development of different types of biographical timelines have been part of clinical social work, psychology, and other like professions (at least in theory) for years. The late Herb Lovett, PhD, exemplified a type of biographical timeline with his variation on the Individual Service Design. William Bento, an anthroposophical psychologist, often walks his clients through their own biography as part of initiating therapy. Robert Post, MD, from the National Institute for Mental Health, uses a timeline approach to track symptoms of mental illness correlated with life events, medications, and other dynamic factors.

The biographical timeline as I employ it, and as we teach it through the OMR Statewide Training and Technical Assistance Initiative, utilizes the work of many sources, along with a respect for the group dynamics of the team participating in the timeline process. As with Herb's practice, the biographical timeline works best when the entire team supporting the individual is present. The transformation of attitudes that occurs during the process is as important as the facts that emerge from the research.

In this article, I will first illustrate the timeline process and its potential via an examination of a case study. Then I will describe the process as I generally use it in my own practice.

A Case Study

To illustrate the use of a biographical timeline as an assessment tool, as well as a team development and systems change tool, I will use the example of a young man I'll call John. (His name has been changed, and key elements of his biography have been withheld to protect his confidentiality.)

John was referred to the facilitator for a biographical timeline, because he was considered to be a very difficult young man to support. He was sometimes talkative, affectionate, and friendly to staff. At other times he was highly aggressive, sexually provocative, and verbally and physically abusive to the very people he said were his friends among the staff. He would be self-abusive on other occasions. He was referred to as being paranoid, and had a diagnosis of "Borderline Personality Disorder." A psychiatrist had advised support workers to keep John at arm's length, to think of him as being "manipulative," and to keep him on a rigid schedule of activities, devised by staff.

When John injured a staff person, who in turn pressed charges against him, a new psychiatric evaluation was requested, as was a biographical timeline assessment. At the start of the timeline, it became clear that the direct care staff members were very hurt by and hostile towards John. Furthermore, they did not feel that their opinions were valued by professional staff or by administrators. They perceived that their role in this process was to just sit and listen passively.

They didn't understand why they should go through all of this research and discussion about someone who seemed to enjoy being out of control and hurting people. They also felt unsupported by the administration, and felt they were stuck trying to support John with few resources, little training and no hope of really being able to help him. They were angry with John for being so hurtful and thought he was "sexually perverted," because of his making sexual advances and inserting objects into his penis and rectum.

John did not attend the timeline facilitation. He was aware that it was going to take place and gave his permission for the meeting to be held. The facilitator used the meeting as an opportunity to explore the meaning behind his behavior and to offer the staff an empathetic view of John. She made sure people knew that the timeline was a prelude to person-centered planning, and not in and of itself a person-centered plan.

It is not the purpose of this article to go into depth in portraying an analysis of John's biography and its consequences (that will have to be put off for an article on the case study alone). An abbreviated version of the timeline follows, with a discussion of some of the key elements to illustrate the value of learning from a person's biography. (Indented text refers to the biographical information from the timeline process; text in italics is a representation of the comments and reflections of the participants).

As we see from the timeline, John has had a very hard life. Born the first child to a mother who suffered from depression and had epilepsy, he reached his early developmental milestones in a typical fashion. However, at the age of two and a half, John had a fever of 105. He started seizuring and, according to the records, continued having periodic seizures after the fever was resolved. During this time, John stopped talking and started demonstrating overactive behavior. After he was sent for tests at the community hospital, his parents were told that John was cognitively behind due to his language delay. He was placed on Phenobarbitol for seizure control. Staff reported that John's father blamed his wife for having a damaged child because she, herself, had seizures.

At this juncture in the process, the facilitator might ask the team to reflect on young John's experience so far. "What might it be like to lose capacities at that age? Remembering that this is an important stage in development, where we are growing in our pride of mastery and are pursuing being more independent, do you think John noticed that he had lost skills? That he was no longer able to communicate as well as before? That his father considered him to be 'damaged goods' and fought with his mother about him?" The team is then encouraged to make "respectful guesses." [1] "A failure, rejected, unloveable, frustrated, afraid."

The team's responses would then be recorded in a section devoted to the respectful guessing of the team in response to the information presented.

John's language gradually improved, but he continued to be a very hyperactive little fellow. Although he liked to be read to, liked to be held and cuddled, he still needed to be on the go all of the time. At four years old, John fell during a "staring spell" and hit his

head. Once again, he lost his verbal skills and this time developed enurisis. His hyperactivity increased. He was placed in a hospital in another state, away from his family for three months, for evaluation. The conclusion was that he was having "extreme side effects" from the Phenobarbitol, and the medication was discontinued.

Again, the facilitator would stop the action to ask the team to reflect on the experience of being so "out of control" that he was sent away to a hospital to live for three months. "Loss, abandonment, rejected, afraid, jealous of my baby sister who gets to stay home."

John started kindergarten. He was assessed as functioning "within normal range non-verbally." His issues were around his verbal communication and his hyperactivity level. The other children in his class judged him by his verbal skills and teased him, calling him a "retard." John reacted with extreme anger and hit the kids who were teasing him. "No friends, kids are mean to me, school isn't fun for me, I'm different, I'm not good enough."

John was moved to a class for children with learning disabilities when he entered the first grade and then to a class for children with severe emotional disturbances. "Segregated, not positive and typical role models."

Meanwhile, at home, his father got John an old truck, parked it in the back yard, gave him tools and let him work on the vehicle. John was pleased by this, because it gave him something in common with his dad. However, when John's dad was angry at him, he would lock him in the cab of the truck for hours. "Things I like will be used against me. Nothing I can do will please my dad. I am always bad. It isn't safe to like things."

John started to run away from home. School considered him a behavior problem for his inability to sit still, and as a result they put him on home-bound schooling, in the same home he was running away from. He started having severe temper tantrums at home, masturbating frequently, having periods of aggression and assaultiveness and spending hours on end pulling his wagon around in circles in the yard. He also had periodic spells of staring blankly at the walls. "I can't get enough stimulation, I can't sit still, and people don't like me because of it. I can't help myself, and no one else can help me either."

One day, while riding his "big wheels," John ran over his cat, who was lying in the walk. The cat died. John's father was incensed by the incident. He beat John so severely on the back with a stick that John was removed from the home, taken to a psychiatric hospital, and placed on the children's unit. "I'm no good; nobody loves me; my father hates me."

John was the youngest person on his unit, not yet eight years old. Staff reported that John was routinely beaten and sexually abused by other patients. A 1:1 staff assignment was made during the day shift, but according to a staff person who knew John when he was on this living area, most of the abuse occurred at night when he was not protected. The staff person further added that John didn't appear to know how to play with others. He would go up to the other kids on the unit and tease them until they

would start beating on him. "Getting hit and sexually used are the only ways to get attention. Painful touch is better than no touch at all. I can use my body to get attention. No one is paying attention to me unless they are doing something to me. Big people get to do this to little people."

John was diagnosed as having "Mixed Organic Brain Syndrome," "Mild Mental Retardation," and "Temporal Lobe Epilepsy." He was placed on Serentil (dose unknown) Valium (dose unknown) for behavioral control, and Depakote (no dose or blood level available) for seizure control. Despite the medications, John continued to be considered hyperactive - impossible to tire out. "The medications seem to have been prescribed to calm and quiet John down. They did not seem to be effective."

John's mother and father continued to fight over him. His mother wanted him to come home; his father did not. John's mother would call her son and promise visits, but never show up. She would tell him that she had a room at home ready for him someday . . . but that day would never come. "My parents don't want me; they never keep their promises to me. It is all my fault. I'll never be anybody until they love me."

John lived in the psychiatric hospital for several years until the unit closed, and he was then sent to a series of specialized foster care homes funded by Children and Youth Services. The first placement went well, until the foster parents split up, and John was sent to a second home. While he was there, he was abused by the foster parents and was sent to his third home in one year. Here, at the age of ten, he was labeled as a "tough kid" and physically restrained for the first time. "No one wants me. Adults hurt me or abandon me. I have to be tough to keep people from hurting me."

The next few years show John moving through service systems, living in a series of group homes interspersed by psychiatric hospitalizations. Finally, at age fourteen, he was placed in a large institution. Nine moves during a three year period. During these years, John attempted suicide by throwing himself in front of a car. The incident was labeled as "attention getting behavior." He had periods of high energy; he was aggressive, assaultive, sexually assaultive, and masturbated incessantly. During these periods he was said to be paranoid and heard voices telling him what to do. This would last for several weeks and would be followed by a period of being withdrawn, crying, and having less energy. People found him much easier to work with during these periods. Despite these signals, he was diagnosed as having "No Significant Mental Health Issues," but having Atypical Organic Brain Syndrome and possibly ADD. He was placed on behavior management programs, and given a preschool curriculum in school. (Remember that this is a young man who was assessed earlier as functioning within normal range, except for his verbal skills.)

Despite the absence of an MH diagnosis, he was continually placed on a variety of Neuroleptics, including Haldol, Mellaril and Serentil, until he developed neuroleptic malignancy syndrome and was subsequently taken off all of the neuroleptics. "What effect did these medications have on John?"

Discussion

Looking at even this shortened version of John's biography leads one to ask many questions. What is the impact of the trauma in his life? There are also many possible symptoms of mental illness that have been presented. We have to wonder if the information had ever been laid out in an organized fashion to the various psychiatrists involved in John's case. The staff present at the session didn't think so, since this was the first time they had seen the events in his life correlated in this way. Psychiatrists, then, were being asked to diagnose and prescribe based largely on "snap shot in time" information, namely how John was behaving at a given time. Their answer was to go the sedation route, not the syndrome specific route, since no syndrome was apparent from the way in which the data was presented.

When a psychiatrist who was receptive to working with people who have mental retardation and possible mental illness reviewed John's information in the context of his life, he wanted to rule out the possibility of a mood disorder driving John's behavior.

And indeed, staff noticed a change for the better when John was placed on a therapeutic dose of a mood stabilizer. John was much less hyperactive, slept better, was less irritable, and less sexually invasive.

However, getting an appropriate diagnosis and medical treatment was only a part of the puzzle. John still had experienced a lifetime of hurts, rejection, and promises that were broken. He had experienced his own body letting him down and being driven involuntarily to be in constant motion, reaching for whatever stimulation he could get to attempt to ease his discomfort.

When the team was asked to reflect on the issues that had surfaced during John's biography, they cited: "Trust, permanency in living arrangements . . . he has never known what it is to be loved, to feel that someone was there for him no matter what . . . he never learned how to be with others and to play with them . . . he is always afraid that someone, even people he likes, will hurt him or will abandon him when he makes a mistake or when his body lets him down, because he has been so isolated and excluded from typical experiences and education . . . really doesn't know where to start to get his needs met appropriately . . . ."

These staff, his direct support people, who had been so turned off by John, were now feeling empathetic towards him and were in the position to become his social therapists.[2]

We then spent several hours looking at how they could change their support to John, by using every interaction as an opportunity for healing.[3] The staff proceeded, over time, to set up "person- centered" environment and supports. In recognizing that John had never learned how to be in positive and fulfilling relationships with others, a staff person volunteered to work with him as a mentor, guide and friend. He provided modeling, guidance and constant encouragement as John experienced opportunities to develop

trust, acquire new skills, make friends, and feel much better about himself. As a result, John is now handling everyday upsets and struggles without resorting to aggression.

The Process

When do we employ the process?

Usually, when we come together as a team to do a biographical timeline, we are called because there is an individual who needs special support. Generally, the folks who are endeavoring to help the individual to lead an "Everyday Life" are feeling frustrated in their attempts to really listen to what the person is telling them that he/she needs, or are unable to understand the individual because he/she can't communicate those needs. Sometimes the person's needs are inconsistent with this request. These are all times when the support staff may feel that they don't know what to do or think, or that the person that they are attempting to support is trying to take advantage of them.

Often the team supporting the individual is in conflict, burned out, feeling hopeless and helpless. At other times there is an active and supportive team who just can't figure out how to help the person. Sometimes the team is supportive, but the macro structures that support the team, such as agency, administrative, or professional staff, state and county personnel, education staff or members of other teams and programs, are not.

The Initial Phase

The first step in the biographical process is, of course, to identify the person the team wants to work with. The next step is to consider who needs to be on board. Who must be present at the biography for it to be of maximum success? If we think of the process as one that builds empathy for the person and cohesiveness among the team, we can see that all of the people who support the person on a regular basis need to be present - family members, direct care staff, teachers, case managers, therapists, and other support persons.

If we also think that this is an opportunity to explore systems change and to reevaluate resources (unpaid and paid), then agency executives and project directors, and in some cases, county administrative staff should also be present. In situations where physical environmental changes are anticipated, then the person who contracts for the work should be there as well. (We have seen maintenance people work more efficiently and more creatively when they are involved in the process from the beginning and can understand why they are being called upon to make changes.)

Scheduling the Biographical Timeline Session

Since it is vital that the people invited have every opportunity to attend, and because there is a significant research component to the process, the meeting should be scheduled several weeks in advance. For best results, at least two days should be allotted for the process, preferably consecutively, with follow up dates set for developing action plans as needed.

Involvement of the Subject of the Biography

I always leave it up to the individual (the subject of the biography) and his or her team to decide if the person supported should come to the timeline session. If at all possible, the team asks the individual for permission to hold the biographical timeline and offers them the opportunity to attend. The individual is also asked who they would like to attend the meeting and who they would definitely not like to be there. If at all possible, this request is honored. Many times, however, we work with people who cannot talk or who cannot as yet communicate their wishes to us. We must remember to be respectful of that person's wishes as we can understand them.

If the individual we are learning about through the biography process is not present, then it is very important that all team members understand that:

1. This is not a person-centered plan. It may be a prelude to person-centered planning, to help us be more open and receptive to the person during subsequent planning opportunities.

2. We cannot know anything for sure about the person's subjective experience. We can only make what Herb Lovett would call "respectful guesses." These guesses are very valuable, however, when we seek to expand our capacity to be empathetic towards the person we wish to discover through the timeline process.

If the person chooses to attend, it is essential that the focus of the timeline is built around the comfort and emotional safety of the individual. I prefer to work with a smaller group under this circumstance, including only people that the person selects to attend. This may sacrifice some potential for team and resource building, in order to honor the right of choice of the person whose biography is about to unfold.

Still, I have been involved in biographies with the individual present that included 20 to 40 group members, when this was desired by the person being supported. Flanked by friends and loved ones, these individuals steer the unfolding of their own lives, witnessed in ways they determine to be beneficial.

Preparation Phase

Much preparation must take place before the biographical timeline session. The person's entire record must be gleaned for pertinent information, and this information should be supplemented by interviews, in person, or by phone, if knowledge- able people cannot be present for the session. Participants should also bring records with

them, in the event that questions arise during the timeline process that the researchers did not think to include in their notes. (See Appendix 1.)

The Role of the Facilitator During the Process

The facilitator bears responsibility for several aspects of the process. First, she must recognize that the telling of the story is only one small piece of the puzzle. She must prime the group in attendance, initially, so that they can fully participate in the analysis of the information being presented.

Each participant should be helped to feel safe, welcome to participate, and acknowledged in a valued role. This is especially true for family members and direct care staff, who very often feel outnumbered and devalued during team meeting experiences. It must be made clear that the timeline tool, in the long run, will only be effective if the people who support the person (the subject of the biography) are fully involved, engaged and invested in the process. The facilitator must keep part of her awareness focused on the level of participation going on in the group, during the entire process.

Secondly, the facilitator must see that pertinent facts are listed on the charted timeline and that once listed, the relevance of the information is explored with the group. "Why is this important? What ramifications might this have for this person? What life lessons might the individual have learned?" Periodically, the facilitator stops the action to have the group assess the person's development to date. "How does this person's life experiences match those of typical contemporaries? What opportunities did the person have to feel loved, admired and respected? To develop praise-worthy skills? To explore independence through the context of interdependence?" The facilitator also continues to emphasize that everyone is engaging in "respectful guessing" as they try to make sense of past events and develop a rich approach to supporting the person in the context of the person's life story.

While the facilitator should have a good understanding of typical developmental processes, as well as experience with positive approaches and a fundamental knowledge of mental health issues in individuals with mental retardation, it is not expected that he or she be an expert in all areas of practice. Instead, the facilitator will be expected to draw on the expertise of the team members, including asking for more team supports when preliminary research indicates that some additional expertise might be important, such as the presence of a nurse, a psychologist, or an occupational therapist who is trained in sensory integration. We have, of course, found it very helpful when we could have a physician or a psychiatrist as part of the team as we go through the biographical timeline process.

The facilitator works with the team, to highlight key issues that present themselves during the process, and to help the team look at the impact of these issues on the current challenges that the person presents. The issues are then explored with the group in the context of unmet needs and mechanisms that the team could employ

through consultation, therapies, and more importantly, through the day to day interaction of support persons, social therapists, a well orchestrated environment and person-centered life style.

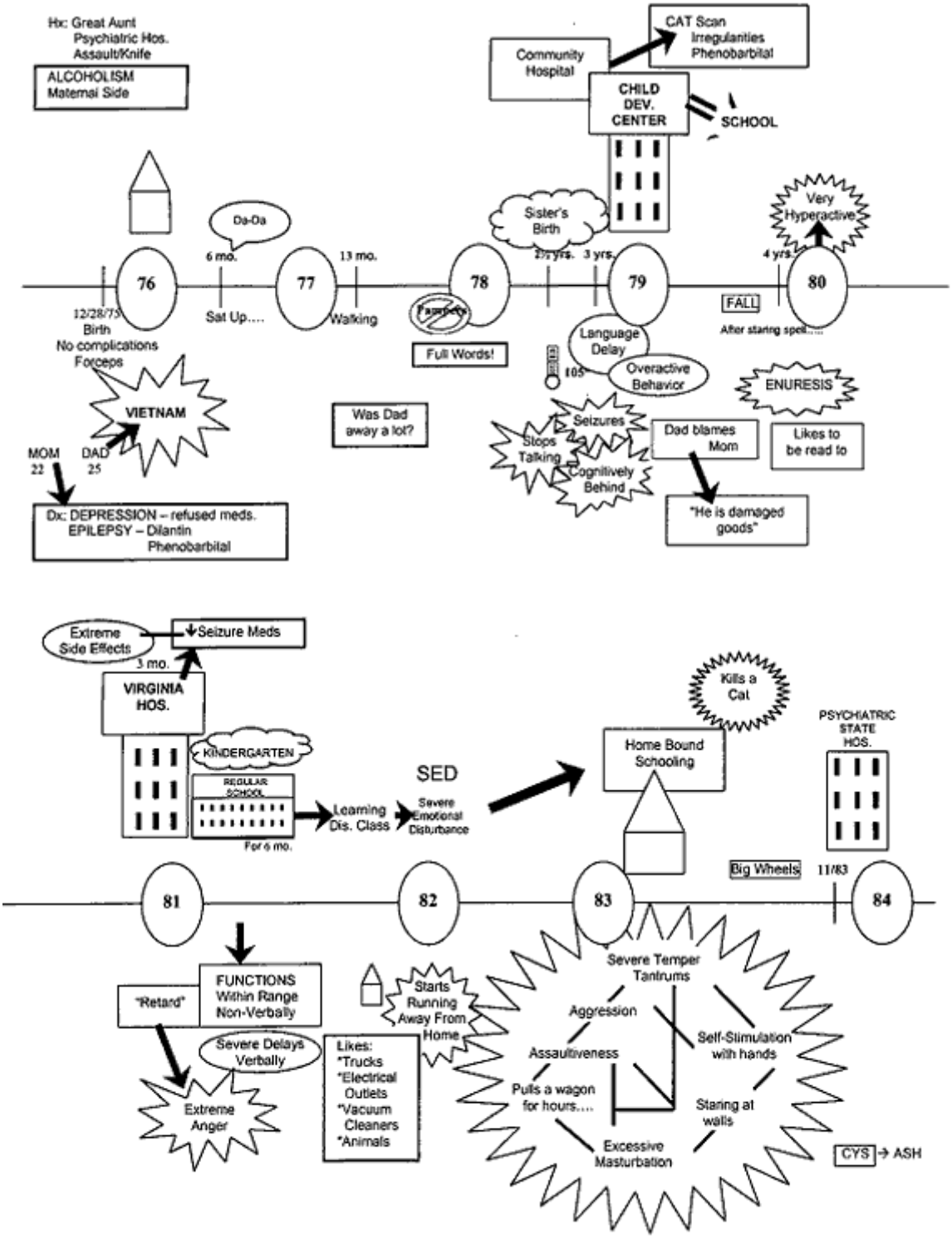
Conclusion

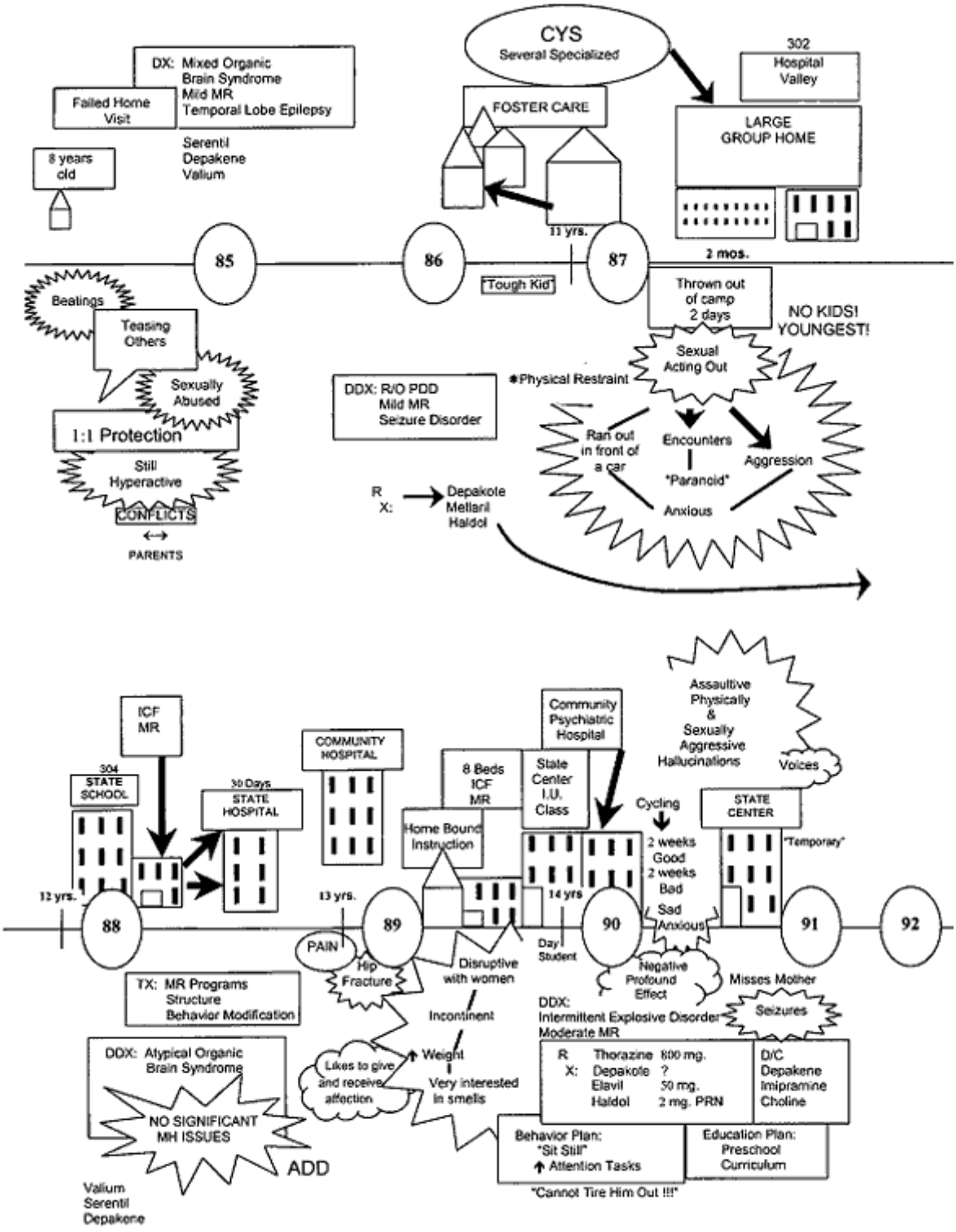
The biographical timeline is a multipurpose tool. It can be used for assessment to aid in building supports for an individual who has unmet needs and/or who presents with behavioral challenges or mental illness. It can be used as a unifying experience for a team, helping members to clarify their mission and focus, while building empathy for the person they are endeavoring to support.

The tool can also be used by the supporting agency and service system, because it identifies problems within support services and the effects of our well-intentioned decisions on the lives of individuals we assist. Learning from a person's biography can have ramifications at a systems level as well as at an individual level, if staff are willing to participate in an analysis of the effects of the system on the people they seek to support. The biographical timeline can, in essence, be utilized as a quality enhancement tool by providers of service, as well as broader based system staff.

Finally, it must be reinforced that the biographical timeline is only a tool. It does not have a life of its own. Success depends on the willingness of participants to do the necessary research, to participate fully, to plan based on what surfaces through the process, and most importantly, to act. The best process and the most person-oriented plans are worthless, if the participants don't act on the information and honor their commitments over the long haul.

When participants do take action, we have seen inspiring results, time and time again, from this major investment of time and energy in the biographical timeline process.


Hx: Great Aunt
Psychiatric Hos.
Assault/Knife
ALCOHOLISM
Maternal Side
Community Hospital
CAT Scan
Irregularities
Phenobarbital
CHILD DEV. CENTER
SCHOOL
Da-Da
6 mo.
13 mo.
Sister's Birth
2½ yrs.
3 yrs.
Very Hyperactive
4 yrs.
76
77
78
79
80
12/28/75
Birth
No complications
Forceps
Sat Up....
Walking
Full Words!
FALL
After staring spell....
Language Delay
Overactive Behavior
105°
ENURESIS
VIETNAM
MOM
22
DAD
25
Was Dad away a lot?
Seizures
Stops Talking
Cognitively Behind
Dad blames Mom
Likes to be read to
"He is damaged goods"
Dx: DEPRESSION – refused meds.
EPILEPSY – Dilantin
Phenobarbital
Extreme Side Effects
Seizure Meds
3 mo.
VIRGINIA HOS.
KINDERGARTEN
REGULAR SCHOOL
For 6 mo.
Learning Dis. Class
SED
Severe Emotional Disturbance
Kills a Cat
Home Bound Schooling
PSYCHIATRIC STATE HOS.
Big Wheels
11/83
81
82
83
84
FUNCTIONS Within Range Non-Verbally
"Retard"
Severe Delays Verbally
Extreme Anger
Likes:
*Trucks
*Electrical Outlets
*Vacuum Cleaners
*Animals
Starts Running Away From Home
Severe Temper Tantrums
Aggression
Assaultiveness
Self-Stimulation with hands
Pulls a wagon for hours....
Staring at walls
Excessive Masturbation
CYS → ASH



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[1] Herb Lovett used to refer to "respectful guessing." These "guesses" on the part of the team are displayed in italics.

[2] The term Social Therapists refers to individuals who work directly with and offer support to people. Direct care workers, family members and friends can all be considered social therapists. Their repertoire includes: Health Care, Education and Skill Building, Developing Status, Overcoming Trauma, Problem Solving, Counseling on the Spot, Friendship and much more.

[3] While relevant to the case study, details of the ensuing planning must be described at another time, and don't fall within the parameters of this article.

Appendix 1[4]

The following points are intended to expand your focus, not to restrict it. If additional information seems relevant, by all means bring it to the timeline session.

- Prenatal care
- Was it a planned pregnancy?
- Were there any incidents during pregnancy, delivery or shortly after?
- Age of parents at child's birth
- Education of the parents
- Early childhood developmental milestones from birth and on. When did he or she first walk, talk?

Questions about hearing or eyesight?

- Behavior of the baby, sleep patterns, crying? Ability to relate to others?
- When were concerns noticed? Were tests administered? What were the results? Were there any reactions by the family or the child?
- Psycho/social/medical information
- Record of accidents and injuries
- Educational background, schools, placements, classes and friends
- All admissions to residential and/or treatment facilities
- Strengths and issues as they arose chronologically
- Relationships with family members, friends etc.
- Are the parents married? Separated? Divorced?
- What was the relationship like between the parents? The children?
- Education of parents?
- How many siblings? Anyone else living at the house?
- Are there step-siblings, grandparents? (Deaths and when they occurred)
- Family reactions to person's behavior or challenges
- Separation and loss issues
- Police records?
- Was there any physical, sexual or emotional abuse?
- Any substance abuse?

- Information about the significant people in the person's life
- How do people interact/react with the person?
- Significant life events
- Interventions, activities, supports and therapies that were successful or unsuccessful
- Adaptive or assistive devices
- List various diagnoses given over the years and how they were determined
- If medications were used, which ones? Why? For how long? Doses? Blood levels for relevant medications such as Tegretol, Lithium, and Depakote? Response, if any? Reasons for discontinuation?
- Describe what has been important and meaningful for the person
- How does the person spend his or her day?
- Include the exact age of the individual for each event

[4] Many thanks go to Ellen Wagner and Chris Gaughler for compiling this list.