

University of Southampton

**Nursing staff responses to challenging behaviour: attributions, emotions and
evaluations.**

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Thesis Abstract

This thesis looks at the responses of nursing staff to challenging behaviours in severely mentally ill populations, from a cognitive-behavioural perspective.

The first paper discusses the concept of challenging behaviour as it relates to severely mentally ill populations, defining the scope of such behaviours and outlining their nature and prevalence. Emotional reactions experienced by staff to such behaviour are highlighted, and their impact on both staff, and patient care. The importance of understanding such reactions is explored in relation to psychological theory, in particular cognitive-behavioural and attribution theory.

The second paper explores suggestions for future research made in the literature paper. Using a cognitive framework, staff responses to challenging behaviours are explored on three levels: attributions; emotions and evaluations. Actual incidences of self-harm, attempted suicide/suicide, aggression and serious violence are elicited from nursing staff. Results suggested emotional reactions were understandable in terms of attributions and evaluations held by staff. Descriptive statistics revealed that the different behaviours evoked different ranges and intensities of emotions.

Literature Review:

Understanding staffs' responses to challenging behaviour: the contribution of
cognitive models

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**Understanding staffs' responses to challenging behaviour: the contribution of
cognitive models**

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ABSTRACT

This paper reviews literature on professionals' reactions to challenging behaviours in clinical populations. Research on learning disability populations will be referred to, although this article focuses on behaviours associated with severely mentally ill populations. The prevalence, nature and definitions of these behaviours are explored. Emotional reactions are discussed across different challenging behaviours. Factors that may affect staff emotional reactions are highlighted.

The rationale for focusing on staffs' reactions is presented. Psychological models locating staff responses as important in their interactions with patients are discussed. Behavioural models, as the dominant causal and treatment models of challenging behaviour, are briefly outlined. However, this review places more emphasis on cognitive models, and their focus on beliefs as predictive of emotional and behavioural reactions. Attributional models are also presented to explain how we search for causality for negative events along specific dimensions. Their applications to helping behaviour are discussed, with reference to studies testing these models. Two areas of research, challenging behaviours and expressed emotion, are reviewed in more depth.

This article comments on methodology used in research in this area, and suggestions for future research. Clinical implications of such research are outlined in terms of patient care, staff support and training needs.

INTRODUCTION

Definition and context of challenging behaviours

Challenging behaviours are commonly referred to in the context of learning disabled populations, and have been heavily researched in the learning disability literature from a predominantly behavioural paradigm (Hastings, 1997). Challenging behaviours in this context commonly include self-injury, aggression and stereotypy, although inclusion is operationalised by Emerson (1995) in terms of the impact on others (physical safety) and the extent to which they limit or deny access to ordinary community facilities.

Behaviours labelled as challenging occur with other clinical populations. Of particular interest to this review are challenging behaviours displayed by patients with severe mental illnesses. Within this context, challenging behaviour is defined by Shepherd (1998) as referring to people clearly suffering from a serious mental illness (usually schizophrenia), who in addition to this symptomatology, also show a range of behavioural problems, such as aggression (verbal or physical), violence (destruction of property, assault etc.), repeated self-harm (cutting, overdosing), extreme self neglect (endangering health and safety), fire setting and inappropriate sexual behaviour.

The nature of these behaviours in addition to often intractable symptomatology represents a challenge to services in terms of placement and service provision. Following the closure of mental hospitals, such patients are increasingly found on acute wards or become “revolving door patients”, with many forming the group also referred to as “new long stay inpatients”. Therefore the challenge is not

the behaviour per se, but also its impact on professionals and services providing care for these clients.

Prevalence and nature of challenging behaviours

Violence and aggression

Violence amongst psychiatric patients is becoming increasingly common, but prevalence rates are elusive either due to failure to agree on operational definitions, or wide variations in recording practices (Nolan, Dallender, Soares, Thomsen & Arnetz, 1999). Only a small number of violent incidents get reported (Cottle, Kuipers, Murphy & Oakes, 1995). In a recent study, Steinert, Wiebe & Gehhardt (1999) used psychiatric patients' charts to obtain information about aggressive behaviour. They reported that 75% of male patients and 53% of female patients exhibited some type of aggressive behaviour during hospitalisation, ranging from verbal aggression, to aggression against self, others or property.

In a review of violence in psychiatric inpatients, Noble (1997) reported that most inpatient violence is minor and repetitive. Although serious violence may be uncommon, staff have to cope with the threat of aggression and assault every day (Wykes & Whittington, 1994). Patient assault has been increasingly recognised as a serious problem for nurses (Lanza, 1990) especially compared to other professionals (Nolan et al., 1999), with Poster (1996) presenting statistics showing that 92% of nurses in the UK have been assaulted at least once in their careers.

Suicide and Self harm

Suicide is the major cause of premature death in patients with schizophrenia (Alston & Robinson, 1992). Among these patients, 40% report suicidal thoughts, 20-40%

make unsuccessful suicidal attempts and 9-13% end their lives by suicide (Meltzer, 1998). Suicide remains difficult to predict given its low base rate and the relative homogeneity within groups of patients with schizophrenia (Reid, 1998), causing much anxiety to professionals working with this client group. Previous self harm increases the risk.

The prevalence of self harm is problematic to assess accurately as it depends upon how it is defined, and currently there is no consensus in the research field (Suyemoto, 1998). Self harm is not suicidal in intent although it may include suicidal gestures. It is often differentiated by its extent, the proposed function of the behaviour and the patient's perception of it. It is also differentiated from self injurious behaviour in learning disabled patients which often has the function of self stimulation, or is stereotypic. The incidence of self harm in psychiatric populations is much higher than in the general population, ranging from 4.3% to 20% of all psychiatric inpatients (Darche, 1990 Doctors, 1981 Langbehn & Pfohl, 1993). Self harm commonly includes cutting, burning, interfering with wound healing, self hitting and biting, hair pulling and insertion of foreign objects into the body.

Importance of staff

Staff working in such settings are an important consideration. Direct care staff are acknowledged to be the linchpin of the care process (Rice & Rosen, 1991) with the personality of the carer often as the therapeutic tool (Watts & Morgan, 1994). Relationships between staff and patients are important for patients with 'treatment resistant schizophrenia' who tend to have long hospitalisations and long standing relationships with staff members (Heresco-Levy, Ermilov, Giltsinsky, Lichtenstein & Blander, 1999). The therapeutic relationship is an important non-specific factor in all

therapies. Even with case management, where there is little direct contact with the patient, the absence of a positive relationship between case manager and patient has been found to be significantly associated with poorer outcome (Tattan & Tarrier, 2000). Disturbed interpersonal relationships with staff have been linked to suicide in psychiatric inpatients (Flood & Seager, 1968, Watts & Morgan, 1994).

Staff perceptions of patient behaviours can influence what gets defined as challenging, and therefore referred on for specialist help (Lowe, Felce & Blackman, 1995). Staff attitudes influence diagnosis, placement and discharge (Crichton, 1997). Staff attitudes and behaviour have been suggested to contribute to maintaining cycles of violence and aggression (Maier, Stava, Morrow, Van Rybroek & Bauman, 1987, Whittington & Wykes, 1994) and inpatient suicide (Watts & Morgan, 1994).

Given that patients with severe mental illness and challenging behaviour often represent a difficult task therapeutically, Shepherd (1998) sees that the central challenge with such “difficult patients” is to help staff continue to work in a humane and supportive way. He claims that the strong reactions that challenging behaviours tend to provoke, especially aggression, can easily interfere with the process of treatment and management through undermining the determination to provide humane, sympathetic, good quality care; or in extreme cases leading to acts of violence directed towards the patient. Shepherd (1998) notes that stigma and rejection of such patients by professionals is likely.

Staff may be vulnerable to the consequences of working with patients with severe mental illness in terms of emotional exhaustion and low personal accomplishment (Jackson, Schwab & Schuler, 1986); especially in the context of low staffing levels (Lavender, 1985). Working with challenging behaviour has been identified as a source of staff stress (e.g. Bromley & Emerson, 1995, Jenkins, Rose &

Lovell, 1997, Liebling, Chipchase & Velangi, 1997). In addition, staff working with patients with severe mental illness encounter behaviours which can be life threatening to the patient, or personally threatening to staff, and patient suicide is common.

EMOTIONAL REACTIONS TO CHALLENGING BEHAVIOURS

Emotional reactions experienced by staff working in care settings with challenging behaviours, have been noted in the clinical and research literature, and will be briefly outlined below.

Emotional reactions towards violence and aggression

Fear, anger and rage are noted to be common reactions to aggressive patients, and violence or threatened violence (Maier et al., 1987, Gillig, Markert, Barron & Coleman, 1998). In a correlational study examining nursing staff responses to assault which matched assaulted nurses to a non-assaulted control group, Wykes & Whittington(1998) reported that assaulted staff had poorer mental health than at baseline, and poorer anger control compared to controls. 5% of staff met criteria for a diagnosis of PTSD. Many developed a short term anxiety reaction, a finding also reported by Cottle et al. (1995). Although the impact of assault has generally been assessed in terms of physical damage, Conn & Lion (1983) reported that victims of assault almost unanimously agreed that the emotional impact of the incident far exceeded the impact of the physical injury. The objective level of threat may not be as important as the appraisal of that threat, at the time, by the victim (Lazarus &

Folkman, 1984). Threat may be perceived as more severe if staff have to interact with the assailant a few hours after the assault (Whittington & Wykes, 1994).

Emotional reactions to suicide and self-harm

Talseth, Lindseth, Jacobsson & Norberg (1997) note that there is little in the literature about professional carers' reactions to patient suicide. A range of emotional reactions have been listed in the literature, and include fear, anxiety, absence of empathy and anger (Alston & Robinson, 1992); hatred, guilt, incompetence, fear, anxiety and anger (Talseth et al., 1997). Midence, Gregory & Stanley (1996) studied nursing staffs' attitudes and reactions to suicide, and reported that while the majority of nurses felt sad, shocked, fearful, angry and guilty, a minority were not affected. Hodgkinson (1987) presents a detailed personal account of inpatient suicide suggesting that staff experience emotion in stages; being shocked, numb and subdued initially, then experiencing a wider range of emotions including relief, anger and sadness. Many authors have reflected on the fear, anger and anxiety that self harm provokes in professionals, with such patients often provoking rejecting and hostile attitudes in those who attempt to help them (Ramon, Bancroft & Skrimshire, 1975). Liebling et al. (1997) reported that patient self harm was clearly a source of stress for staff in institutions, with shock and guilt being typical responses.

FACTORS AFFECTING EMOTIONAL REACTIONS

An important finding is that not all staff respond in the same way to challenging behaviours. A number of variables that influence staff responses have been noted in the literature, and these are drawn together and outlined below.

Topography

Behavioural research on emotional reactions to challenging behaviour in learning disability populations has begun to demonstrate differing emotional reactions to challenging behaviour based on its topography. Hastings & Remington (1995) presented care staff working with vignettes describing three common categories of challenging behaviour (self-injury, stereotypy and aggression). Staff were asked to rate their likely emotional responses using supplied emotion scales. Results showed a significant main effect of behaviour type on three of the emotion scales (disturbingness, sadness, and fear). Stereotypy was rated as less disturbing than aggression, which was rated as less disturbing than self-injury. Staff rated that they would feel more sadness witnessing self-injury than when dealing with stereotypy, and less fear when dealing with stereotypy than self-injury and aggression. Similar results were found by Bromley & Emerson (1995).

Staff factors

Lanza (1983) noted that some staff who had been victims of patient assault felt that they would become overwhelmed if they allowed themselves to admit their feelings about the assault, and therefore suppressed or denied these. Whittington & Wykes (1989, 1992) used staff self report and objective measures to study symptoms in staff



who had experienced patient assault. Staff self report often denied that they had been affected by patient assault when their symptomatic profile on objective measures showed otherwise, also suggesting that staff denial may be a factor in clouding symptoms. The under reporting of symptoms in an occupational context may be a factor, especially as the prevailing ethos is that staff should be able to handle powerful emotions and violence maybe assumed to be part of the job (Wykes & Whittington, 1994).

Experience

Hastings, Remington & Hopper (1995), found that in relation to challenging behaviour vignettes, experienced care staff rated feeling disturbed and fearful as less likely, and rated feeling nothing as more likely in response to challenging behaviour, than inexperienced staff. Heresco-Levy et al. (1999) reported that older nurses were associated with higher levels of rejecting attitudes to patients with treatment resistant schizophrenia. Experience in terms of repeated exposure to challenging behaviour may also be influential in generating differing emotional reactions. Fallon (1983) investigated initial and current/typical emotional reactions to self-injury in an interview study with care staff. The most common initial reactions were empathy and fear; with feelings ranging from being upset, horrified, distressed and disbelieving; to optimism, frustration, curiosity, anger and anxiety. However, anger was the most common current and typical reaction, and this ranged from impatience to suppressed rage and impulses to punish. Frustration and feelings of personal failure were nearly as common. Therefore, rather than an absence of emotional responding, type of emotion experienced changed over time.

The experience of repeated assault was found to have two main effects on staff emotional reactions in a study by Wykes & Whittington (1998). Staff who were repeatedly assaulted reported either significantly higher or significantly lower distress than those assaulted once. This may indicate early differentiation into violence distressed and violence habituated groups.

Experience in terms of knowledge and involvement with the patient may also be a factor, at least in suicide, as Midence et al. (1996) reported that two thirds of nursing staff were more affected by a patient's suicide if they had nursed the patient themselves. For suicide, knowledge and experience of encountering suicide both have been associated with more favourable and understanding attitudes (Samuelsson, Med, Sunbring, Winell & Asberg, 1997, Schynder, Valach, Bichsel & Michel, 1999).

Beliefs and evaluations

Issues of moral censure may be relevant to emotional reactions and staff behaviour. Crichton (1997) found moral censure to be a central theme in how staff respond to patient behaviours described as misdemeanours and rule breaking. These ranged from arguments, refusal to keep a minor rule or swearing to life threatening assault. The mad bad dichotomy is prevalent in legal and health systems and seems to centre on whether patients are perceived to have control over their behaviour or not. This itself may affect the diagnosis and treatment they are given. Using psychiatric nursing staff from low, medium and maximum security settings, Crichton (1997) examined attitudes and concepts of patient's rule breaking. Two case vignettes describing an assault on a nurse and setting off a fire alarm were rated by subjects for how personally threatening they found the incident and whether it resulted from

mental disorder or the patients free choice/lack of self control. A list of strategies were rated for their perceived helpfulness in responding to the incident.

Results showed that patients with a past history of violence were generally regarded as being more responsible, suggesting that a past history of violence may be stigmatising. Perceived blameworthiness of the patient had an impact on strategies chosen, those blaming mental disorder preferred medication, and those blaming patient choice/lack of self control preferred sanctions, a telling off, encouragement of an apology and police involvement. Seclusion was rated as more helpful when subjects felt personally threatened. Although there were suggestions that diagnosis affected responses, especially for patients diagnosed with personality disorder, its influence was not clear and consistent. Previous research by Lewis & Appleby (1988) has identified patient diagnosis as an important factor with patients diagnosed with personality disorder believed to be more in control of their behaviour.

IMPACT OF EMOTIONAL RESPONSES AND BELIEFS ON BEHAVIOUR

The above study indicated that staff attitudes and beliefs can influence their hypothesised behaviour. Staff interpersonal relationships with patients and attitudes have also been related to inpatient suicide. 'Malignant alienation' (Morgan, 1979) has been identified as a theme in inpatient suicides. This refers to a progressive deterioration in their relationship with others, including loss of sympathy and support from members of staff who tended to construe these patients' behaviour as provocative, unreasonable, or over dependent. Such alienation appeared to have been malignant in that it gained momentum and was associated with a fatal outcome (Morgan & Priest, 1984 Morgan & Priest, 1991).

Links have also been made between staff's emotional reactions and their subsequent behaviour in relation to patient violence. Whittington & Wykes (1994) reported that coping strategies employed by staff, after they had been a victim of patient assault, were linked to whether their anxiety levels increased or decreased two weeks later. Subjects rated their use of the eight coping strategies described by Folkman, Lazarus, Dunkel-Schetter, De Longis & Gruen (1986). Distancing was the most common coping strategy used by 62.5% of subjects with positive reappraisal and accepting responsibility not used by any subjects. Staff employing confrontative coping had increased anxiety levels two weeks later, whereas using avoidant and escape strategies was associated with decreased anxiety. Importantly for patient care, the two main strategies adopted were suggested to imply contrasting changes in staff behaviour with either a decrease or increase in rates of staff-patient interaction. The authors suggest that if coping strategies are linked to high risk behaviours, then a vicious circle of violence could develop. This has also been highlighted by Maier et al. (1987) who suggested that unless emotions were dealt with and resolved, then future conflict could be set up.

PSYCHOLOGICAL MODELS FOR UNDERSTANDING EMOTIONAL REACTIONS TO CHALLENGING BEHAVIOUR

This section will briefly outline behavioural models of challenging behaviour, before proposing that cognitive models provide a useful framework for understanding emotional reactions to challenging behaviour. Psychodynamic models of challenging behaviour will not be reviewed here but the interested reader is referred to Beail (1998) for analytic work with challenging behaviours predominantly within learning

disability populations, Campbell & Hale (1992) for psychoanalytic models of suicide, and Suyemoto (1998) for a review of psychoanalytic models of self harm.

Behavioural models

Behavioural models are the dominant treatment and causal models for challenging behaviour in the learning disability literature (Hastings & Remington, 1994). These identify the actions of others as important factors in the development and maintenance of challenging behaviour through processes of positive and negative reinforcement. This is important as behavioural models suggest that challenging behaviours often serve social functions such as “attention seeking” and task or social avoidance (Mitchell & Hastings, 1998).

Behavioural research has identified that challenging behaviour is experienced by staff as aversive and stressful, and that emotional responses are linked to topography. Staff beliefs about the causes of challenging behaviour have been studied in terms of general causal models, and are hypothesised to influence the way staff respond to challenging behaviour. However, as yet this remains largely untested. Fenwick (1995) notes that it is not clear from behavioural research how staff form such beliefs, why they experience particular feelings, or how these beliefs and emotions affect behaviour and motivation towards interventions. Cognitive-emotional models may be able to explain this as they provide a framework for linking beliefs to emotional and behavioural responses.

Cognitive models

Cognitive models place emphasis on emotional and behavioural responses to events as mediated by thoughts, images and beliefs. Cognitive models of emotion have

documented the existence of relationships between specific emotions and specific cognitions, and demonstrated that cognitions are antecedent to emotion. There are many cognitive models, but clinically, Ellis' (1962/1994) ABC framework is probably the clearest and most heuristically useful (Chadwick, Birchwood & Trower, 1996). The table below illustrates this.

A	B	C
Activating event	Belief about activating event	Emotional or behavioural consequence

The emotional or behavioural consequence that accompanies the activating event is understandable in terms of the beliefs held about the activating event. Chadwick et al. (1996) stress that it is not that the beliefs cause the feelings (as there are both philosophical and phenomenological reasons for B's not causing the C's), rather that they are part of the same phenomena and there are predictable connections between B's and C's.

B's consist of images, inferences, evaluations and dysfunctional assumptions. One way of making an inference is by means of an attribution (a hypothesis that can be true or false, but goes beyond the factual information that is available). Evaluations are good-bad judgements. Of particular importance clinically are person evaluations, defined as stable, global and total condemnations of an entire person, that may be made about oneself or someone else. Evaluations can also be applied to a piece of behaviour (Chadwick et al., 1996).

Clinical problems are located at point C. Although problems are generally associated with events (A), the cognitive model states that an event is only a problem

if it is associated with significant emotional distress. It follows that problems are also not located at point B, as the importance of identifying and changing a B is not an end in itself, but as a means to an end, namely to resolve problems at point C. Therefore C's are not a product of A's but reflect personal meanings (B) that the event has for us. As well as assessing the type of emotion, it is important to assess the intensity of the emotion as negative cognitions are likely to be associated with strong emotions, whereas cognitions associated with mild emotions are likely to be a realistic appraisal of the event (Chadwick et al., 1996).

Applying this cognitive model to staff, the C is their emotional and behavioural reaction to the challenging behaviour event (the A). Knowledge about what B's staff hold can help predict responses at C. Similarly, strong emotional reactions are likely to be linked to negative beliefs. Therefore this model helps us make sense of staff's experience of challenging behaviour.

Using dimensions of attribution proposed by attribution theory, specific B-C predictions can be made and tested. The main tenets of attribution theory and related research are outlined.

Attribution theory

Attribution theory states that people seek to explain the events that they observe, or that happen to them, in order to gain a sense of control. The tendency to seek causes for events has been labelled "causal reasoning" and was first examined by Heider (1958). The theory suggests people may explain the behaviour of others in terms of causes that "reside within" the person (internal attribution) or in terms of environmental causes (external attribution). Attributional search is most likely to

occur following a negative or unexpected event (Wong & Weiner, 1981), as challenging behaviours are perceived to be.

ATTRIBUTIONAL RESEARCH

Causal attributions have been studied extensively and found to be related strongly to emotion. Weiner's (1985) theory of achievement motivation and emotion has examined the role causal ascriptions play. In following with the cognitive tradition, motives and emotions are not seen as how a person makes sense of the world but as a consequence of causal beliefs. Weiner argued that perceived causes of success and failure share three common properties: locus, stability and controllability (with intentionality and globality as other possible causal structures which may be associated with particular domains). All three dimensions of causality affect a variety of common emotional experience, although Wong & Weiner (1981) demonstrated that the locus and controllability dimensions had the highest priority in attributional research, coming first in temporal order, being more salient and more frequent than others.

Weiner, Graham & Chandler (1982) applied an attributional analysis to the emotions of pity, anger and guilt. They asked students to recall a situation in which they experienced pity, anger and guilt, and to state the perceived cause of each situation. Dimensions of controllability and locus were important, with uncontrollable causes of events correlated with pity independent of cause. Anger and guilt occurred when the associated cause was perceived as controllable and internal to the target of the emotion. Stable causes influenced the magnitude rather than the direction of the emotions. In an experimental test, the students were presented with

situations revolving around a central theme, and indicated the degree of anger and pity that they might experience in these situations. Results supported the linkages of the previous study for uncontrollable causes and pity, and controllable causes and anger. The authors concluded that causal thoughts may precede and determine emotional responses and in many instances anger, pity and guilt are experienced if, and only if, the hypothesised causal antecedent is present.

Applications to helping behaviour

Weiner's model of motivation is sequenced attribution-affect-action. Although the main testing ground has been in achievement related contexts, it has also been applied to help-giving (Weiner, 1980, Schmidt & Weiner, 1988). In such research, students typically read a vignette about lending money or college notes, and then rate their perception of the controllability of the cause of the need, affective reactions of anger and pity and the likelihood of help-giving. The attribution-affect-action path in these situations has been shown by studies to be: controllable causes lead to anger which leads to neglect; and uncontrollable causes lead to pity and judgements of help-giving. This suggests that there is not a direct pathway between thinking and action.

Attribution research on stigmas illustrates that people view different illnesses differently and this is associated with their attributions and judgements of help giving. 'Mental-behavioural' stigmas were perceived as onset-controllable and elicited little pity, much anger and judgements to neglect compared to 'physically' based stigmas (Weiner, Perry & Magnusson, 1988, Schwarzer & Weiner, 1991). The experimental design of these studies enabled the researchers to manipulate perceptions of causal controllability. These attributional shifts resulted in changes to

affective responses and behavioural judgements. However, attributional alteration was not equally possible for all the stigmas. Those viewed as more controllable i.e. mental-behavioural stigmas, were subject to relatively minor change.

Lester (1996) extended this research to include attempted suicide, using vignettes and students. People attempting suicide were viewed as more responsible for their condition than people with cancer, or PTSD, but less responsible than people with drug addiction. Compared to AIDS, PTSD and cancer, attempted suicide aroused more anger, less pity and less willingness to help. Attempted suicide had the same unstable/controllable quality as drug addiction. Lester concluded that negative reactions to suicide may inhibit the expression of support/ elicit a less helpful response from professionals.

Application of Weiner's model to clinical situations

It has been questioned what range of situations Weiner's helping model can be applied to, given that it was mainly formulated and tested using college student studies. For example, the context of caring for a person with an illness e.g. schizophrenia, may be unlike those in which attributional analyses of the emotions were developed. Unlike a student who has received a request to lend his or her class notes, a situation typically used in basic research on attribution, emotion and helping behaviour, staff and relatives have a daily duty of care. Settings and situations may also be important, and so findings need to be interpreted in the light of what is known about these (Brewin, McCarthy, Dudda & Vaughn, 1991).

Although plausible, Hilton (1998) claims that Weiner's model has not been tested in a wide range of studies, and research has not always confirmed the model. Mixed support has been found in studies using clinical populations, and looking at

clinical issues e.g. hyperactive and aggressive child behaviours (Johnson, Patenaude & Inman 1992); emotional reactions of mothers of children with nocturnal enuresis (Butler, Brewin & Forsythe, 1986), care-giving behaviour in staff caring for residents with Alzheimer's (Fopma-Loy & Austin, 1997) and seclusion and restraint of psychiatric patients (Fetter & Lowery, 1992).

Two areas of research have applied attribution theory to emotional reactions to challenging behaviour and severe mental illness, and will be discussed in more detail.

Expressed emotion (EE) research

Attribution theory has recently been employed to help explain how EE in caregivers is related to relapse. High levels of three key emotional reactions of hostility, criticism and over-involvement in familial caregivers have been linked to relapse, and in staff, to negative consequences e.g. a higher turnover of residents for negative reasons (Ball, Moore & Kuipers, 1992) and poorer quality of life (Snyder, Wallace, Moe & Liberman, 1994).

Research by Brewin et al. (1991) and Barrowclough, Johnston & Tarrier (1994) has found that the type of attribution made was a powerful predictor of emotional attitudes e.g. critical relatives made more personal and controllable attributions. Such findings led these researchers to conclude that any predictive significance of EE is due to its association with key causal beliefs of relatives, and that these account for relapse possibly through relative's attempts to limit or control difficult situations.

As well as these attributions about the person, Brewin et al. (1991) and Barrowclough et al. (1994) found different attributions for different types of problem

including illness, negative symptoms, antisocial behaviour and difficult interpersonal behaviour. Different categories of problem did not differ on the internality dimension. However, negative interpretations of interpersonal behaviour were seen as more stable; interpersonal and antisocial behaviours were perceived as having more personal causes, and antisocial behaviours were perceived as having more controllable causes.

This research has limitations in that the EE interviews typically used in such research are lengthy and elicit multiple attributions. Therefore they could be measuring general attributional style of relatives for negative events, rather than measuring their response to specific situations. Such interviews do not directly solicit beliefs so it is impossible to discern whether each relative's causal belief profile in terms of quantity, content and type of attribution is equally representative of their "true" causal belief structure (Barrowclough et al. 1994).

This research has been extended by Weisman & Lopez (1998) who applied attribution theory to study factors leading to unfavourable reactions towards patients with schizophrenia. University students read two vignettes describing a patient with schizophrenia. One vignette described positive symptoms (e.g. hallucinations, delusions) and the other described negative symptoms (e.g. social withdrawal, apathy). Subjects were asked to state the cause of the disorder and rate this in terms of controllability, intentionality and responsibility. Subjects noted any specific symptomatic behaviours that stood out to them, and rated their perceptions of controllability and responsibility. Emotions were divided into unfavourable and favourable emotions for each vignette.

Results showed that positive and negative symptoms elicited different beliefs about a patient's ability to exert control over symptomatic behaviours. Negative

symptoms were associated with greater perceived control than positive symptoms, and provoked more intense negative affect, and less positive affect than positive symptoms. Overall findings offered partial support for Weiner's model for favourable affect, which was related to controllability; but no relationship was found between controllability attributions and negative emotion. Behavioural deficits or negative symptoms were more likely to be viewed as intentional, whereas positive symptoms were seen more as part of the core symptoms of mental illness. However, a limitation of this study is its validity as it used students rather than actual relatives of people with schizophrenia.

Lopez, Nelson, Snyder & Mintz (1999) tested an attribution affect model of schizophrenic relapse with relatives. They note that attributions are important in predicting schizophrenic relapse only to extent that they are related to EE, which is known to be related to outcome, as the relationship of attributions to outcomes has not been directly examined. From an attributional perspective, the way that family members perceive the patients behaviour is central to the household's emotional climate. This study focused specifically on perceptions of whether behaviour was in or outside the patient's control, predicting that this would determine whether they reacted with anger or sympathy to the patient, and that high EE increased attributions of controllability and low EE increased attributions of uncontrollability. Results supported a link between families' perceptions of an ill relative's behaviour and symptoms as under the patient's control and EE, particularly criticism. This was predictive of relapse and symptomatology within a nine month follow up period.

Challenging behaviour research

Sharrock, Day, Qazi & Brewin (1990) and Dagnan, Trower & Smith (1998) have applied Weiner's model of helping behaviour to staff working with challenging behaviours.

Sharrock et al. (1990) considered whether Weiner's theory of helping behaviour could usefully be applied to helping professionals. Although it could be argued that professional staff have a moral obligation to help clients, given limited time and resources, staff attributions may have an important bearing on such decision making. Linking attribution theory to recent demonstrations of the close association between staff optimism and quality of care, Sharrock et al. (1990) placed emphasis on stability, predicting that unstable attributions of a patient's negative behaviours would be associated with greater staff optimism and expectations of helping behaviour being successful.

Sharrock et al. (1990) tested this prediction in a medium secure unit for mentally disordered offenders. A sample of predominantly nursing professionals (N=34) completed a questionnaire covering staff optimism, helping behaviour, emotional ratings and staff attributions of patient behaviour; with reference to one target patient. The optimism scale consisted of 11 negative statements reflecting levels of expectations of the target patients' accomplishments, and the extent to which staff considered they could beneficially intervene. Helping behaviour was measured by staff rating how much extra effort they would exert in helping this patient. Emotional reactions of anger, disgust, sympathy and pity evoked by the target patient were rated. A modified form of the Attributional Styles Questionnaire (ASQ; Peterson, Semmel, Von Baeyer, Abramson, Metalsky & Seligman, 1982) was used, staff chose the major cause for 14 supplied negative institutionally relevant

behaviours commonly associated with mentally ill patients. These included acting with hostility to another patient, theft and argument with a family member. None were of a life threatening nature. Staff rated this cause along each of the four seven point bipolar scales of internal-external to the patient, stable-unstable, global-specific and controllable-uncontrollable by the patient. Subscale scores were summed across the 14 target behaviours for each subject to examine the staff's tendency to make different attributions overall.

Sharrock et al. (1990) found that staff in general made internal, controllable, stable and global attributions about the target patient. Responses on the optimism scales fell close to the mid-point. The target patient evoked levels of anger and sympathy that fell slightly lower than the scale midpoint. Of the emotional ratings, only sympathy was negatively associated with controllability, although neither were related to helping. Correlations showed that optimism was the variable most clearly associated with helping behaviour, and was significantly negatively correlated with stable, internal and controllable attributions. Therefore, the authors concluded that an important determinant of helping was optimism arising from attributions of a patient's problems.

The influence of affective judgements proposed by Weiner was not supported in this study. However, Weiner was chiefly concerned with emotional reactions to specific situations, whereas here the focus was on the tendency of staff to form emotional reactions and make attributions across situations. Another possibility may be that Weiner's theory does not translate easily from help-giving for relatively infrequent events, to a high frequency of problem behaviours in a psychiatric setting. If staff habituate to problem behaviour, then affective reactions may no longer provide the levels of motivation presumed by Weiner.

Dagnan et al. (1998) replicated Sharrock's study with care staff (N=40) working with people with learning disabilities, making a few methodological changes. Attributions, emotion, optimism and helping behaviour were rated in relation to six example behaviours from the Sharrock's original list. Five additional emotions were rated (anxiety, depression, happiness, loving and relaxed). A further variable asking respondents to evaluate the person showing the behaviours and the behaviour itself was included.

The nine emotions were subjected to a factor analysis which revealed a two factor loading for a 'negative' and 'positive' emotion factor, these were then used in the analysis instead of individual emotions. A single score for each of the other measures was derived by summing across behaviours. Path analysis indicated that helping behaviour was most predicted by optimism, optimism was most predicted by negative emotion, and negative emotion was most predicted by the attribution of controllability. Therefore, partial support was found for Weiner's model of helping behaviour, but for negative and not positive emotion.

Attributions of controllability, and negative evaluations of the behaviour and the person were significantly correlated, demonstrating a relationship between global person and behaviour evaluations and specific attributional inferences. Dagnan et al. (1998) interpret this as perceived responsibility leading to blame, which is regarded negatively. They found that negative evaluations of the behaviour and person as a whole were equally high, suggesting generalisation of behaviour evaluations to whole person evaluations, an example of an erroneous and dysfunctional global attribution.

Dagnan et al. (1998) make a number of suggestions for future research including the need to study carers of people with a range of disabilities, ages and behaviour in order to see how Weiner's model generalises. The effects of individual

variables including age, gender, training, experience may be important. Contextual factors should also be studied, as in this study the lack of this information in the vignettes could mean that broad and possibly generalised attributional styles concerning challenging behaviour were accessed. The relationships of attributions and emotions with a range of actual staff behaviours need to be studied. Here the helping behaviour variable will need to be considered to determine what constitutes helping or not helping in clinical situations.

METHODOLOGICAL CONSIDERATIONS AND AREAS FOR FUTURE RESEARCH

Studies applying attributional models and examining emotional reactions in both social psychological and clinical situations have generally used vignette methodology. There are obvious advantages to this in terms of standardisation of data collection, control of extraneous variables and manipulation of variables of interest (Lanza, 1990). Practically you do not have to wait for events to happen, and this avoids problems of differential recall as everyone is responding to the same incident within the same time frame.

However, simulation methodology has disadvantages. Vignettes are artificial, even if based on real life examples, and this therefore limits their external validity. Typically, subjects are asked to imagine how they would respond to a situation described in a vignette. Responses to vignettes cannot be assumed to be identical to responses to actual events, which might produce different responses. Therefore any generalisation of findings from vignette studies to the actual situation must be tentative.

It is difficult to imagine that staff could access the same intensity and range of affect when imagining challenging behaviour scenarios as compared with the actual situation. Personal involvement in such situations is likely to intensify this. Additionally, a vignette provides artificial or limited information about the context of the behaviour, person and environment. It may therefore access broad and possibly generalised attributional styles concerning challenging behaviours. Behaviours rated by staff e.g. in Sharrock et al.'s and Dagnan et al.'s studies were not life threatening. More serious behaviours are likely to produce stronger emotions, and it is this level of emotional intensity that cognitive theory is based upon.

Attributional research is open to the influence of various biases which need to be considered in future research designs and when interpreting results. These include the "fundamental attribution error" (Ross, 1977) described by Burger (1991) as the tendency to attribute another person's actions to something about the person at the expense of giving adequate consideration to the situational causes of the behaviour, encouraged by scales used here e.g. ASQ which splits locus into internal-external. A more recent attribution measure, the Internal, Personal and Situational Attributions Questionnaire (IPSAQ; Kinderman & Bentall, 1996) divides locus into individual, person and situation, and may counteract this. Hilton (1998) has listed other biases in the attributional process including self-serving biases, actor observer differences and cultural differences in the explanation of events.

A next step for research seems to be to study staff emotions, evaluations, and attributions to events that staff experience in their clinical work. This could extend the clinical populations sampled and the range of challenging behaviours studied to incorporate more serious ones.

CLINICAL IMPLICATIONS

Research on the responses of professionals to challenging behaviour is important clinically. Experiencing negative emotions in the work place is distressing to staff and can impair the quality of care received by patients, as well as playing a role in setting up or maintaining future incidents of challenging behaviour. Research in this area advances our understanding of why staff experience the emotions they do, and enables us to identify training and support needs. Such information can also be used to generate CBT interventions for staff. Knowledge about staff's emotional reactions can be taken into account when designing behavioural interventions (Hastings & Remington, 1993).

CONCLUSIONS

Cognitive models provide a framework for explaining why challenging behaviours are experienced as aversive by staff through their emphasis on beliefs. Attributional models are potentially informative in linking specific emotional reactions to beliefs, and specifying B-C connections. Furthering our knowledge in this area is important clinically to inform interventions and support and train staff in their work. Interventions that modify attributions can have an impact on behavioural and emotional responding and this is important in the treatment of challenging behaviour given that staff responses may be a factor in the development and maintenance of challenging behaviour.

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Empirical Paper:

Staff experience of patient self-harm, suicide, aggression and violence: attributions,
evaluations and emotions

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**Staff experience of patient self-harm, suicide, aggression and violence:
attributions, evaluations and emotions.**

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Running Head: Responses to challenging behaviour

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Abstract

Objectives. To explore whether staff's cognitive responses were predictive of emotional reactions to different categories of challenging behaviour.

Design. The design was a between subjects correlational study.

Method. 54 care staff working with patients with severe mental illness completed a questionnaire measuring emotional reactions to, and beliefs about instances of self-harm, attempted suicide/suicide, aggression and serious violence.

Results. Different challenging behaviours tended to evoke different ranges and intensities of emotions. Overall, sadness and anxiety were correlated with internal causal attributions, and anger with external attributions to patient. Contrary to the literature, controllability was not related to anger. Evaluations of the person and the behaviour were correlated, and linked to emotional responding. Attributions of controllability were correlated with evaluations.

Conclusion. The results show a considerable proportion of care staff experience a high level of emotion in response to challenging behaviour events that occur in their daily work. Cognitive models can help make sense of these through a focus on beliefs as predictive of emotional reactions.

Introduction

Behaviours labelled as challenging are prevalent in clinical populations. Challenging behaviours associated with patients with severe mental illness include aggression, self-harm, violence, self-neglect, fire setting and inappropriate sexual behaviours (Shepherd, 1998). In addition, suicide is common in this patient group (Reid, 1998). The challenge presented by such behaviours resides not just in the behaviour, but to professionals managing these behaviours, and services to provide appropriate placement for patients exhibiting these behaviours in addition to their illness. Such behaviours can limit access to community facilities, leading to more restrictive placements (Shepherd, 1998).

Staff are an important resource in the care process for patients with severe mental illnesses. Such patients are often described as 'difficult' to treat and work with. Challenging behaviours are an additional source of stress (e.g. Bromley & Emerson, 1995, Jenkins, Rose & Lovell, 1997, Liebling, Chipchase & Velangi, 1997). Rates of violence in hospitals have increased, and although serious violence is uncommon, staff have to cope with the threat of aggression and assault every day (Wykes & Whittington, 1994). Staff play a role in which behaviours get defined as challenging (Lowe, Felce & Blackman, 1995). Staff attitudes and behaviour have been linked to violence (Maier, Stava, Morrow, Van Rybroek & Bauman, 1987, Whittington & Wykes, 1994) and suicide (e.g. Watts & Morgan, 1994).

Behaviour analytic formulations of challenging behaviour e.g. Hastings & Remington (1994), suggest that staff actions and responses may even play a role in the development and maintenance of challenging behaviour through processes of positive and negative reinforcement. Research with learning disability populations

(e.g. Hastings, 1995, Bromley & Emerson, 1995) indicates that care staff experience aggression, self-injury and stereotypy as aversive, and that they themselves respond with predominantly negative emotions including anger, annoyance and disgust. Emotional responding may be linked to topography, with some behaviours reported as more distressing or disturbing to staff than others (Bromley & Emerson, 1995 Hastings & Remington, 1995). Experiencing challenging behaviours as aversive has been hypothesised as one reason for poor adherence to behavioural interventions (Hastings & Remington, 1993).

It is unclear from such behavioural research why staff experience such emotions (Fenwick, 1995). Cognitive models may be able to address this, as they place emphasis on beliefs (about events etc.) as mediating emotional and behavioural consequences (of such events), and therefore rendering emotional reactions more understandable. Ellis' (1962/1994) ABC framework is among the most clear and useful (Chadwick, Birchwood & Trower, 1996). Here the A is the activating event, the B is the beliefs, thoughts and images about the event, and the C is the emotions and behaviours that follow. The beliefs a staff member holds about a person and his/her challenging behaviour, may make sense of the professional's emotional reactions to that behaviour.

Attributional models detail the processes people go through in making sense of events, and suggest specific cognition-emotion (B-C) connections. Originating with Heider (1958), such models suggest that people seek to explain events, particularly negative ones, in order to gain a sense of control. Weiner (1985) detailed the common properties of attributional search into locus (internal/external), stability (stable/unstable) and controllability (controllable/uncontrollable) with intentionality

and globality as other possible causal structures which may be associated with particular domains.

Causal attributions have been linked to emotions e.g. pity has been linked to uncontrollable causes and anger to controllable causes (Weiner, Graham & Chandler, 1982). Applied to helping behaviour (in social psychology), an attribution-affect-action pathway has been demonstrated (Weiner, 1980 Schmidt & Weiner, 1988) with controllability as a primary determinant of emotional reactions and helping behaviour. Here, attributions of controllability lead to anger which leads to neglect; and attributions of uncontrollability lead to pity which leads to judgements of help giving.

Whilst generally empirical evidence for the theory is mixed (e.g. Hilton, 1998), the concept of attributions remains useful for researchers. Two key studies have applied Weiner's theory to challenging behaviours in patients with learning disability and a mentally disordered patient in a medium secure setting.

Sharrock, Day, Qazi & Brewin (1990) linked attribution theory to recent associations between staff optimism and quality of care, and hypothesised that stability attributions would be more important than controllability attributions in determining staff reactions. They predicted that unstable attributions of a patient's negative behaviours would be associated with greater staff optimism and expectations of helping behaviour being successful. They tested this in medium secure unit using predominantly nursing staff, in relation to one target patient but using example negative patient behaviours.

Sharrock et al. (1990) found that staff made internal, controllable, stable and global attributions about the target patient. Sympathy was the only emotion associated with uncontrollability. Optimism was the variable most clearly associated

with helping behaviour. Therefore the influence of affective judgements in helping behaviour emphasised by Weiner was not supported. However, Weiner focused on emotional reactions to specific situations, whereas Sharrock et al. (1990) focused on the tendency of staff to form emotional reactions and make attributions across a number of situations.

Dagnan, Trower & Smith (1998) replicated Sharrock's study in a learning disability context, with some methodological changes. A larger range of emotional responses were used initially, then factor analysed into positive and negative emotion factors. Ratings were made in relation to six of Sharrock's example behaviours. An additional question assessing whether staff evaluated the patient and the behaviour as neutral or bad was included. Path analysis indicated that helping behaviour was most predicted by optimism, optimism was most predicted in the reverse sense by negative emotion, and negative emotion was most predicted by controllability. Therefore, partial support for Weiner's model of helping behaviour was reported, for negative but not positive emotion. Negative evaluations of the person and the behaviour were equally high, and significantly related to perceived controllability.

The present study extends and refines these two studies. First, participants report their reactions to actual episodes of challenging behaviour they have experienced. Vignette methodology has advantages in terms of standardisation of data collection, control of extraneous variables and manipulation of variables on interest. However, vignette studies are limited in terms of their external validity (Lanza, 1990) and generalisability, as one cannot assume that imagined responses would be equivalent to actual responses. Research using actual examples can complement such studies.

Second, we extend the population sampled to staff working with people with severe mental illness, predominantly psychosis. Patterns of beliefs and emotional responding may differ here as compared to prior populations studied. Third, in keeping with contemporary attribution research e.g. Kinderman & Bentall (1996), external attributions are separated into other person (patient) or situation.

Fourth, this study selects four main types of challenging behaviour: self-harm, attempted or actual suicide, aggression and serious violence. These represent behaviours of a more serious nature than previous studies, which may increase emotional responding. Intensity of emotion experienced is crucial because it has been argued that cognitive-behavioural theory applies only to severe emotions (Chadwick et al., 1996).

Hypotheses

The study makes specific hypotheses derived from the cognitive-behavioural model and attributional research. First, that data on emotional reactions will be associated with beliefs. Second, that strong, or severe emotional reactions will be predicted by specific attributions and evaluations. Specifically:

- Internal attributions to self will be associated with sadness and anxiety;
- External attributions to the patient will be associated with anger;
- Attributions of controllability by the patient will be associated with anger;
- Negative person evaluations will be associated with anger.

Finally, the study offers valuable descriptive data on whether type and intensity of emotions vary according to challenging behaviour category.

Such research has important clinical implications as exploring the relationships between emotions, attributions and evaluations extends our

understanding of professionals' responses to challenging behaviour, and can inform interventions, and identify staff training and support needs.

Method

The methodology used in this research was similar to that of earlier studies (Sharrock et al., 1990 Dagnan et al., 1998) with some important revisions.

Participants

Questionnaires were distributed in mental health acute and rehabilitation services in Bournemouth and Southampton, to qualified and unqualified nursing staff. The total number distributed via ward and hostel managers was 390. 54 were returned representing a 14% response rate.

39% of respondents were male and 61% were female. The average age was 34 years (SD 10.25) ranging from 19 years to 59 years. Staff from Grades A through to H responded with Grade E representing the largest category of respondents (49%) followed by B grades (23%). The average time of working was seven years (SD 5.65) ranging from six months to 22 years. 66% of staff had worked with a patient who had committed suicide, and 64% had been the victim of patient violence.

Measure construction

The questionnaire was piloted on three nursing staff (A, E and H grades). Staff reported that completing the original questionnaire was time consuming, especially the section of behavioural responding. Answers to this tended to be lengthy and reflect standard procedures/programmes. For these reasons, this section was

dropped. Also, disgust was dropped from the list of emotions as no-one endorsed it, and it is suggested to be highly correlated with anger (Sharrock et al., 1990). Frustration was added after piloting, as commonly expressed by pilotees. The scales measuring evaluations based on previous research (Dagnan et al., 1998) were refined to encompass a positive as well as a negative or neutral dimension. Wording was tightened (e.g. to direct staff to select main cause of behaviour only).

Measure

Questionnaire format. The questionnaire layout was in line with clinical use of cognitive ABC models (Chadwick et al., 1996). The A (challenging behaviour event) is assessed first, then the C (emotional responses), and then the B (evaluations and attributions).

Challenging behaviour scenario (A). Staff were instructed to describe a recent challenging behaviour incident involving a patient they were providing care to, for each of the following categories: self-harm, attempted/actual suicide, aggression, and serious violence, and provide a brief description of the incident. Definitions taken from the clinical literature were supplied to help staff identify appropriate incidents.

Emotional responses (C). Staff rated the extent to which they had experienced, at the time of the incident, each of the following six emotions (anger, fear, frustration, anxiety, sadness and pity/sympathy). Pity and sympathy were combined as found to be highly correlated by previous research (Sharrock et al., 1990). Emotions were rated on a seven point bipolar scale with “not at all” and “extremely” as the anchor points.

Evaluations (B). Staff rated how they viewed the patient's behaviour and the patient, at the time of the incident on a seven point scale with "good" and "bad" as the end points and 'neutral' as the mid point.

Attributions (B). An open-ended question asked staff to state what they thought the main cause of the challenging behaviour incident was. This cause was then rated on dimensions of locus (patient, staff, situation/circumstances), controllability (by the patient) and stability/globality. All dimensions were rated on a seven point bipolar scale.

Validity and reliability checks

Re-test reliability. A small sample of staff completed the questionnaire on two occasions of 10 days apart, using the same challenging behaviour incidents on which to base their ratings, in order to test the reliability of the questionnaire. Spearman correlations were computed for 10 scenarios, comparing each item at time one and time two. The majority of items were significantly correlated, with coefficients ranging from .748 to .977. Reliability coefficients for patient evaluations and situation attributions were weak and insignificant, and only approaching significance for sadness and anxiety; so this needs to be accounted for in the analysis.

Validity. A small sample of staff (n=6) were interviewed as to their responses on a scenario from the questionnaire. The interviewer was blind to their questionnaire answers. This was to examine whether a questionnaire was a valid way of exploring staff responses to challenging behaviour in comparison to interviewing them about it. Generally there was agreement between staff responses on the questionnaire compared to their interview data. The emotions experienced most strongly on the questionnaire were the same as those offered spontaneously by each interviewee. For

evaluations, five out of six and four out of six staff evaluated the patient's behaviour, and the patient respectively, in the same way. For attributions, five out of six staff made congruent internal attributions, and three out of six rated external attributions to the patient and situation in the same way. Controllability was rated in the same way by four out of five staff.

Results

Descriptive statistics

Type and intensity of emotional response

Responses were divided into two 'intensity' categories for each of the emotions. Responses up to four were labelled 'mild' and responses of four and above were labelled 'severe'. Categories were calculated for each participant, on each emotion for each scenario.

For self harm; sympathy, sadness, and frustration were experienced by the majority of respondents (54%, 59% and 52% respectively) as 'severe' whilst anger, anxiety and fear were experienced as 'mild' (79%, 74% and 82% respectively). Sadness was the most intensely experienced emotion. For attempted suicide/suicide; the pattern of emotional responding was similar to self harm, with sadness, sympathy and frustration experienced by the majority of respondents as 'severe' and anger, anxiety and fear as 'mild'. Again, sadness was the most intensely experienced emotion.

For aggression, scores were consistent, with all emotions rated as 'severe' by between 52% and 61% of staff. For serious violence, anger, frustration and anxiety were experienced as 'severe' emotions by a majority of staff, with sympathy, sadness

and, to a lesser extent, fear experienced as 'mild'. Anger was the most intensely experienced emotion with 78% of staff experiencing a 'severe' level of anger, and this was closely followed by frustration.

Insert table 1 about here

Evaluations

Evaluations were divided into three categories of 'good' (1-3), 'neutral' (4) and 'bad' (5-7), as the mid point of the scale had been defined as neutral.

For self harm, staff made an equal amount of neutral and negative evaluations of the patient's behaviour (47% each). However, the patient themselves was more likely to be evaluated neutrally (63%) than negatively (22%). For attempted suicide/suicide, staff made more negative evaluations of the patient's behaviour (55%) than neutral or positive evaluations. However, the patient themselves was more likely to be viewed neutrally (58%) than positively or negatively.

For aggression, staff predominantly evaluated the patient's aggressive behaviour as bad (81%). They were also more likely to make negative evaluations about the patient here (62%) than positive or neutral. For serious violence, staff made predominantly negative evaluations about the patient's behaviour (92%). Staff were also more likely to make negative evaluations about the person (65%).

Attributions

For the purpose of these descriptive statistics, attributions were divided into two categories, using their endpoints as names for the categories. Responses were categorised as for emotional responses (1-3, and 4-7).

Locus. Across all challenging behaviour categories, staff were most likely to make external attributions to the patient (73% for self harm, 76% for attempted suicide/suicide, 69% for aggression and 83% for serious violence) . Attributions to the situation were a consistent second (52%, 68%, 48% and 56% respectively) and were endorsed almost as frequently as those to the patient for the attempted suicide/suicide category. Internal attributions to self were rare, although were more common in scenarios involving serious violence (18%), and aggression (9%) than attempted suicide (5%) or self harm (2%).

Controllability. Percentages of staff making controllable and uncontrollable attributions to the patient were similar overall. Self harm was the only behaviour that was viewed as more controllable than uncontrollable, rated as controllable by 68% of staff. Suicide was viewed as more uncontrollable than controllable, with 60% of staff viewing it as uncontrollable. Aggression and violence were marginally viewed as more uncontrollable than controllable.

Uniqueness of cause of incident. Generally, staff viewed the cause of the incident as one that would be likely to cause future incidents, although this was less pronounced for the attempted suicide/suicide category.

Inferential Statistics

Non parametric tests were used to analyse the data, due to their not being normally distributed.

Factor Analysis

Emotional responses for each scenario were subjected to a factor analysis. However, although there were consistently two factors for each scenario, the loadings were not consistent across the four scenarios, suggesting an underlying instability to the factor structure. When the four scenarios were taken together, although a two factor structure emerged, all emotions loaded onto the first factor, and anxiety and fear loaded onto the second factor. Therefore, there were not two distinct factors. Factor analysis was abandoned at this stage.

Correlations

Spearman's correlations were used to test for associations between the variables as predicted by the hypotheses. Hypotheses were tested for scenarios overall, and individually.

Evaluations and emotions

The present study assessed a specific theoretical hypothesis, predicting a positive association between person evaluations and anger. Taking all of the scenarios together, this was supported (r_s (N=51) = .637, $p < .01$, one-tailed). For self harm, (r_s (N=47) = .344, $p < .01$, one-tailed), attempted suicide/suicide (r_s (N=37) = .485, $p < .01$, one-tailed), and serious violence (r_s (N=22) = .41, $p < .05$, one-tailed); patient evaluations were significantly related to anger. No significant association was found for aggression.

Attributions and emotions

Internal to staff. The hypothesis here predicted that internal attributions to staff would be associated with anxiety and sadness. Taking all scenarios together anxiety (r_s (N=48) = .626, $p < .01$, two-tailed) and sadness (r_s (N=49) = .572, $p < .01$, two-tailed) were significantly associated with an internal attribution. For self harm, sadness was significantly correlated with an internal attribution (r_s (N=47) = .384, $p < .01$, two-tailed). There were no other significant associations for the other scenarios.

External (to patient). The hypothesis here predicted that an external attribution to the patient would be associated with anger. Taking all scenarios together, anger was significantly associated with external attributions to the patient (r_s (N=50) = .283, $p < .05$, two-tailed). There were no significant associations for individual scenarios.

External (to situation). External attributions to the situation were weakly associated with a range of emotional responses overall, e.g. anger, anxiety and sympathy. External attributions to the situation were weakly associated with external attributions to the patient overall (r_s (N=51) = .291, $p < .05$, two-tailed), but not for individual scenarios.

Controllability. The hypothesis here predicted that anger would be related to controllability attributions. This was not supported overall. For individual scenarios, attributing the cause as controllable by the patient was negatively related to anger (r_s (N=35) = -.366, $p < .05$, two-tailed) for attempted suicide/suicide. There were no other significant correlations for other scenarios.

Evaluations

We found that overall, staff did not discriminate between evaluations of the person and of the behaviour. Evaluations of the patient's behaviour and the patient themselves were significantly correlated (r_s (N=52) = .925, $p < .01$, one-tailed).

On individual scenarios, correlation between the two evaluations were also significant. However, the size of the correlation varied. It was relatively weak (r_s (N=49) = .362, $p < .01$, one-tailed) for self harm, and moderate for attempted suicide/suicide (r_s (N=38) = .571, $p < .01$, one-tailed) and for aggression (r_s (N=47) = .542, $p < .01$, one-tailed). For serious violence the correlation was very strong (r_s (N=23) = .876, $p < .01$, one-tailed).

Evaluations and attributions

We found that overall, evaluations of the patient were associated with attributions of controllability (r_s (N=50) = .335, $p < .05$, two-tailed).

Analysis of descriptive categories

It was intended to test the hypotheses on another level, using the descriptively coded nominal data to test the hypotheses. Chi square (χ^2) was the analysis of choice using the phi coefficient to determine the existence of a statistical association. However, a chi square is proscribed in two by two tables when any of the expected frequencies are less than five, and this applied to much of the data for these hypotheses, and therefore we could not proceed with this analysis.

Discussion

The present study has explored cognitive and emotional reactions to actual instances of challenging behaviours. Four categories were studied, namely self harm, attempted suicide/suicide, aggression and serious violence. Hypotheses tested in this study were taken from cognitive behavioural and attribution models. Mixed support was found for these hypotheses.

Type and intensity of emotions experienced

This study demonstrates that staff experience a range of emotions in response to the challenging behaviours they encounter day to day. By categorising the ratings staff made of the extent to which they experienced each of the emotions, into categories of mild or severe, we have been able to report information on the intensity to which staff experience such emotions.

The clearest findings relate to serious violence where 'severe' emotional reactions of anger and frustration were experienced by three quarters of staff. Interestingly, these emotions were also experienced as severe for aggression, but also in conjunction with other emotions of sympathy and sadness. Patterns of emotional responding for self harm and attempted suicide/suicide were similar, although the proportion of staff experiencing emotions in the severe category was higher for attempted suicide/suicide suggesting that this is more difficult to deal with than self harm. This differential responding to categories of challenging behaviour links in with findings from behavioural research on staff emotional reactions to challenging behaviours in learning disability populations e.g. Hastings & Remington (1995) and Bromley & Emerson (1995).

Knowledge of the intensity of emotional reactions is vital for cognitive behavioural models which place emphasis on strong emotion as linked to specific negative beliefs and attributions. When severe emotion is experienced, the theory suggests core negative beliefs are activated. When staff experienced emotions categorised as 'mild', these beliefs are hypothesised to be absent, and the theory is relatively quiet (Chadwick et al., 1996).

A striking finding in the present study is that staff experience (perhaps over time), a range of diverse emotions about the same event. Cognitive behavioural theory posits that when we experience a particular emotion, the core beliefs driving that emotion will become conscious. When we experience a different emotion, the beliefs pertinent to that emotion are activated. This is backed up by the validity interview data in this study. For example, in response to suicide, a staff member reported sadness at loss of life, anger that the patient did not ask for help, and anxiety that he as a staff member could have done something to stop it happening. Clearly, reactions are diverse, and can change, and this poses a challenge for research in this field.

Evaluations

Overall this study found a relationship between evaluations of the person and the behaviour, in line with Dagnan et al. (1998). The strength of the correlations varied between challenging behaviour categories suggesting that staff discriminate differently according to challenging behaviour type. Staff were able to discriminate between viewing self harming and suicidal behaviour negatively to a greater extent than for serious violence. This may link with type of emotional response experienced i.e. more sympathy and sadness in relation to self harm and suicide, compared to

more anger and frustration for aggression and violence. Also the intensity of negative emotion (especially anger) experienced here was greater, suggests that as staff experience such emotions more intensely, they are less able to discriminate between the person and the behaviour. Expressed differently, it may be an inability to distinguish people from their behaviour which drives emotional responding to certain challenging behaviours.

This study found support for an association between person evaluations and anger. This is important as it suggests that when staff have difficulty separating out evaluations of the patient and their behaviour, emotional reactions of anger get generalised to the person. This represents a key training challenge for psychologists to help staff separate these evaluations out.

Evaluations and Attributions

Overall, support was found for an association between evaluations of the person and the behaviour and attributions of controllability, although these were relatively weak. This association was reported by Dagnan et al. (1998). This has implications for staff training as it implies that inferring the patient can control their behaviour is linked with negative evaluations of the person and behaviour. This could explain staff comments of patients as 'manipulative' and 'attention seeking' etc.

Attributions

Overall, there were mixed findings for the hypotheses relating to emotional reactions and attributions. This is hardly surprising given the mixed picture of emotional responding that staff present. As predicted, anxiety and sadness were associated with internal attributions overall, but generally not for individual categories. The

hypothesis that anger would be associated with external attributions to the patient was supported overall, but not for individual categories. External attributions to the situation were weakly associated with a variety of different emotions. Theoretically it is not clear which emotions would be associated with such an attribution. External attributions to the patient and the situation were weakly associated suggesting that staff may not distinguish between such causes. Measuring situation attributions may still be of value as they were a much used category.

Controllability was not found to be associated with anger as predicted. Attribution theory predicts this (e.g. Weiner, 1980) and some studies find this link (Schmidt & Weiner, 1988) whereas others do not (Johnson, Patenaude & Inman, 1992, Sharrock et al., 1990). In the present study, self harm was viewed as the most controllable behaviour by the patient and yet the sadness and sympathy were experienced more intensely than anger. In this context, anger may be more related to intentionality or responsibility which may be different from controllability.

Research and clinical implications

Previous studies have used vignette examples of challenging behaviour upon which staff rated their emotional response (Bromley & Emerson, 1995 Dagnan et al., 1998, Hastings & Remington, 1995). Such ratings have then been used as a basis upon which to test hypothesis for relationships between attributions and emotions. Whilst such research has strengths in terms of standardisation, control of extraneous variables etc., it may have limitations in terms of external validity and generalisability. The present study addresses similar hypotheses, but uses actual challenging behaviour events. It also categorises the emotions that staff experienced into intensity, which is central to cognitive-behavioural models.

It may be argued that there are methodological weaknesses inherent in using recall of actual events. The researcher has little control over scenarios elicited. We would argue that the focus was not on the challenging behaviour event itself, but the beliefs, evaluations and emotions around it. Also, it may be argued that the events recalled were extreme and unrepresentative. This is possible, although the challenging behaviours sampled are common within this population. The low response rate also means that the findings of this study may not be representative of nursing staff in general. It is not possible to know whether a similar pattern of responses would be found for the large percentage who did not respond; or whether biases operated for those responding e.g. experiencing stronger emotions in response to challenging behaviour prompting participation in such a study. Finally, the study is correlational and does not allow for causal inferences to be drawn, nor does it exclude the possibility of another unaccounted variable that may account for identified relationships. Non parametric statistics, while appropriate for non normally distributed data, also limit statistical power and therefore important associations may have gone undetected. Re-test reliability coefficients were non-significant for some items, and therefore analysis involving these should be treated with caution. However, the validity data suggested that staff were able to reliably recall which emotions they had experienced most strongly when questionnaire responses were compared to those elicited in the interviews.

The mixed support for the hypotheses, both in this study and previous ones, indicates that to make sense of staff's emotional reactions to challenging behaviour, a more sophisticated methodology is needed. Questionnaire methodology is static in sampling a moment in time and cannot track the process of responding illustrated in interviewing staff about their reactions to challenging behaviour. Emotional

responses to challenging behaviours may be better understood in stages. Reactions to suicide have been related to stage models of bereavement Hamel-Bissell (1985). The necessarily limited range of responses on a questionnaire may not cover staff experience in full. Sampling one moment in time does not address how long emotional reactions last. Cottle, Kuipers, Murphy & Oakes (1995) sampled two time points for assaulted staff, and found anxiety often to be short term, decreasing to baseline levels after a month, although remaining high in some staff. This could be affected by coping strategies staff use to deal with increased anxiety levels. Whittington & Wykes (1994) found type of coping strategies used to deal with anxiety following an assault were related to increases and decreases in anxiety levels two weeks later. This suggests our understanding of emotional reactions over time is incomplete without including coping strategies. It also suggests that even if emotions have calmed, support may still be needed.

Although emotional reactions may diminish over time, beliefs may not. Beliefs may be cumulatively reinforced leading to generalised views e.g. patients as manipulative. Cottle et al. (1995) found that beliefs did not change in the same way as emotions, but became stronger over time with critical comments increasing after a month, and external attributions to the patient as more likely a month later. Therefore, knowledge of staff beliefs is important both in the short and longer term.

This study has found a significant level of emotional responding. This is a cause for concern for several reasons. Firstly it suggests a need for support mechanisms for staff. Patients with severe mental illness are a difficult patient group to work with (e.g. Shepherd, 1998). Burnout is a consideration here (Nichols, 1985 Jackson, Schwab & Schuler, 1986) especially with low staffing levels (Lavender, 1985) as commonly encountered in this research setting. Secondly, it indicates a

need for regular training of staff. Psychological models relate staff responses to the development and maintenance of challenging behaviour. Relationships with staff are vital in rehabilitation, and staff attitudes and relationships with patients have been linked to patient suicide e.g. Watts & Morgan (1994). Strategies used by staff to cope with anxiety, following patient assault, imply contrasting changes in staff behaviour and staff-patient interaction, and may set up future conflict (Whittington & Wykes, 1994) especially if emotions aren't dealt with (Maier et al., 1987). Interview data suggested that staff did recognise that their emotional responses could affect their behaviour, e.g. inhibiting a helping response to self harm, and producing an urge to be violent back to a violent patient, or shout at them.

Conclusion

This study has extended our knowledge of staff attributions, emotions and evaluations in relation to actual challenging behaviour events. The merits of this study need to be considered alongside that of vignette studies in determining where research efforts in this area should next be directed; and how to make methodological improvements to better capture the complexity of emotional responding to challenging behaviours. Such research is important to enable us to support staff in their work and identify specific training needs to improve patient care in this complex and challenging area.

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Table 1: Emotional response to challenging behaviour categories.

Percentages (%) indicate the percentages of respondents in each category, and numbers indicate the number of respondents in each category.

SELF HARM

EMOTION	MILD	SEVERE
anger	79% (37)	21% (10)
frustration	48% (22)	52% (24)
anxiety	74% (34)	26% (12)
fear	82% (37)	18% (8)
sympathy	46% (21)	54% (25)
sadness	41% (20)	59% (29)

ATTEMPTED/ACTUAL SUICIDE

EMOTION	MILD	SEVERE
anger	65% (24)	35% (13)
frustration	49% (18)	51% (19)
anxiety	53% (20)	47% (18)
fear	66% (25)	34% (13)
sympathy	40% (15)	60% (22)
sadness	32% (12)	68% (26)

AGGRESSION

EMOTION	MILD	SEVERE
anger	42% (19)	58% (26)
frustration	40% (18)	60% (26)
anxiety	39% (17)	61% (27)
fear	47% (21)	53% (24)
sympathy	42% (18)	58% (25)
sadness	48% (21)	52% (23)

SERIOUS VIOLENCE

EMOTION	MILD	SEVERE
anger	22% (5)	78% (18)
frustration	29% (7)	71% (17)
anxiety	41% (9)	59% (13)
fear	54% (12)	46% (10)
sympathy	70% (16)	30% (7)
sadness	65% (15)	35% (8)

Critical Overview

This study sought to focus on actual challenging behaviours that staff experience in their clinical work, and test predictions from cognitive and attributional models in order to gain an understanding of staff's emotional responses to such behaviour. As such, this study has provided useful data about how staff actually respond, including type and intensity of emotion experienced, and how patterns of emotional responding differ across different challenging behaviours. Hypotheses tested reveal mixed results, and it is important to consider these together with results from previous studies, and in the light of potential limitations of this present study.

The measure used in the present study was similar to that used in previous studies, although it incorporated various refinements. The measure was more succinct in order to maximise response rates. Cognisant of reliability issues, an attempt was made to examine the reliability of the questionnaire on a re-test basis. Reliability has not always been addressed in previous studies. Although the researcher approached many staff who agreed to complete questionnaires on two occasions, only a few completed and returned both questionnaires. The minimum 10 scenarios on two occasions were collected to enable reliability to be examined. However, more confidence in reliability may have been possible with greater numbers, and this may have increased the reliability of certain items.

Similarly, the researcher sought to examine the validity of the questionnaire by conducting interviews with staff who had completed the questionnaire. Although only a selection of staff were interviewed, results did suggest that the questionnaire was a valid way of exploring staffs' responses to challenging behaviour, especially in

terms of the main emotions experienced. However due to limited numbers this cannot be regarded as conclusive.

Using staffs' own scenarios limited the control the researcher had over the scenarios elicited. As such, it must be borne in mind that such scenarios cannot be taken as representative of staff experience in general. The relatively low response rate also limits generalisability of results. In settings where the researcher was unknown, distribution of questionnaires was via the manager, so there is no way of knowing how many staff actually received questionnaires. The researcher was aware of practical considerations that may have contributed to the low response rate including chronic staff shortages and the preponderance of questionnaires staff have to complete, from which they often do not receive feedback. Trainee status was also likely to have been an issue as this meant the researcher was unknown or transient. Recommendations for overcoming this would be to incorporate such research into staff training, thus ensuring they get something in return for their participation. Change following training interventions with staff could also be evaluated using this measure.

Finally, this study is important in that it can be taken alongside other studies based on vignettes, to assess where the next step for research in this area is, and the methodological enhancements needed to study this complex, but clinically important area. In particular, what constitutes helping in clinical contexts needs to be addressed before it can be measured. The attempt made by this study shows that staff helping behaviour may be difficult to categorise.

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Appendix I

Ethical Approval

(University)

Training Course in Clinical Psychology
Department of Psychology
University of Southampton

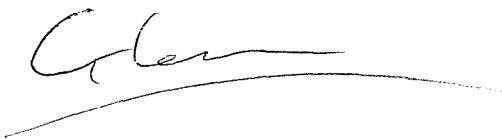
Memorandum

To: Rachel Newman
From: Glenn Waller
Date: 14th July 1999
Re: Project proposal - dissertation

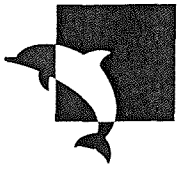
Dear Rachel

This is just to say that I am happy with the project proposal that you have submitted, and that you have the Course's permission to proceed. You should now get all appropriate local ethical approval. I have forwarded your application to the Department's Ethical Board. You should expect a two-week wait while they process it. They will be in direct contact with you on the subject.

Best wishes



Glenn Waller



**University
of Southampton**

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FAO Rachel Newman
Clinical Psychology Department
University of Southampton
Highfield
Southampton

23rd July 1999

Dear Rachel,

I am writing to confirm you that your ethical application titled, "Nursing staff responses to challenging behaviour", has been given approval by the department.

Should you require any further information, please do not hesitate in contacting me on (01703) 593995.

Yours sincerely,

Kathryn Smith
Academic Secretary

Appendix II

Ethical Approval

(East Dorset)

Dorset HealthCare NHS Trust

DEPARTMENT OF PSYCHOLOGICAL THERAPIES

Providers of Psychology, Psychotherapy, Counselling and Research Services

St. Ann's Court, St. Ann's Hospital, 69 Haven Road, Canford Cliffs, Poole, Dorset, BH13 7LN
Telephone: (01202) 708881 Fax: (01202) 706562 E-mail: dopt.ac@virgin.net

RMR/TH

05 August 1999



Awarded for excellence

Ms Rachel Newman
Clinical Psychologist in Training
DOPT
The Chines
Herbert Hospital

Dear Rachel

RE: RESEARCH PROJECT FOR CLINICAL TRAINING DOCTORATE

Thank you for your recent note regarding the project which you are carrying out on nursing staff responses to challenging behaviour. As I understand it from you, the study only involves staff, is anonymous, voluntary and uses questionnaires and does not require any identifiable patient information. As this is the case and as the project has received ethical approval from Southampton University, I am quite happy that the project does not need to go to get local ethical approval.

With regards.

Yours sincerely

A large, handwritten signature in black ink, appearing to read 'Tim Hollingbery'.

Tim Hollingbery
Consultant Clinical Psychologist
Head of Service



Appendix III

Ethical Approval

(Southampton)



Southampton
University
Hospitals
NHS Trust

Southampton & S.W. Hants
Joint Research Ethics Committee
Trust Management Offices
Mailpoint 18
Southampton General Hospital
Tremona Road
Southampton SO16 6YD

Tel 01703 794912

Fax 01703 798678

Ref: CPW/DBL

12th January 2000

Miss R Newman
3rd Year Clinical Psychology
University of Southampton
Highfield
Southampton

Dear <iss Newman

Submission No:369/99 - Nursing staff reponses to challenging behaviour.

Following the conditional approval and in response to your letter dated 4th January 1999, I am pleased to confirm **full approval** having received clarification of question 26 and the signature of the Care Group General Manager as requested for the above study.

This approval was granted under Chairman's action by Dr Mary Carroll and will be brought to the attention of the Committee at their meeting on 26th January 2000.

This committee is fully compliant with the International Committee on Harmonisation/Good Clinical Practice (ICH) Guidelines for the Conduct of Trials involving the participation of human subjects as they relate to the responsibilities, composition, function, operations and records of an independent Ethics Committee/Independent Review Board. To this end it undertakes to adhere as far as is consistent with its Constitution, to the relevant clauses of the ICH Harmonised Tripartite Guideline for Good Clinical Practice, adopted by the Commission of the European Union on 17 January 1997.

Yours sincerely,

Clair Wilkinson (Ms)
Research Ethics Administrator

Appendix IV

Questionnaire and Participant Information



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Research Questionnaire

As part of my clinical psychology training, I am required to undertake a research dissertation. I have chosen to study key challenging behaviours that nursing staff experience in their clinical work, and the impact of these upon staff and their well being. Such information can then be used to identify support and training needs for staff working with challenging behaviour.

Participation in this study is voluntary and there is no requirement for you to complete this questionnaire. You are entitled to withdraw from this research at any time.

The answers that you give on this questionnaire are confidential and anonymous. You are not asked to give your name or your work setting. Questionnaires will not be looked at individually but analysed on a group basis together with other nursing staff taking part in this study both in East Dorset and Southampton.

The results of this study will be made available to all those taking part.

The questionnaires should take approximately 30 minutes to complete. Instructions to help you fill them out are given overleaf.

If you have any comments that you would like to make, please write them at the end of the questionnaire.

Please return completed questionnaires in the envelope provided to myself Rachel Newman, Trainee Clinical Psychologist at the Department of Psychology, Royal South Hants Hospital. Please return questionnaires by

THANK YOU FOR YOUR TIME AND CO-OPERATION

Rachel Newman

Trainee Clinical Psychologist

University of Southampton Training Course in Clinical Psychology

INSTRUCTIONS

We would like you to think about an incident that occurred **within the last month (or the most recent)** at your workplace **with a patient you considered yourself to be personally providing some care to**, for each of the following categories:

1. Self harm
2. Attempted or actual suicide
3. Aggression
4. Serious violence

A definition of each of these is provided to help you identify each situation. Please think of an incident and then answer the following questions.

Please answer a set of questions for **each** of the four incidents. Please make sure you answer every question, even if you do not feel it is relevant to you.

There are no right and wrong answers to these questions, please answer honestly accordingly to how you felt regarding the incident. Your answers are given on an anonymous basis.

For most questions you will be asked to circle the number between 1 and 7 that best describes your response.

E.g. Please rate the degree to which you experienced the following emotion.

	Not at all							Extremely
Anger	1	2	3	4	5	6	7	

E.g. If you felt extremely angry, you would circle '7'.

Thank you again for your co-operation.

Scenario one: Self harm

“Self inflicted, non accidental injury producing bruising, bleeding or other temporary or permanent tissue damage.”

Please describe the incident briefly below.

How recently did it happen? _____

What is your involvement with the patient? _____

(key-worker, co-worker, team member etc.)

**At the time of the incident how much did you experience each of the following emotions?
Please circle the number that best describes this.**

	Not at all						Extremely
Anger	1	2	3	4	5	6	7
Frustration	1	2	3	4	5	6	7
Anxiety	1	2	3	4	5	6	7
Fear	1	2	3	4	5	6	7
Sympathy/pity	1	2	3	4	5	6	7
Sadness	1	2	3	4	5	6	7

At the time the incident occurred how did you view the patient’s behaviour? (Please circle)

Good	Neutral	Bad
1 2	3 4 5	6 7

At the time the incident occurred how did you view the patient? (Please circle)

Good	Neutral	Bad
1 2	3 4 5	6 7

Scenario one: Self harm (Continued)

Please write below what you feel the major cause of this incident was. (If there is more than one, please choose the one most likely cause).

Was the cause of this incident due to something about. (Please circle)

I. you

Totally due to me 1 2 3 4 5 6 7 Nothing to do with me

II. the patient

Totally due to the patient 1 2 3 4 5 6 7 Nothing to do with the patient

III. situation/circumstances

Totally due to the situation 1 2 3 4 5 6 7 Nothing to do with the situation

Was the cause of this incident uncontrollable or controllable by the patient? (Please circle)

Totally uncontrollable by the patient 1 2 3 4 5 6 7 Totally controllable by the patient.

Was the cause of this incident unique to this incident, or is it likely to be the cause if this incident occurs in the future?

Unique to this incident 1 2 3 4 5 6 7 Likely to cause future incidents

Please continue for next scenario →

Scenario Two: Attempted or actual suicide

"Taking of own life, or serious attempt on own life necessitating medical intervention."

Please describe the incident briefly below.

How recently did it happen? _____

What is your involvement with the patient? _____

(key-worker, co-worker, team member etc.)

At the time of the incident how much did you experience each of the following emotions?
Please circle the number that best describes this.

	Not at all							Extremely
Anger	1	2	3	4	5	6	7	
Frustration	1	2	3	4	5	6	7	
Anxiety	1	2	3	4	5	6	7	
Fear	1	2	3	4	5	6	7	
Sympathy/pity	1	2	3	4	5	6	7	
Sadness	1	2	3	4	5	6	7	

At the time the incident occurred how did you view the patient's behaviour? (Please circle)

Good	Neutral			Bad		
1	2	3	4	5	6	7

At the time the incident occurred how did you view the patient? (Please circle)

Good	Neutral			Bad		
1	2	3	4	5	6	7

Scenario Two: Attempted or actual suicide (continued)

Please write below what you feel the major cause of this incident was. (If there is more than one, please choose the one most likely cause).

Was the cause of this incident due to something about (Please circle)

I. you

Totally due to me	1	2	3	4	5	6	7	Nothing to do with me
-------------------	---	---	---	---	---	---	---	-----------------------

II. the patient

Totally due to the patient	1	2	3	4	5	6	7	Nothing to do with the patient
----------------------------	---	---	---	---	---	---	---	--------------------------------

III. situation/circumstances

Totally due to the situation	1	2	3	4	5	6	7	Nothing to do with the situation
------------------------------	---	---	---	---	---	---	---	----------------------------------

Was the cause of this incident controllable or uncontrollable by the patient? (Please circle)

Totally controllable	1	2	3	4	5	6	7	Totally uncontrollable
----------------------	---	---	---	---	---	---	---	------------------------

Was the cause of this incident unique to this incident, or is it likely to be the cause if this incident occurs in the future?

Unique to this incident	1	2	3	4	5	6	7	Likely to cause future incidents
-------------------------	---	---	---	---	---	---	---	----------------------------------

Please continue for next scenario →

Scenario three: Aggression

"Physical aggression towards another person resulting in minor or no injuries."

Please describe the incident briefly below.

How recently did it happen? _____

What is your involvement with the patient? _____

(key-worker, co-worker, team member etc.)

At the time of the incident how much did you experience each of the following emotions?
Please circle the number that best describes this.

	Not at all						Extremely
Anger	1	2	3	4	5	6	7
Frustration	1	2	3	4	5	6	7
Anxiety	1	2	3	4	5	6	7
Fear	1	2	3	4	5	6	7
Sympathy/pity	1	2	3	4	5	6	7
Sadness	1	2	3	4	5	6	7

At the time the incident occurred how did you view the patient's behaviour? (Please circle)

Good		Neutral			Bad	
1	2	3	4	5	6	7

At the time the incident occurred how did you view the patient? (Please circle)

Good		Neutral			Bad	
1	2	3	4	5	6	7

Scenario three: Aggression (Continued)

Please write below what you feel the major cause of this incident was. (If there is more than one, please choose the one most likely cause).

Was the cause of this incident due to something about (Please circle)

I. you

Totally due to									Nothing to do
me	1	2	3	4	5	6	7	with me	

II. the patient

Totally due to									Nothing to do
the patient	1	2	3	4	5	6	7	with the patient	

III. situation/circumstances

Totally due to									Nothing to do
the situation	1	2	3	4	5	6	7	with the situation	

Was the cause of this incident controllable or uncontrollable by the patient? (Please circle)

Totally									Totally
controllable	1	2	3	4	5	6	7	uncontrollable	

Was the cause of this incident unique to this incident, or is it likely to be the cause if this incident occurs in the future?

Unique to this incident									Likely to cause future
	1	2	3	4	5	6	7	incidents	

Please continue for next scenario →

Scenario four: Serious violence

“Physical assault of another person resulting in major physical injury requiring medical attention.”

Please describe the incident briefly below.

How recently did it happen? _____

What is your involvement with the patient? _____

(key-worker, co-worker, team member etc.)

At the time of the incident how much did you experience each of the following emotions? Please circle the number that best describes this.

	Not at all						Extremely		
	1	2	3	4	5	6	7	8	9
Anger	1	2	3	4	5	6	7	8	9
Frustration	1	2	3	4	5	6	7	8	9
Anxiety	1	2	3	4	5	6	7	8	9
Fear	1	2	3	4	5	6	7	8	9
Sympathy/pity	1	2	3	4	5	6	7	8	9
Sadness	1	2	3	4	5	6	7	8	9

At the time the incident occurred how did you view the patient’s behaviour? (Please circle)

Good	Neutral	Bad
1	2	3
4	5	6
7	8	9

At the time the incident occurred how did you view the patient? (Please circle)

Good	Neutral	Bad
1	2	3
4	5	6
7	8	9

Scenario four: Serious violence (Continued)

Please write below what you feel the major cause of this incident was. (If there is more than one, please choose the one most likely cause).

Was the cause of this incident due to something about (Please circle)

I. you

Totally due to me	1	2	3	4	5	6	7	Nothing to do with me
-------------------	---	---	---	---	---	---	---	-----------------------

II. the patient

Totally due to the patient	1	2	3	4	5	6	7	Nothing to do with the patient
----------------------------	---	---	---	---	---	---	---	--------------------------------

III. situation/circumstances

Totally due to the situation	1	2	3	4	5	6	7	Nothing to do with the situation
------------------------------	---	---	---	---	---	---	---	----------------------------------

Was the cause of this incident controllable or uncontrollable by the patient? (Please circle)

Totally controllable	1	2	3	4	5	6	7	Totally uncontrollable
----------------------	---	---	---	---	---	---	---	------------------------

Was the cause of this incident unique to this incident, or is it likely to be the cause if this incident occurs in the future?

Unique to this incident	1	2	3	4	5	6	7	Likely to cause future incidents
-------------------------	---	---	---	---	---	---	---	----------------------------------

BACKGROUND INFORMATION

Work Setting: Acute Ward / Rehabilitation Service (Please delete as appropriate)

Grade:

Age:

Gender: Male / Female

Number of years working in mental health

Please list any training you have had for working with challenging behaviour:

Have you ever been the victim of violence perpetrated by a patient? Yes / No

Have you ever worked with a patient who has committed suicide? Yes / No

Please use the space below to make any comments about the questionnaire.

THANK YOU FOR FILLING OUT THIS QUESTIONNAIRE. PLEASE RETURN IN THE ENVELOPE PROVIDED TO RACHEL NEWMAN

Appendix V

Instructions to authors

1. Clinical Psychology Review
 2. British Journal of Clinical Psychology
-

CLINICAL PSYCHOLOGY REVIEW

INSTRUCTIONS TO AUTHORS

AIMS AND SCOPE: *Clinical Psychology Review* publishes substantive reviews of topics germane to clinical psychology. Its purpose is to help clinical psychologists keep up-to-date on relevant issues outside of their immediate areas of expertise by publishing scholarly but readable reviews. Papers cover diverse issues, including: psychopathology, psychotherapy, behavior therapy, behavioral medicine, community mental health, assessment, and child development.

Reviews on other topics, such as psychophysiology, learning therapy, and social psychology, often appear if they have a clear relationship to research or practice in clinical psychology. Integrative literature reviews and summary reports of innovative ongoing clinical research programs are also sometimes published. Reports on individual research studies are not appropriate.

SUBMISSION REQUIREMENTS: All manuscripts should be submitted to Alan S. Bellack, The University of Maryland at Baltimore, Department of Psychiatry, 737 W. Lombard St., Suite 551, Baltimore, MD 21201, USA. Submit three (3) high-quality copies of the entire manuscript; the original is not required. Allow ample margins and type double-space throughout. Papers should not exceed 50 pages (including references). One of the paper's authors should enclose a letter to the Editor, requesting review and possible publication; the letter must also state that the manuscript has not been previously published and has not been submitted elsewhere. One author's address (as well as any upcoming address change), telephone and FAX numbers, and E-mail address (if available) should be included; this individual will receive all correspondence from the Editor and Publisher.

Papers accepted for *Clinical Psychology Review* may not be published elsewhere in any language without written permission from the author(s) and publishers. Upon acceptance for publication, the author(s) must complete a Transfer of Copyright Agreement form.

COMPUTER DISKS: Authors are encouraged to submit a 3.5" HD/DD computer disk to the editorial office. Please observe the following criteria: (1) Send only hard copy when first submitting your paper. (2) When your paper has been refereed, revised if necessary, and accepted, send a disk containing the final version with the final hard copy. If the disk cannot be converted, the hard copy will be used. (3) Specify what software was used, including which release, e.g., WordPerfect 6.0a. (4) Specify what computer was used (IBM compatible PC, Apple Macintosh, etc.). (5) The article file should include all textual material (text, references, tables, figure captions, etc.) and separate illustration files, if available. (6) The file should follow the general instructions on style/arrangement and, in particular, the reference style of this journal as given in the Instructions to Contributors. (7) The file should be single-spaced and should use the wrap-around end-of-line feature, i.e., returns at the end of paragraphs only. Place two returns after every element such as title, headings, paragraphs, figure and table call-outs. (8) Keep a back-up disk for reference and safety.

TITLE PAGE: The title page should list (1) the article; (2) the authors' names and affiliations at the time the work was conducted; (3) a concise running title; and (4) an unnumbered footnote giving an address for reprint requests and acknowledgments.

ABSTRACT: An abstract should be submitted that does not exceed 200 words in length. This should be typed on a separate page following the title page.

KEYWORDS: Authors should include up to six keywords with their article. Keywords should be selected from the APA list of index descriptors, unless otherwise agreed with the Editor.

STYLE AND REFERENCES: Manuscripts should be carefully prepared using the *Publication Manual of the American Psychological Association*, 4th ed., 1994, for style. The reference section must be double spaced, and all works cited must be listed. Avoid abbreviations of journal titles and incomplete information.

Reference Style for Journals:

Raymond, M. J. (1964). The treatment of addiction by aversion conditioning with apomorphine. *Behavior Research and Therapy*, 3, 287-290.

For Books:

Barlow, D. H., Hayes, S. C., & Nelson, R. O. (1984). *The scientist practitioner: Research and accountability in clinical and educational settings*. Elmsford, NY: Pergamon.

TABLES AND FIGURES: Do not send glossy prints, photographs or original artwork until acceptance. Copies of all tables and figures should be included with each copy of the manuscript. Upon acceptance of a manuscript for publication, original, camera-ready photographs and artwork must be submitted, unmounted and on glossy paper. Photocopies, blue ink or pencil are not acceptable. Use black India ink and type figure legends on a separate sheet. Write the article title and figure number lightly in pencil on the back of each.

PAGE PROOFS AND OFFPRINTS: Page proofs of the article will be sent to the corresponding author. These should be carefully proofread. Except for typographical errors, corrections should be minimal, and rewriting the text is not permitted. Corrected page proofs must be returned within 48 hours of receipt. Along with the page proofs, the corresponding author will receive a form for ordering offprints and full copies of the issue in which the article appears. Twenty-five (25) free offprints are provided; orders for additional offprints must be received before printing in order to qualify for lower publication rates. All co-author offprint requirements should be included on the offprint order form.

COPYRIGHT: Publications are copyrighted for the protection of the authors and the publisher. A Transfer of Copyright Agreement will be sent to the author whose manuscript is accepted. The form must be completed and returned to the publisher before the article can be published.

NOTES TO CONTRIBUTORS

1. The *British Journal of Clinical Psychology* publishes original contributions to scientific knowledge in clinical and health psychology. Topics covered reflect the broad role of clinical psychologists and include descriptive studies as well as studies of the aetiology, assessment and amelioration of disorders of all kinds, in all settings and amongst all age groups. Empirical investigations from any theoretical perspective of the relation of intrapersonal and interpersonal processes to disorder are welcome, as are studies of the delivery of health care in hospital or community settings. Relevant populations include people with psychiatric and neuropsychological disorders, and people with learning difficulties/mental retardation. Studies with samples not currently experiencing any disorder may be considered if they bear directly on clinical theory or practice.

The Health Psychology Section of the Journal will be launched in 1996 as a separate journal—*British Journal of Health Psychology*—in recognition of the growing importance of the applications of psychology outside the traditional psychiatric domain. Submissions are encouraged of clinical and experimental research on the development and management of medical conditions. Empirical research into psychosocial responses to illness, and the behaviours that put health at risk, is also welcome.

2. The following types of paper are invited:

- (a) Papers reporting original empirical investigations.
- (b) Theoretical papers, provided that these are sufficiently related to empirical data
- (c) Review articles which need not be exhaustive, but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications.
- (d) Brief Reports and Comments (see paragraph 6).

Case studies are normally published only as Brief Reports. Papers are evaluated in terms of their theoretical importance, contributions to knowledge, relevance to the concerns of practising clinical psychologists, and readability. Papers generally appear in order of acceptance, except for the priority given to Brief Reports and Comments.

3. The circulation of the Journal is worldwide, and papers are reviewed by colleagues in many countries. There is no restriction to British authors, and papers are invited from authors throughout the world.

4. The Code of Conduct of The British Psychological Society requires psychologists 'Not to allow their professional responsibilities or standards of practice to be diminished by considerations of religion, sex, race, age, nationality, party politics, social standing, class or other extraneous factors'. The Society resolves to avoid all links with psychologists and psychological organizations and their formal representatives that do not affirm and adhere to the principles in the clause of its Code of Conduct. In cases of doubt the Journals Office asks authors to sign a document confirming their adherence to these principles.

5. Papers should be prepared in accordance with The British Psychological Society's *Style Guide*, available at £3.50 per copy from The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR, England. Contributions should be kept as concise as clarity permits, and illustrations kept as few as possible. Papers should not normally exceed 5000 words. A summary of up to 200 words should be provided, but a shorter abstract with shorter papers. The title should indicate exactly but as briefly as possible the subject of the article, bearing in mind its use in abstracting and indexing systems.

- (a) Contributions should be typed in double spacing with wide margins and only on one side of each sheet. Sheets should be numbered. The top copy and at least three good duplicates should be submitted and a copy should be retained by the author.
- (b) The Journal operates blind review; authors are required to eliminate clues to their identity. Information revealing authorship (such as authors' names and institutional affiliations, and personal acknowledgements) must be confined to a removable front page, and the text must be free of such clues as identifiable self-citations ('In our earlier work...') and the names of localities or institutions. The paper's title should appear at the top of the first page of text.
- (c) Tables should be typed in double spacing on separate sheets. Each should have a self-explanatory title and should be comprehensible without reference to the text. They should be

referred to in the text by arabic numerals. Data given should be checked for accuracy and must agree with mentions in the text.

- (d) Figures, i.e. diagrams, graphs or other illustrations, should be on separate sheets numbered sequentially 'Fig. 1', etc., and each identified on the back with the title of the paper. They should be carefully drawn, larger than their intended size, suitable for photographic reproduction and clear when reduced in size. Special care is needed with symbols: correction at proof stage may not be possible. Lettering must not be put on the original drawing but upon a copy to guide the printer. Captions should be listed on a separate sheet.

- (e) Bibliographical references in the text should quote the authors name and the date of the publication thus; Hunt (1993). They should be listed alphabetically by author at the end of the article according to the following format:

Moore, R. G. & Blackburn, I.-M. (1993). Sociotropy, autonomy and personal memories in depression. *British Journal of Clinical Psychology*, 32, 460-462.

Stepcoe, A. & Wardle, J. Cognitive predictors of health behaviour in contrasting regions of Europe. In C. R. Brewin, A. Stepcoe & J. Wardle (Eds), *European Perspectives in Clinical and Health Psychology*, pp. 101-118. Leicester: The British Psychological Society.

Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.

- (f) SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses (see *BPS Style Guide*).

- (g) Authors are required to avoid the use of sexist language.

- (h) Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The materials should be submitted to the Editor together with the article, for simultaneous refereeing.

6. Brief Reports and Comments are limited to two printed pages. These are subject to an accelerated review process to afford rapid publication of research studies, and theoretical, critical or review comments whose essential contribution can be made within a small space. They also include research studies whose importance or breadth of interest is insufficient to warrant publication as full articles, and case reports making a distinctive contribution to theory or method. Authors are encouraged to append an extended report to assist in the evaluation of the submission and to be made available to interested readers on request to the author. To ensure that the two-page limit is not exceeded, set typewriter margins to 66 characters maximum per line and limit the text, including references and a 100 word abstract, to 150 lines. Figures and tables should be avoided. Title, author name and address for reprints and data of receipt are not included in the allowance. However deduct three lines from the text each and every time any of the following occur:

- (a) title longer than 70 characters,
- (b) author names longer than 70 characters,
- (c) each address after the first address,
- (d) each text heading (these should normally be avoided).

A character is a letter or space. A punctuation mark counts as two characters (character plus space) and a space must be allowed on each side of a mathematical operator.

7. Proofs are sent to authors for correction of print, but not for introduction of new or different material. They should be returned to the Journals Manager as soon as possible. Fifty complimentary copies of each paper are supplied to the senior author on request: further copies may be ordered on a form supplied with the proofs.

8. Submission of a paper implies that it has not been published elsewhere and is not currently under consideration for publication elsewhere. Authors are responsible for getting written permission to publish lengthy quotations, illustrations etc., of which they do not own copyright.

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