GENDER, VICTIM STATUS AND ATTRIBUTIONS:
IMPLICATIONS FOR THE MANAGEMENT OF AGGRESSION
IN A HIGH SECURE HOSPITAL

Thesis submitted for the degree of Doctorate in Clinical Psychology
at the University of Leicester
by
Julie Ann Clarke
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ABSTRACT

The current study aims to explore the explanations and favoured management approaches of High Secure Hospital staff, concerning aggressive behaviour by patients. It sets out to establish whether staff’s attributions and preferred approaches vary according to whether the patient is male or female, and the target a member of staff or another patient. More specifically, it attempts to explore a bias often mentioned in criminological studies; that men who offend are seen as bad, whilst women are viewed as being mad. A secondary aim was to establish whether relationships between the attributions, preferred management approaches and attitudes to High Secure Hospital patients exist for staff who work in this setting.

The 118 participants in this research completed a questionnaire (consisting of a number of statements with Likert scales) in response to a hypothetical vignette. Participants were allocated to one of eight conditions on the basis of the gender of the vignette figure, the target of aggression, and the participants’ gender. The sample consisted of 63 men and 55 women. Participants’ responses were scored on a seven point Likert scale and then grouped on the basis of factorial analyses.

Analyses of variance indicated that staff viewed internal enduring attributions as important in explaining the behaviour, but that a wide range of explanations were considered to be important. However, there were few differences perceived according to gender of the vignette figure. Whilst the male vignette figure was not seen as bad, nor the female counterpart as more mad, there were some differences in attributions of blame, responsibility and controllability according to the staff gender, patient gender and target of aggression. Some relationships were found between attributions, management strategies and attitudes to patients.

The study provides evidence that some differences in attributions occur according to the target, patient’s and staff’s gender, and also as a result of the hospital context. The findings are discussed in relation to past research, the double deviance and mitigation hypotheses, and theoretical models of attributions and helping behaviour. Finally, attention is drawn to the wider clinical and research implications.
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1. INTRODUCTION

The primary focus of this research is to determine if the attributions that High Secure Hospital staff make about patient aggression are affected by whether the patient is a male or female and whether the target is a member of staff or a patient. Further, the research attempts to ascertain whether the attributions made are associated with the management of aggressive behaviour. In addition, the current study aims to investigate whether attitudes to ‘Special Hospital’ patients also affect the attributions and management strategies that are chosen.

Theories of violence and aggression are briefly reviewed. Attribution theory is discussed and critically evaluated in addition to other social cognition models, such as labelling theory. Sex differences in person perception are outlined. Literature on violence and aggression, attributions, attitudes and management strategies are then discussed. Gender issues are reviewed and methodological issues are explored.

Ethical issues that the current study might raise are explored later in the method section.
1.1 Background

The growing number of publications on inpatient violence and aggression since the 1980's demonstrates the issue of managing such incidents, and may reflect the greater level of concern and interest in this area. Researchers have begun to acknowledge the magnitude of such a problem. Crichton (1995a) points out that British Health Service staff are three times more likely to suffer injury compared with industrial workers. Whilst psychiatric nursing staff have been found to be the most frequent victims of assaults (Larkin et al., 1988; Noble and Rodger, 1989), Mortimer (1995) found that a high number of victims of psychiatric inpatient assault were other patients of the same gender.

Traditionally, our understanding of violence and aggression is guided by a number of theoretical models, all of which focus on the perpetrator and their behaviour, sometimes extending to environmental or social factors.

Researchers have variously proposed aggression to be instinctive (Lorenz, as cited in Bond et al., 1997) a drive (Dollard et al., 1939), and cognitively mediated (Berkowitz and Heimer, 1989). Aggressive behaviour has also been conceptualised as being acquired and maintained by social learning, for example by reinforcement, or by modelling (Bandura, 1973).
Important correlates of aggression have been highlighted; disinhibiting substances such as alcohol (Hodge, 1993) shame-proness (Tangey et al., 1992) and personality (Blackburn, 1993).

Some authors have argued that commonly held beliefs may perpetuate ineffective practises in dealing with violence and aggression (Morrison, 1993b). For example, the 'myth' that a person with a mental illness who is violent is out of control or impulsive, often results in medication, seclusion, or restraint being given. Morrison found, from direct interviews with patients (1990b) that most patients viewed such responses to their aggression as reinforcing (for example, being given medication). Furthermore, when questioned about their violence, many stated that this was used in order to get what they wanted. In contrast, Kaplan and Wheeler (1983) propose that violence is a result of a disequilibrium of power; any attempts to control violence by the use of authority will actually escalate aggression because it increases powerlessness.

1.1.2 The Role of Appraisal

As Vala et al. point out, "increasingly, aggression is considered as a special kind of interaction whose features are socially defined; it is the meaning of the act, rather than its physical characteristics, which is important" (1988 page 1). A number of researchers have acknowledged the impact of individual differences in cognitive appraisal and the impact of such processes upon subsequent responses. Lazarus and Folkman's (1984) theory of stress emphasises that it is the appraisal of threat that is significant in predicting the psychological outcome effects, and not the actual threat itself. Wykes cites Feinstein and Dolan (1991) who found that, amongst people who had suffered
fractures as a consequence of assault, the initial perceptions of the injury exerted the most significant effect on the long-term outcome. It is possible that explanations offered by staff for their understanding of inpatient aggression could influence their emotional and behavioural reactions to such incidents.

Morrison (1993a) found a low rate of agreement in psychiatric nurses’ perceptions of the seriousness of various acts of aggression. Whilst both student nurses and psychiatric nurses viewed physical violence to others as the most serious type of behaviour, there was a low consensus within the experienced group regarding the seriousness of other types of violence, particularly for verbal violence to others and violence to property. Morrison interpreted these discrepancies as failures to accurately predict violence in potentially dangerous persons. Perhaps more alarmingly, a study by Thomas et al. (1995) indicated that mismatches existed between staff and patient perceptions of the safety of a hospital environment with the actual incidence of physically and sexually threatening behaviour that occurred there. This may suggest a culture of acceptance of aggression as the norm, or even worse, a denial of the potential for such incidents. Morrison (1993a) suggested that by investigating how perceptions influence clinical predictions of violence one can better understand the processes involved in predicting dangerousness and possibly increase the accuracy of predictions.

Attributional research has been significant in terms of helping to understand the cognitive processes involved in depression (Abramson, Seligman and Teasdale, 1978) and health related behaviour (Maiman and Becker, 1974). Attributional research has contributed to understanding the factors which might lead to a decision to use physical
restraint in managing an incident of violence (Apel and Bar-Tal, 1996). These authors found that, when an act of violence by a psychiatric patient was believed to be ‘calculated’, staff were more likely to use physical force than they were when the act was believed to be arbitrary and unpredictable. Further exploration of attributions for inpatient violence may be important. For example, staff who attribute patient violence to internal enduring factors would be predicted to view the behaviour with greater concern and to respond differently, than if the violence was perceived as being externally caused.

Whilst there are a substantial number of publications on attributions for violence and aggression, there are few papers on the subject of causal explanations by staff for psychiatric inpatient aggression, and more specifically, High Secure Hospital staff. Additionally, the paucity of research on sex and gender issues has been noticeable. In a review of the literature on sex differences in person perception, Wallston and O’Leary (1991) concluded that “sex and gender are central constructs in person perception” (pp. 30). Some researchers have commented on the lack of an intellectual framework in psychiatry with which to consider gender issues (Mezey and Bartlett, 1996). Subsequently, “insufficient attention has been paid to the relevance of the social construction of gender role and its likely impact on both the explanation and differential labelling of male and female patterns of offending behaviour as well as on the accompanying categorisations of madness” (page 136). Therefore, a study of staff perceptions of male and female inpatient aggression is needed, in order to explore the causal and other types of attributions offered, with greater attention to gender issues.
The rationale for the study is based on three main objectives.

Firstly, it aims to explore the relationship between the gender of patient and the target of aggression with how staff understand and manage aggression in a High Secure Hospital.

Secondly, it attempts to address an area that is not widely researched, by investigating the attributions of High Secure Hospital staff that might be important in social constructions of patient aggression, and if these attributions influence their response to the incident. Finally, it investigates whether staff attitudes influence attributions about violence and whether they influence subsequent treatment decisions. The exploration of staff's attitudes was highlighted as an important area for future research by Gresswell's (1988) study of Rampton Special Hospital staff.

1.1.3 Context of the Study - The ‘Special’ Hospitals

Section four of the National Health Service Act 1977 requires that the Secretary of State provides Special Hospitals for mentally disordered patients who “require treatment under conditions of special security on account of their dangerous, violent, or criminal propensities” (Hamilton, 1985, pp84). There are currently three Special Hospitals in England: Broadmoor, Ashworth and Rampton.

Originally, Rampton only accepted patients who had a mental handicap, until 1960. At present, the patient population at Rampton comprises 53.8% of those classified as mentally ill, 33.2% psychopathic, and 13% learning disability. Of this total, 85.2% are male, and 14.8% are female (Brown, 1998). Despite the significantly lower proportion of female patients, the women's services are the most expensive. This is thought to be the result of the higher rates of self-injury, the subsequent greater levels of observation.
by staff, and the higher rates of escorts needed to the local general hospital as a consequence (Brown, 1998).

Staff who work in Rampton Hospital indicated in the pilot interviews that, across male and female patient services, a number of aggressive behaviours ranging from physical assault to verbal abuse and self-harm were regular occurrences that had to be managed. Such incidents can be considered across a number of variables: whether the aggressor is believed to have a particular mental disorder classification, is of a particular ethnic origin, and according to the type of index offence committed.

Special Hospitals have been the subject of much critical scrutiny (Potier, 1993; Pilgrim, 1995), with more recent attention to the question of the appropriateness of these facilities for women patients (Hemingway, 1996).

In order to investigate the explanations of staff for inpatient aggression, and how they might interact with attitudes and management approaches, it is necessary to review theory and research on attributions and attitudes.

1.2 Attributions

1.2.1 Attribution Theory

The current study employs aspects of attribution theory as a main framework. Attribution theory is a collection of diverse theories that concern themselves with how
people explain their own actions and the actions of others. This process of inferring causality is assumed to allow one to predict certain outcomes. An attribution therefore may describe a perception about causality.

Our perceptions of events can be expressed in terms of assigning causality to factors within the person (internality), or to factors outside of the person, (externality), (Heider, 1958). Furthermore, attributions of stability (that is, whether the cause is seen to be stable over time) and controllability (the extent to which the cause of an event is perceived as controllable) can also be made (Weiner, 1980). Attributions can also be categorised along the dimensions of globality (the degree to which a cause applies in a range of situations) and specificity (the degree to which a cause is specific to a certain situation) (Abramson et al., 1978). Other dimensions that have been proposed are the personal/universal (Stratton et al., 1986). These dimensions include factors that are either idiosyncratic to the person, or to universal attributes of most people in the same situation. More recently, proposals for a three-way discrimination of causal judgements into internal, external-personal (attributing the causes of events to the actions of others) and external-situational (attributing the causes of events to circumstances or chance) rather than a simple internal/external distinction have been made (Kinderman and Bentall, 1996).

The causal item controllability has been the focus of some studies (White and Barrowclough, 1998). When a causal factor of an undesirable event is perceived as being within control of the agent, the attributions and emotions that this elicits are likely to be negative. For example, a homeless person may elicit anger and a negative
personal attribution that laziness caused their situation. This may give rise to a hostile response from the observer. Schmidt and Weiner (1988) demonstrated that controllable causes of a need state may result in anger in caregivers and subsequent avoidance of helping. According to Weiners' attributional analysis of helping behaviour (Weiner et al., 1988), when low ability and lack of control are perceived, pity and helping responses are elicited.

Attributions are not bias free. Jones and Nisbett (1971) point out that actor-observer differences occur in which actors tend to assign their own actions to situational (external) factors, whereas observers tend to explain others' actions in terms of stable, personal (internal) qualities, ignoring situational forces (as cited in Jones et al., 1972). This tendency is called the fundamental attribution error. Self-serving biases also tend to occur whereby actors tend to produce more self-justifying attributions for their negative behaviour (Kelley, 1972, in Jones et al.).

Attributions may also extend to other types of perceptions about behaviour, such as responsibility and blame. When an attribution of responsibility is made, a further process of evaluation takes place, to encompass moralistic types of judgement, (Eiser, 1980). This type of evaluation is a logical process which follows that of causal inference.

Weiner was interested in the way that causal dimensions related to these other judgements. For example, the perception that a person is responsible for a certain outcome may depend upon the perceived causal locus of the behaviour (internal-
external). Hamilton (1980) suggests that sanctioning attributions are not affected by the fundamental attribution error. Instead, he proposes that assigning responsibility and blame rest upon whether a person “could have done otherwise” (pp. 770).

Heider (1958) distinguished between different levels of responsibility by association: if the person is perceived to have foreseen the consequences of their behaviour (foreseeability); if it is believed that they have been instrumental in producing certain effects (commission); if there is no external factor with which to justify their behaviour (justification) and if the effects were foreseen and intended (intentionality). Whether the behaviour itself is positive or negative will also affect judgements.

Jones and Davis (1965) also studied the process of inferring intentionality about a person’s behaviour. The two criteria for inferring intentionality are: that the ‘actor’ knows what the consequences of her behaviour will be, and that she is capable of producing the observed effects.

The Correspondent Inference Theory, developed by Jones and Davis (1965, in Berkowtiz) further explored the concepts of personal causality and responsibility. The central assumption of the theory is that people can judge an actors’ behaviour as being caused by, or correspondent with, a stable, dispositional quality. For example, one may assume that a person who has in the past, behaved violently, who is currently behaving in a hostile manner, is doing so because he or she is a violent person.

Kelley further extended the model proposed by Jones and Davis, to encompass self and situational attributions. Kelley’s (1967) principle of non common effects proposed that
when characteristics between two options are non common, or more distinct, explanations about the choice that a person makes can be more easily made. For example, if one had the choice of going to two different colleges and one was arts based, the other more scientifically oriented, and the person chose the former, we could infer that the person's choice was based on her preference for arts based subjects. Hence, the less differences that there are between the choices, the more ambiguous the attribution is likely to be.

His main model, the *Analysis of Variance* (Kelley, 1967), described how different causes could be assigned to the same behaviour according to different types of information about it. For example, perceptions formed are based on *consensus* information, (whether the behaviour varies across people); *distinctiveness* information (whether the behaviour varies over similar entities), and *consistency* information (whether the behaviour varies over time or situations). Based on the statistical procedure of Analysis of Variance, Kelley demonstrated how these three types of information, combined in eight possibly different ways, may produce different explanations for a behaviour. Some studies (for example, Cann *et al.*, 1980) have explored how these variables influence the type of attributions that are made.

### 1.2.2 Functional Extensions of Attribution Theory

It is recognised that motivational factors play an important role in the process of causal inference (Hewstone, 1989). For example, making an internal attribution for one's success is functional in maintaining self-esteem. Similarly, staff who deal with violent incidents at work might have a tendency to use more internal attributions about the
person who is violent, in order to relieve themselves of blame or responsibility in the causal process. Further, making attributions about otherwise unpredictable aggressive behaviour may enhance one's sense of control in predicting and dealing with future incidents. Bains (1983) proposes that if a person's objective is to change rather than to predict another's behaviour, then external, rather than internal attributions may be more appropriate. This was confirmed in a study whereby subjects who anticipated having to change females' racist attitudes in a video, believed that her attitudes were less strongly held than subjects who were asked to predict her political attitudes (Bains 1983).

Some theorists have also pointed out the social control functions of inferring causality and responsibility (Jaspars et al., 1983).

Legally, attributing responsibility can have serious consequences for a causal agent, and for their victim. Judgements of causation and punishment are more remote than judgements of either causation and responsibility or responsibility and punishment evaluations (Fincham and Schultz, 1981). Straub (1996) has recently highlighted the more negative types of self-serving functions of attributions, by pointing out that people might attribute responsibility to others in order to relieve oneself of the responsibility to help them.

An extension of control motivation is when certain attributions are made in order to preserve one's sense of distance from undesirable events and behaviours. Defensive Attribution Theory (Walster, 1966) explains how attributional inferences play a role in this process. In the case of men who attribute more responsibility to abusive partners,
it has been suggested that such views function to maintain the notion that they are not similar to the perpetrators and would never be abusive to their own partners. Evidence for such findings (for example, Cohn and Sugarman, 1980) have supported Walsters’ theory. These authors found that male participants found a male abuser as more responsible than did female participants. Alternatively, Festinger (1954) suggests that when others are perceived as being similar to oneself, it is social comparison with them that results in less responsibility being assigned to them. In the case of marital violence, since females may empathise more with abused wives, they would not hold them as responsible as male observers, but would view the male perpetrator as more responsible. These predictions derive from Social Comparison Theory. Latta’s study (cited by Cohn and Sugarman, 1979) provides results which are consistent with these predictions. That is, female observers perceived the female victim of marital abuse as less responsible than did males observers, but that male observers viewed the male abuser as less responsible than female observers.

1.2.3 Sex Differences and Gender in Attributions for Achievement and Behaviour

Research on both adults and children above the age of ten years suggests that females tend to make more ‘self-derogatory’ rather than ‘self-enhancing’ attributions (Nicholls, 1975). One explanation for such differences is that they originate from sex role socialisation (Lochel, 1983), whereby societal and cultural expectations of children guide their behaviour and attitudes. Gender schema theory (Bem, 1981) asserts that people become sex-typed by perceiving and acquiring events and behaviours in terms of qualities prescribed by the cultural norms as appropriate for men and women. In
addition, they come to impose gender-based classifications on social reality. These gender schemas, like any other schemas, may inform the process of causal inference.

Deaux (1976) asserts that a person who infers causality about her own or others’ behaviour draws from two sources of information; the actual behaviour itself in its situational context, and the expectancies concerning the behaviour. The latter source includes sex role stereotypes whereby males are expected to be logical, instrumental and adventurous and females to be sensitive to the feelings of others, dependent and so forth (Bern 1974; Oelsthorpe 1989; Naffine 1987).

The expectancy model (Feather, 1969) predicts that performance that is congruent with expectancies (for example, success in men, failure in women) leads to attributions being made to stable causes, whilst performance that is incongruent with expectations are predicted to be attributed to unstable factors. Feather and Simon (1975) demonstrated these differences in stereotyping by observers. They varied success and failure in stories about men and women and found that male success was attributed more to ability than was female success, and female failure to a lack of ability more than male failure. In their extensive review of research into person perception, Wallston and O’Leary (1991) concluded that “observers of both sexes tend to attribute the behaviour of women to different factors than the behaviour of men”, (pp. 27). They suggest that such differences exist because of sex-typing of the task or gender of the behaviour.
This raises the question as to whether the same principle applies to aggressive behaviour. For instance, it could be proposed that in the case of an act of physical aggression by a woman, because it is least expected and incongruent with sex role stereotypes (Maden, 1993), attributions to less stable, external factors are more likely to be used, hence less assignment of responsibility would follow. In contrast, the same behaviour by a man, which confirms our stereotypes, would be made to more stable, internal causes, leading to responsibility being attributed.

The theories outlined thus far are intended to describe the general process by which people determine causality and the common biases that influence the attributions made. Whilst the theories are diverse, their importance lies in explaining how social and personal goals may motivate people to assign causality and responsibility to others. Furthermore, they have advanced our understanding of the way in which the process of causal inference may influence a person’s sanctioning evaluations, and emotional and behavioural reactions to an event (Schmidt and Weiner 1988).

1.2.4 **Attitudes and Labelling**

When an individual has insufficient knowledge to infer a causal attribution, she or he will draw from general attitudes (causal schemata) that they have acquired through their lifetime (Kelley, 1972, in Jaspars et al.). There has been a remarkable absence of direct definitions of what constitutes an attitude. Jonas *et al.*, (in Argyle and Colman, 1994 pp. 2) define an attitude as “a psychological tendency to evaluate a particular entity with some degree of favour or disfavour.”
Attitudes allow one to make more general predictions and assumptions about individuals, particularly according to the individuals’ known association or membership of certain groups. By association with such groups, one may infer certain characteristics about the individual. One can favour a particular view, even though there may be very little evidence available that supports it. Thus, as with causal attribution, having a particular attitude will involve biases in information processing. For example, Hudson-Allez and Barrett (1996) studied the attitudes of local residents in an area where people with intellectual disabilities were moving to ordinary housing. They found that, over time, the attitudes of the local residents became significantly more positive. In addition, people who had experience of individuals with a disability were more in favour of community living for this group, implying that more contact and knowledge of them facilitated more favourable attitudes. Similarly, Levey and Howells (1995) found that people who held less stereotypical beliefs about people with schizophrenia were those that had friends who had mental health problems, as compared with those whose family relatives had such problems. It was proposed that having a relative with such mental health problems has more negative consequences such as burden of care and stigmatisation, whilst contact through friendships has an element of choice and positive identification. The contact hypothesis (Amir, 1969) would predict that as contact with outgroups increases under more favourable conditions, so do attitudes become more positive.

Heider’s (1958) belief was that attitudes functioned to give structure and consistency to a persons’ perceptual world. He proposed cognitive balance as a form of cognitive simplification, that people tend to organise their attitudes and beliefs into consistent
internal structures. For example, when a perceiver disagrees with somebody whom he or she admires, then he or she will strive for cognitive consistency or balance. In order to achieve congruency, the individual will be motivated to change the internal structure of his beliefs. If a state of imbalance cannot be changed, it will create tension.

High Secure Hospital staff may also be expected to have schemas about the patients that they work with. Depending on whether these patients are viewed as an ingroup (that is, members of one’s own category group) or an outgroup (that is, members of a different category group to oneself), they might be viewed positively or negatively in order to enhance the staff’s self-esteem.

As *Social Identity Theory* (Tajfel, 1981) assumes, the aim to understand oneself can be achieved by social categorisation and social comparison. This theory would predict that staff may hold more negative attitudes to High Secure Hospital patients (a potential outgroup), as a function of the need for self-enhancement.

To the author’s knowledge, no study to date has explored attitudes to High Secure Hospital patients.

A central notion of *labelling theory* (Scheff, 1966) is the idea that once a person is labelled, responses from other people will change towards him. A study by Jaffe (1966) indicated that attitudes to people with learning and developmental impairments were more negative if the referent group were described as “mentally retarded” than if the same description was given without the label.
Being labelled is also proposed to have negative repercussions on ones' identity and lead to more deviant behaviour. The labelling perspective has received mixed empirical support. Although Kirk (1975) found that the mentally ill were more likely to be rejected if their behaviour was consistent with their label, Ryan and Poster (1989) found that in a sample of psychiatric nurses who had been assaulted, 67% of them believed that the mentally ill patient was not responsible for their violent behaviour. This had subsequent implications in terms of the nurses not pursuing legal action against assaultive patients.

Rotenberg (1975) highlighted the individual differences that may result in some labelees accepting a deviant label, and others rejecting it, with different repercussions for each group.

Two distinct hypotheses have emerged with respect to labelling. Firstly, the double deviance hypothesis, which predicts that a deviant person (for example, an offender) will be judged even more harshly if he or she has an additional label, such as a mental illness. Alternatively, the mitigation hypothesis proposes that a label such as mental illness will mitigate negative evaluations because offenders will be seen as less responsible and less blameworthy for their acts. Additional labels, such as ethnicity, gender, and type of mental disorder may be important in how people perceive and respond to others. Duncan (1979) found evidence to support the double deviance hypothesis, by demonstrating the tendency for white male observers to perceive an ambiguous act of aggression by a black actor as more violent than when it was
committed by a white actor. However, some studies have produced findings which are more consistent with the mitigation hypothesis. Knowledge that an offender is a woman, has been shown to reduce attributions of responsibility and the severity of sentencing recommendations (Faulstich, 1984). Crichton (1997) draws the distinction between different psychiatric labels, and how they affect attributions. Using vignette methodology, he found that aggressive behaviour in a person with schizophrenia was attributed more to illness and perceived as requiring more medical interventions. In contrast, a person with a diagnosed personality disorder was viewed as having more control of the behaviour and as requiring more punitive responses. These findings might be explained in terms of the discounting principle, (Kelley, 1972, in Jones et al., 1972), whereby people rely on causal schemata when there is not enough information about the person. In this case, salient schemas about types of mental illness are drawn upon, whilst other possible causes are discounted as being less plausible.

*Thus the research suggests that being a woman, or having a psychiatric label, might mitigate against responsibility being assigned, and milder sanctions being applied.*

Gove (1975) argues that in the case of mental illness, labelling can have positive effects, by mobilising support and treatment for the individual who is labelled. Some confirmation for this proposal is provided by Meddings (1996). She found that when a person with a label of schizophrenia was aggressive, there was a greater tendency for staff to employ less internal enduring attributions and to choose more psychiatric and medical strategies. However, this may imply conceptualising the aggression as purely due to illness at the expense of considering other underlying factors such as power.
relationships between the staff and patients, and between patients themselves (Feely, 1995).

The present study attempts to ascertain whether the salient schemas associated with being a High Secure Hospital female patient discount other information and reduces attributions of responsibility and blame.

**In summary,** research has shown that attributions can influence peoples’ emotional and behavioural responses (Weiner, 1988). Biases in the attribution process may arise because of social and personal goals (Bains, 1983). In addition, different information about a behaviour, may result in different attributions being made (Kelley, 1967). Sex differences in attributions have been explored (Wallston and O'Leary, 1991) and demonstrate that sex-typing of the task and gender norms may influence the process of causal inference. Attitudes, as with attributions, might be the result of biases in information processing, and the need for self-enhancement. A persons’ attitude towards a certain group might be strong, even in the absence of evidence for such beliefs. People may strive to attain balance across their beliefs (Heider, 1958), which might influence their attributions. Biases that result from labelling, might lead to the mitigation of responsibility and sanctions. Alternatively, labelling might increase such consequences, thus reinforcing negative stereotypes about a person or a group.

Whilst some studies have focused on attitudes towards offenders, people with mental health problems and people with learning disabilities, there has been no known research (to the author’s knowledge) which explored attitudes to High Secure Hospital.
patients. There has also been limited exploration of sex differences in attributions for aggression, particularly in the context of psychiatric or secure hospital settings. This study will attempt to address these issues, by exploring the attitudes of staff to patients in the High Secure Hospital, and their attributions about male and female aggression.

1.3 Attributions for violence and aggression

A number of studies have explored both lay and professional explanations of aggressive or offending behaviour, which may differ from the theories proposed by academics.

Studies into observers' perceptions of aggression or offending behaviour have indicated that causal explanations may be multi-dimensional (Meddings, 1996) and may vary as a result of demographic and attitudinal factors (Ryan and Poster, 1989; Kafer et al., 1993) in addition to group membership of both actors and observers (Vala et al., 1988).

Meddings (1996) found a range of staff explanations of aggression in hostels for the homeless, but identified four emergent factors, which together, accounted for 58% of the variance of her data. These factors comprised 'Externality' (for example, it was noisy), 'Internal Temporary' (for example, he is an unstable person) and 'Internal Enduring' (for example, he is mentally ill; he is a violent man). The fourth factor
comprised of ambiguous items such as 'he didn't understand the request' and was called 'Other'.

Overall, staff considered specific external explanations (for example, he had argued with his girlfriend) and specific internal enduring explanations (for example, he is a violent man) as most important for the perpetrator without a label of schizophrenia. However, they attributed mental illness to be the most important cause for the perpetrator with schizophrenia, and the internal enduring factor as less important.

Gresswell (1988) found that High Secure Hospital staff used mental instability as the most common internally attributed explanation for offending behaviour. The external factor ‘alienation’ was considered to be least causal.

These findings are consistent with the fundamental attribution error and other theories such as defensive attribution theory. That is, observers tend to have a bias towards choosing more internal attributions for others’ (negative) behaviours, and they may also do so as a function of the need to see themselves as being more different compared to people who behave aggressively.

Findings that duration in one’s job and past psychiatric experience may affect attributions, were reported by Ryan and Poster (1989). They found that nurses with more psychiatric experience and a greater length of time in their job tended to attribute more responsibility to patients for their violent behaviour.
Kafer et al., (1993) explored college students' attributions for the real life mass murders in Montreal. Two main interpretations were proposed; that they were the result of unpredictable random behaviour (that is, externally based) or that they were a reflection of prejudice against women (internally based). Out of 348 students, the majority agreed with both positions, indicating the ambivalent nature in understanding these events. Nonetheless, relationships were found between the students’ attitudes towards women and other societal issues (for example media impact and gun control), and their attributions and affective reactions. Interestingly, demographic characteristics were a stronger predictor of attributional choice than actual attitudinal variables. For example, most men who were younger supported the randomness position, although they also scored lower on the attitudes towards women scale and support for gun control. Proponents of the sexism cause, were women who scored higher on the attitudes towards women scale and support for gun control. This study illustrates that observers may not rely on just one type of explanation for a behaviour, and that attitudes may have a stronger relationship to some attributions, according to the age and sex of a subject.

Vala et al., (1988) extended this type of exploration, to include perpetrators’ group membership and its influence on observers’ (university students’) attributions. They investigated how conservative or radical subjects used internal or external attributions, about either a police workers’ and delinquents’ act of aggression. They found that radical participants explained the delinquents’ behaviour more in terms of external than internal attributions, but there was no strong relationship between conservatives’ explanations with the type of perpetrator. It seems that the radical participants used
more social contingencies, whereas for conservatives, this was not so important. Additionally, results indicated that radical subjects were more tolerant of the delinquent than the policeman, whilst the reverse was true for conservatives. Thus, both membership of actors’ and observers’ are important in accounting for differences in the attributional process. In contrast to Meddings (1996) and Gresswell (1988), however, Vala et al. highlighted the tendency for subjects in their study to regard external attributions as more causal than internal ones, raising questions about the fundamental attribution error. The reversal of this principle might be a result of different subjects, that is, university students, who might adopt more ‘liberal’ appraisals of acts of aggression than staff in High Secure Hospital or other secure psychiatric facilities. Such group membership might mediate the effects of the fundamental attribution error.

Gresswell points out that the everyday tasks of the staff (for example, assessing and observing patients) place greater emphasis on the patients, which will inevitably produce more internal causal explanations.

In addition to demographic and attitudinal variables, other features of the observer that might affect the types of attributions made are those of emotional factors over time. Cottle et al., (1995) investigated the attributions of staff for the real-life incidents that they had encountered at work in a learning disabilities service. They found that, over time, anxiety decreased but the cause of the aggression was seen as being more internal to the client. This may indicate that as stress decreases, staff perceive themselves as being more removed from the event and subsequently consider themselves as less of a
causal force. This may be adaptive in coping with the repercussions of the episode, or it might also suggest a “hardening of attitude” towards clients (pp. 181).

An additional temporal influence on attributions is the condition of the environment, for example, noise, heat, and crowding. Vrij et al., (1994) explored the impact of temperature on the perceptions and behaviours of police officers. An increase in temperature lead to a more negative impression of the offender, who was perceived as more threatening, and responded to with more aggression by the police.

Factors that may increase stress or deplete emotional and physical energy are therefore important in exploring the perceptions of staff, particularly in view of the fact that working long shifts on sometimes overheated wards, and dealing with a high level of violence that is unpredictable (Larkin et al., 1988) are common-place amongst nursing staff in secure settings.

In general, these studies imply that given the instability of different situational and temporal contexts, inferring causality, blame and responsibility might be a more unstable process than attribution theories have suggested.

Other studies have demonstrated how specific information about an act, such as consistency, consensus, and distinctiveness, can affect attributions of responsibility and blame. Cann et al. (1980) explored attributions by male and female subjects about a youth’s delinquent behaviour. Findings demonstrated that different causal attribution strategies were employed by the male and female participants, which might affect
different treatment recommendations assigned to young offenders. Whilst females assigned less blame and responsibility to the youth whose delinquent behaviour was consistent with past behaviours and typical of the environment (consensus), males assigned less blame and responsibility when the behaviour was portrayed as being inconsistent and atypical. These results suggest that men and women may rely on different types of information about behaviour (in this case, consensus information) as a function of certain other details (consistency).

Judgements of behaviour may not just be a function of consensus, consistency and distinctiveness information. Other features, such as predictability, and congruency with role expectations is particularly relevant to patients with a psychiatric diagnosis who might be expected to behave in a particular manner by staff.

Apel and Bar-tal (1996) administered two vignettes describing an arbitrary (unpredictable) and a non-arbitrary (predictable) act of violence by a patient, and explored the responses of Jewish nursing staff in rating explanations for each behaviour. They found that participants were more inclined to rate mental illness as more important in the unpredictable scenario as compared to the predictable one, despite the behaviour in the latter being perceived as more severe. It might be suggested that, when the patients’ behaviour is seen as being unpredictable, staff equate this with being irrational and congruent with the mentally ill patients’ role. In contrast, when the behaviour is more predictable, it may be equated with logical reasoning (in this case, an attempt to abscond from the ward).
In summary, there is evidence to suggest that demographic, emotional, attitudinal and environmental factors, in addition to specific details about the aggression can influence causal and sanctioning attributions for such behaviour.

The literature on attributions, violence and offending suggests that different groups (for example, students and professional staff) may use different attributions according to the internality, externality, responsibility and blame dimensions. Research has shown that such dimensions may be crude, and that more specific attributions may be necessary to explore perceptions of inpatient aggression. As Apel and Bar-Tal (1996) and Meddings (1996) demonstrated, mental illness may be an important attribution in the context of violence by psychiatric patients or people in hostels for the homeless. The former study did not explore other causal items which might have reflected external or internal causes. Indeed, few studies address more specific attributions that might be salient to participants, relying on more global concepts of internality and externality. Further, the mad-bad dichotomy highlighted by Crichton (1997) has been neglected by attributional research, (despite frequent reference to it in criminological research) with the dimension ‘internality’ allowing no distinction between these specific concepts.

In addition, many studies have not explored the effect of the patients’ gender on attributions, nor the effect of who the victim is. It could also be suggested that, for staff working with patients who may become aggressive, additional variables may influence the attributional analysis. For example, past experiences of being attacked, knowledge of the perpetrator, and perceived level of support in the working environment. This
study attempts to redress the balance. It is important to investigate staff attributions of aggression by using more specific causal items such as victimisation and the impact of being detained in a secure setting, in addition to statements which might distinguish internal-bad characteristics from mental illness ones. Additional variables such as attitudes, past history of assault and demographic information will also be sought.

Clinical Psychologists might be able to raise awareness of attributional processing and its impact upon how aggression is understood and managed.

However, when attempting to compare and contrast the findings from these studies a number of complexities arise. These seem to have arisen from methodological diversity and are outlined below.

1.3.1 Methodological Issues of Current Research

It is difficult to make broad generalisations from the studies reviewed, due to a number of issues.

These issues include the following:-

i. Different definitions of responsibility being employed (for example, some studies have used only a general statement, whilst others have referred to Heider's five levels). Additionally, responsibility and blame have been used interchangeably (Holtzworth-Munroe, 1988).

ii. Attributions for different types of violence and aggression have been studied.

iii. The way in which information is provided, varies from one study to another. For example, vignettes were used by Meddings (1996) whilst real-life incidents were
used by Cottle *et al.*, (1995). Frieze (1979) points out that people make different attributions for hypothetical as opposed to actual cases of violence in marital relationships.

iv. Studies have employed different ‘actors’ (for example, young offenders and psychiatric inpatients) and different ‘observers’ (students or health care staff).

v. Given that studies originate from different countries, cultural factors may also restrict the generalisation of findings.

vi. A final issue is that situations in which participants are required to make attributions for behaviour may vary. A person required to offer her own personal views in a job situation may feel they have to do so within the context of the job requirements. At Rampton Hospital, nurses might feel particularly sensitive given the regular media attention to allegations of malpractice in the High Secure Hospitals.

### 1.4 Violence and its management

The literature indicates that attributions and attitudes may affect management strategies of violent or aggressive incidents. Meddings (1996) investigated hostel staff’s attributions for violence by a homeless person. She found that medical approaches and calling the police were associated with negative attitudes to people with schizophrenia. She also found that talking/caring strategies were associated with the causal item provocation (*externality*). *Internal enduring* attributions were positively correlated with imposing sanctions, whilst *internal temporary* ones were not correlated with
management strategies. Staff chose medical management strategies only when the aggressor was described as having schizophrenia. Some demographic factors were also found to influence approaches; female staff were found to rate passive approaches (for example, carrying on as if nothing had happened) as significantly more helpful than were male staff. Furthermore, qualified people rated the strategy to counsel the perpetrator as more useful than did unqualified people.

As mentioned previously, Apel and Bar-Tal (1996) studied nurses perceptions of and preferred responses to inpatient violence. They too found that a higher level of education was related to both a higher rate of choosing a therapeutic response, and less preference shown for choosing a violent response. They examined the impact of the two different types of aggression (arbitrary, and non-arbitrary) upon responses. Results indicated that, in the non-arbitrary scenario, the most frequent response would be 'violent' (for example, the use of physical force by the staff member) whilst in the arbitrary scenario, staff were more likely to take a therapeutic role, despite perceiving the behaviour in this scenario as more severe. Given that the behaviour was attributed to the patients' mental illness, (which was construed as being less rational), it was concluded that when a patients' behaviour is perceived as being congruent with a patients' role, staff become more willing to help. Behaviour that is construed as being within the patients' control, or violating the patient role, may elicit more punitive responses.

Labelling may also affect treatment preferences by activating schemas about certain groups. Howells et al., (1983) used vignette methodology to test whether judgements
of offenders varied according to the label of mental illness. They found that a person with such a label was perceived as less responsible and blameworthy, deserving less punishment and requiring more treatment than a non-mentally ill person. This is consistent with the mitigation hypothesis.

Crichton (1997) used vignettes in order to explore nursing staff's responses to inpatients' aggression. Findings indicated that staff rated use of p.r.n (“as required”) medication, relaxation, time out and talking about the incident as most helpful in managing such behaviour. Calling the police, imposing sanctions, use of seclusion and carrying on as if nothing had happened were deemed as least useful. Punitive sanctions were more likely to be chosen when the patient was believed to have a personality disorder and particularly if they were female. A diagnosis of schizophrenia was associated with choosing medication as more helpful. This suggests that schemas about certain groups (in this case, females with personality disorder) may be negative and subsequently, increase punitive responses. In addition, untrained staff were significantly more likely to choose coercive methods, than were trained staff.

In reviewing the literature on violence and its management, it also becomes evident that a number of additional factors may influence how violence is managed.

Carpenter et al.'s (1988) New York state study indicated that rates of seclusion and restraint differed according to hospital location; patients in large town hospitals and the city were more likely to be secluded than in small town hospitals and suburban area ones. They concluded that regional variations might be explained by the fact that in
large town hospitals there is a lower staff: patient ratio, and that more violence is
directed towards staff in these establishments. Whilst males were more likely to be
secluded than females in this study, Way and Banks (1990) found that females had a
greater probability of being secluded. This highlights that the context of the setting
may be an important factor in rates of seclusion, at least in psychiatric wards. Other
significant factors might be the 'culture' of the setting, training and policies, in
addition to individual staff and patient characteristics. Interestingly, at Rampton
Hospital, the Boynton Report (Boynton, 1980), noted that "the widely different usage
rates of seclusion on the male and female sides of the hospital might bear some relation
in this context; it seems to us possible that seclusion, together with the staff attention
and extra medication associated with it, may be positively sought by disturbed female
patients as a way of acquiring status among their peers." (pp. 58).
Whittington and Mason (1995) in reviewing studies on seclusion conclude that some
studies indicate that violence towards staff more often resulted in seclusion than did
violence towards others whilst only two studies known to the authors reported an even
distribution. This implicates that the target of aggression might be important in
decisions about managing violence. In reviewing the literature, Whittington and Mason
(1995) concluded that seclusion is used much more in response to actual than to
threatened violence. Nonetheless the authors discuss the subjective process of deciding
whether or not to seclude a patient. Employing a cognitive theory of stress (Lazarus
and Folkman, 1984) in explaining the processes involved, seclusion becomes
reconstructed as a coping strategy amidst staff anxiety about imminent violence. In
addition to patient behaviour, predictability of the event, nurse characteristics such as
attitudes and beliefs about racial and gender groups, self-perceptions about one's skill to cope are also highlighted. Such a model would account for the occurrence of individual differences across staff members in decisions to seclude.

Given these findings, it might be predicted that High Secure Hospital staff's attributions for aggressive behaviour and attitudes to patients would affect their preferred management approaches. These studies also suggest that demographic factors such as qualifications and sex of participants might produce differences in choosing from a variety of management strategies. In addition, other factors such as the target of aggression, and staff perceptions of threat, could also have an impact upon the strategies that staff might adopt.

1.4.1 Methodological Issues in Studies of Violence and its Management

There are a number of problems with the literature on violence by psychiatric patients and its management. Studies have looked at different groups in different settings, leading to the problems of being able to generalise findings from one study to another. Larkin et al., (1988) studied violence in a High Secure Hospital where admissions are taken nationally, and patients are admitted to either male or female wards, whilst others have studied violence at inner city psychiatric hospitals where mixed sex wards exist (Noble and Rodger, 1989; Mortimer, 1995). Differences in ward milieu, staff training, management structure and other organisational factors may all influence the results found from studies of violence. This makes it difficult to compare findings.
1.5 Gender Issues

1.5.1 Social constructions of women who use violence

Social constructionism is a term describing the idea that people are shaped, constrained, or defined by society (Shilling, 1993). ‘Psychiatric patients’, ‘offenders’ and ‘females’ have all been identified as socially constructed groups perceived as deviant from societal norms and threatening to society (Burns, 1992). Thus the embodiment of normality is linked to gender; the ‘normal woman’ is proposed as being constructed around femininity, domesticity and mental health (Hemingway, 1996). Those women that transgress such roles are sometimes described as being “doubly deviant” to societal norms.

Within criminological research, explanations of female crime has been narrowly defined, yet have not included, or catered for female experiences (Naffine, 1987). That there is more research on women as victims than as offenders (Kruttschnitt, 1995) may partly reflect the stereotypes of men and women, and the greater incidence of violence by men in society.

1.5.2 Sex Differences and the Criminal Justice System

Whilst a great deal of literature on criminology has come from feminist researchers and writers, it is generally thought that this group has been reluctant to think about women as violent in case that it undermined the higher incidence of violence by men (Kelley, 1996). In the courtroom, women are said to come under a different type of scrutiny for their crimes than men and stereotypes of the ‘normal woman’ who conforms to her role
may affect sentencing recommendations (Kennedy 1992). Two conflicting hypotheses have arisen on the subject of female offenders and the Criminal Justice System. The *chivalry hypothesis*, proposing that women receive more lenient sentencing than men when they commit similar trivial offences (Naffine, 1987), and the *double deviance* proposal (Heidensohn, 1985), that female offenders are dealt with more harshly, on the basis of both their crime, and the degree to which they do not conform to appropriate expectations of female behaviour. Therefore, if a woman presents as vulnerable, remorseful or irrational, she is likely to be dealt with more leniently than a woman who is rational, calm, or has an ‘unconventional’ lifestyle.

In reviewing the research studies on gender differences and the juvenile justice system, Elliot (1988) concluded that gender biases operate at a number of stages in the judicial process. She found that females who were charged with violent offences were dealt with more severely than their male counterparts, commensurate with the double deviance hypothesis.

A recent study by Wilczynski (1997) explored forty eight case files from the director of public prosecutions on child killing in London, from 1984 and a sample of fatal and non-fatal cases reported in the Criminal Appeal Reports between 1980 and 1990. She found that, at all stages of the legal process, the Criminal Justice System dealt differently with men and women who kill their children. This difference reflected the view that females who commit filicide are mentally unstable, whilst the male counterparts are bad and ‘normal’. Burns (1992) cites Home Office statistics for England and Wales from 1986 showing “that men are convicted of crimes many more
times than women and that this holds across all the usual types of crime” (pp. 110). She also points out that DHSS (1986b) statistics show the opposite effect in terms of admissions to psychiatric hospitals. This implies that the need for psychiatric care in men may not be recognised, whilst for women, the image of mental instability is perpetuated.

1.5.3 Perceptions of male and female offenders

Whilst four times as many men than women enter the High Secure Hospitals, it is the women that have more “psychiatric labels” and men who are deemed as more “criminal” (Bartlett, 1993).

Lovelock (1996) noted from several interviews with female staff working with women in Rampton Hospital that there was a preference for working with male patients throughout the hospital. Some of the female staff gave the following reasons for this, some of which included: female patients were considered to be more demanding, more disruptive and more unstable than the males. They were also thought to be viewed as more complex, as having had more negative past experiences, and as having more psychiatric problems than the male patients.

This may have implications for the way in which the High Secure Hospitals are providing care and for what happens after sentencing. Once women receive a psychiatric label, their views on life may no longer be considered as important, or rational. This may also be true for females in prison without a psychiatric label because of role norms for prisoners and also according to sex role expectations. A study of
female officers in an American jail illustrated that female inmates were considered as being more manipulative, because misperceptions arose when they asserted their needs (Belknap, 1991). The study also found that whilst the majority of female staff had no preference for working with either male or female inmates, 34% preferred male inmates, whilst 14% preferred female inmates. Pollock (1995, in Price and Sokoloff) found an even greater preference (72%) by female jail officers to work with male inmates. These findings, however, should be considered with caution since they were undertaken in the U.S.A. and may not generalise across cultures.

Horn and Hollin (1997) explored the British general public’s and police officers’ perceptions of male and female offenders. They found that both groups viewed women offenders as more trustworthy than male offenders, as less fundamentally bad, and as more similar to non-offenders. They suggested that police officers may trivialise females offending, or explain the offender’s behaviour in terms of situational factors or personal pathology.

Phillips and DeFleur (1982) explored the general public’s perceptions of ‘deviants’. They found that offenders who were believed to be feminine were judged as being more mentally ill and unable, and those viewed as masculine were judged as being more rational. They also found, however, that the type of crime itself mediated such evaluations.

Gelsthorpe (1989) undertook a qualitative study of the perceptions about young male and female offenders by observing and interviewing staff from three different agencies;
two social services child and family assessment centres (one single sex and one mixed sex agency), and the juvenile liaison department of a police station. She found that residential social workers viewed aggressive behaviour by boys as more acceptable, than by girls. Additionally, girls were expected to follow the examples set by female staff, whilst boys were expected to follow those set by male staff members. In this particular agency, girls were judged on the basis of their character, boys for their actions. In all three agencies studied, the ideal girl was perceived as passive, emotional, caring and sensitive. Police staff viewed girls as more deceitful than boys, and tended to deal more harshly with them if they were not performing well at school, or had less supportive families. Confirmation was found for the hypothesis that sexism existed in the everyday activities of staff across the three different agencies, but that such beliefs and practises were a result of the organisational, political, and administrative influences rather than sexist attitudes per se.

As Hemingway (1996) also points out, breaking gender norms alone may not account for all decisions to detain women in secure psychiatric facilities and men in prisons. Nonetheless, it is important to acknowledge the extent of stereotypes and expectations of men and women who are detained, and the influence of these factors on their treatment. This raises the question regarding the extent to which male and female inpatients’ aggression is understood and dealt with.

1.5.4 Sex Differences and Violence

A number of studies have cited evidence for greater numbers of violent incidents caused by female inpatients (Larkin et al., 1988; Fottrell, 1980). In a retrospective
study over a period of 26 weeks, Larkin et al., (1988), found that an average of one life threatening incident per week occurred in a Special Hospital. Female patients were responsible for a significantly higher proportion of violent incidents, (75%), than were male patients. Binder and McNiel (1990), in a study of violence in America, found that more men than women were violent two weeks before admission to a psychiatric hospital, but that after admission a greater number of assaults on staff were committed by female patients. However, some findings have actually indicated that men and women are almost equally likely to be violent as inpatients, (Myers and Dunner, 1984).

A literature search reveals a striking absence of academic research which takes up further exploration of this area. There have been limited or no attempts at all in explaining these sex differences. Larkin et al., (1988) state that such findings are obscure but do not discuss the types of admissions to female wards, the conditions on the wards and the possibility of different assumptions or stereotypes about female and male patients by staff. Binder and McNiel (1990) speculate that staff members may be less likely to expect violence from female than male patients, giving females more opportunity to become assaultive. This suggests that female aggression is seen as having an opportunistic basis. Conversely, it could be asserted that staff view female patients as more psychologically disturbed and irrational than male patients, which might impact upon the way that patients are treated and subsequently how these patients respond. Binder and McNiel also propose that gender role expectations may not exist at all in a hospital environment, but they give no account for such an absence of these factors. It would seem feasible that such role expectations and other stereotypes might have a strong impact upon the way in which staff interact with such patients. The process of socialisation is largely ignored by most studies. Characteristics
of violent female offenders have been confined only to age, race, and offender-victim status (Kruttschnitt, 1995), with few studies that have explored the factors which increase females risk of becoming violent.

**In summary**, the literature on gender issues and criminal justice agencies suggests that peoples' perceptions of male and female offenders may differ, sometimes falling crudely into the domain of madness or badness. Whilst psychiatric and judicial services might perceive and treat men and women differently, stereotypes may not be the only reason for this, but organisational, political and administrative influences might also play a role.

There is evidence from some studies that females detained in psychiatric settings are more frequently violent, yet there is very limited further exploration of the questions that these findings raise.

### 1.6 Conclusion

The investigation of inpatient aggression is an important area of research. Several factors have been highlighted as being important in the measurement of staff attributions for aggression, and preferences for certain management strategies. Given that female inpatients have been found to cause more violent incidents than their male counterparts, (Larkin *et al.*, 1988; Mortimer, 1995), it seems important to investigate attributions and management strategies according to gender.
In contrast to criminological studies, psychiatric and psychological research about inpatient violence and attributions has paid little attention to the sex of the actor or observer. It is difficult to draw conclusions about sex as a variable, given this absence of research, but this area could be explored by way of vignette methodology including, general and specific causal items.

The attributional literature suggests that attributions are influenced by a variety of conditions, and associated variables.

Negative schemas and stereotypes may exist about people with a mental illness, or more specifically, for people diagnosed with a personality disorder. In order to enhance ones’ sense of distance from certain groups one may assign more responsibility and blame and attribute behaviours to internal causes. This may enhance ones’ self-esteem and sense of difference from the mentally ill. Alternatively, one might hold positive attitudes to certain groups, because of contact with them under more positive conditions. Negative behaviours might therefore be considered as being externally based.

Whilst some studies have explored attitudes to women in relation to attributions, insufficient attention has been paid to attitudes towards men. Staff attributions and attitudes may exert a strong influence on the response to violence in secure settings. Patient role violation might also be significant in affecting helping behaviour.
Exploring the attributions of High Secure Hospital staff may enhance the understanding of salient causal factors in violent incidents. It may enable High Secure Hospital staff, including Clinical Psychologists and Clinical Nurse Specialists to address attributions, attitudes and management strategies in training. Given that the literature on criminology highlights that sentencing patterns reflect the view that men are bad and normal, whilst women are mad and irrational, one could predict that, beyond sentencing, such attitudes may also prevail to a certain extent. In terms of attributions, female patients' aggression may be explained by incompetence (lack of skills) and mental disorder attributions, to a greater extent than aggression by male patients. Should High Secure Hospital staff perceive violence by women to be caused by victimisation experiences and mental disorder, and subsequently, to manage it more leniently, this has important service implications.

This may raise the question as to whether these types of attributions are useful because they may lead to less sanctions, and possibly, consideration of the environment and hospital context as the focus for change, or whether they are unhelpful because they decrease the patients' responsibility.

Consequently, training on such issues would both create a dialogue for staff's perceptions, and a forum for sharing ideas and promoting awareness of implicit areas such as attributions about violence and gender.

The general aims of the study are to explore whether staff apply the same stereotypes to male and female patients aggressive behaviours, as those applied by the criminal
justice agencies. An attempt will also be made to explore the effects of the patients’
gender and the target of aggression (staff or patient) on attributions and favoured
management strategies. Finally, attitudes to High Secure Hospital patients will be
explored, in order to determine any association between staff’s beliefs about patients in
general, with their attributions and preferred management approaches.

1.7 Aims and Hypotheses

Based on the above theoretical background a study was planned with the following
aims:

1. To explore differences in attributions made about male and female violence
towards a member of staff or a fellow patient.

In accordance with the expectancy model (Feather, 1969) one would predict that
aggression by a male patient is attributed to more internal and stable causes, on
the basis of gender norm expectations. In the female patient vignette, aggressive
behaviour would be attributed to external unstable explanations. However,
responses might be mediated by the situational context (High Secure Hospital
environment) which is also considered as a source of information with which to
infer causality (Deaux, 1976). If so, expectations of violence and aggression may
be higher in High Secure Hospital staff, regardless of patients’ gender, given the
setting in which they work. This may lead to a higher proportion of internal
stable attributions to both male and female patients.
Hypothesis 1.i.

On the basis of the literature reviewed, and given the context of the study, it is predicted that staff will make equally high internal enduring attributions for a male and female patients' aggressive behaviour, but for different reasons. In light of the criminological studies, it is proposed that the female patient will be perceived as being more mentally ill, and as more lacking in coping skills, compared to the male patient. The male will be perceived as being a more violent person.

Hypothesis 1.ii.

Given that the female patient will be perceived as more mentally ill, staff will rate victimisation experiences as more important in explaining the female patients' aggression, than the males.

Hypothesis 1.iii.

On the basis of the proposal that the male patient will be perceived as more violent, he will be held as being more responsible and more to blame for his behaviour.

Hypothesis 1.iv.

Where the target of aggression is a member of staff, the aggressor's behaviour will be perceived as being more of a threat to staff. Where the target is a patient, the aggressive behaviour will be viewed as being more of a threat to other patients.

2. To investigate the association between attributions for aggressive behaviour and management approaches.
Hypothesis 2.i.

The preferred management approaches will be associated with the attributions made about the patient. For example, therapeutic approaches will be associated with attributing the behaviour to lack of skills, mental illness and victimisation experience, in addition to viewing the behaviour as less controllable. Controlling approaches will be associated with attributing the behaviour to an inherent tendency to violence and viewing the behaviour as being more controllable.

3. To investigate the management of aggression according to the patients' sex and whether the target is a member of staff or a patient.

Hypothesis 3.i.

The management approaches employed by staff will differ according to the sex of the protagonist, and according to the target of aggression. The female vignette figure will elicit more therapeutic responses; the male vignette figure will elicit more controlling approaches. The staff target vignette will elicit more controlling approaches, whilst in the patient target vignette therapeutic approaches will be preferred.

4. To investigate whether staff with different attitudes to Special Hospital patients will employ different attributions and different management strategies.

Hypothesis 4.i.

There will be an association between specific attitude factors with certain attributions and management strategies. For example, positive attitudes will be
related to perceiving the cause of the behaviour as being externally based and, more specifically, attributing the behaviour to victimisation experiences and mental illness. Therapeutic approaches will be associated with positive attitudes. Negative attitudes will be associated with viewing the patient's aggression as being more controllable and more blameworthy. Negative attitudes will be related to preferences for controlling or avoidant approaches.

5. To explore the relationship between demographic variables, the perceived level of support from colleagues and managers, and history of past attacks, with attributions and management strategies.

Hypothesis 5.i.

Participants' qualifications will affect their ratings of attributions and management strategies.

Hypothesis 5.ii.

Age will also influence attributions and management strategies.

Hypothesis 5.iii.

There will be a relationship between perceptions about how supported one is in their work and the types of attributions and management strategies that are chosen.

Hypothesis 5.iv.

Finally, past level and rate of victimisation of the participants will be associated with their choice of attributions and management strategies.
1.8 Methodological issues

1.8.1 Research Design

The aim of the study is to compare staff attributions and favoured management approaches to aggressive behaviour (towards a patient or a member of staff) perpetrated by female and male in patients. Two possible options for experimental design are appropriate; between subjects or within subjects.

Whilst a within subjects design is more efficient and subjects and conditions are not confounded, order effects in presenting the conditions could affect responses. A between subjects design means that there is no such contamination of the responses for each condition. The design of between subjects was therefore chosen.

1.8.2 Measurement of Attributions and Management Strategies

The central variables in the study are attributions for aggressive behaviour and preferred management strategies. There are no current instruments available with which to measure Special Hospital staff’s attributions for violent incidents and preferred management strategies. Whilst Apel and Bar-Tal (1996) explored nursing staff’s use of management approaches, their measure was based on a sample from Israel. Meddings’ (1996) questionnaire was also based on a group who differed from the current studies’ sample, that is, people who worked in hostels for the homeless. Staff working in the High Secure Hospital cannot be assumed to share similar beliefs and models about (working with) aggressive behaviour as the staff in these studies.
Therefore, these measures might not be appropriate because they may not gauge the salient perceptions and management strategies of High Secure Hospital staff.

Attributions will be measured by the use of statements, in addition to closed and open questions. Closed questions can be used as rating scales and can be considered to have interval properties, enabling the use of parametric tests. But they restrict responses, which may mean that validity is reduced. Open-ended questions have the advantage of allowing subjects to generate their own explanations for events. Stratton et al. (1986) point out that investigating attributions by statements constructed by the researcher may limit the responses of participants. They outline a system for analysing causal attributions, which are produced naturally from the individual respondent. This involves working through transcripts to extract each statement, which indicates a belief that an identifiable event is causally related to an identifiable outcome. Given the time constraints of this study, and the need for a relatively large number of participants (due to having eight experimental conditions), a questionnaire with statements chosen by the researcher was used.

Several factors need to be considered in planning the measurement of these variables. One study has demonstrated that perceived threat is an important factor in affecting decisions about secluding patients (Whittington and Mason, 1995). It is also apparent that mental illness is an important causal item in respondents’ attributional analysis (Meddings, 1996; Gresswell, 1988; Apel and Bar-Tal 1996).
Cann et al. (1980) point out that attributions of personal responsibility are important in influencing recommendations for the treatment of young offenders. It could also be proposed that these attributions have implications for preferred management strategies of inpatient violence. Given that victimisation experiences have received much attention, particularly with respect to female offenders and as a strong predictor of later psychiatric symptoms, (McClellan et al., 1997; Briere et al., 1997), statements attempting to reflect these events will be utilised.

Statements reflecting internality, externality, mental illness, victimisation experiences, and perceived threat are chosen from the literature. Additionally, questions concerning stability, controllability, blame and responsibility are also given, in order to investigate whether such aspects of staff’s perceptions vary according to sex of protagonist and victim status.

Preferred management strategies will be explored by the use of statements and an open question. Initial information about management strategies to inpatient violence was drawn from authors such as Crichton (1997) and modified according to the limitations of some items. One possible constraint on participants’ responses is that of hospital policies about managing incidents of violence and aggression. Such policies may increase the consensus across individual’s choices of strategy, given that certain guidelines have to be followed in certain circumstances. Nonetheless, it is worth noting that the measures in this study attempt to gauge individual perceptions and preferences rather than actual practices.
1.8.3. Other Measures

In their study which examined the police and public's beliefs about offenders, Horn and Hollin (1997) used an adapted version of Melvin, Gramling and Gardener's (1985) Attitude Towards Prisoners Scale. Given the possibility that these factors may influence the treatment of High Secure Hospital patients, this scale will be utilised but adapted to explore attitudes to High Secure Hospital patients. This scale is reported to have reasonable stability over time, good validity and low response distortion. The disadvantages of this measure are that it is a forced choice measure. It may also be criticised for the way in which questions are asked overtly, which might result in more socially desirable responses being given.

Respondents might be particularly sensitive to criticism and therefore become guarded in their responses in general. However, given the anonymous nature of the questionnaires and reassurances of confidentiality, these factors could reduce this problem. Furthermore, the attributional statements are less obviously associated with socially desirable responses.

The disadvantages of self-report measures include the question of reliability and validity over time, and whether they reflect the actual behaviour and beliefs that they are meant to. Whilst observational methods might be able to predict behaviours, they largely fail to clarify the role of perceptual processes.

Self-report measures are more efficient and permit more personal responses from participants.
Most of the measures in the study relate to attributions concerning aggression, management approaches and attitudes to High Secure Hospital patients. These are ordinal variables, being ordered in terms of "more" or "less" properties. To be considered as interval data, differences between categories would need to be identical, but given that these differences on the rating scale are not the same, interval qualities do not strictly apply (for example, the differences between 1 and 2 on the attribution scale is not the same as that between 3 and 4). Nonetheless, Bryman and Cramer (1990) point out a trend, in that variables in such scales have been treated more as interval measures. Considering the data as interval would allow the use of more sensitive statistical procedures and help to avoid errors.

Demographic variables such as age are interval, whilst qualifications and gender are categorical ones.

The current study assesses attributions, preferred management strategies and attitudes to Special Hospital Patients, following the presentation of a vignette.
2. METHOD

2.1 Participants

The 118 participants comprised all grades of nursing staff (including unqualified and bank staff) recruited from 24 wards at Rampton Hospital on the basis of them having a nursing qualification or being ward-based. Initially it was hoped that participants could be selected randomly by sending out questionnaires to the wards but this was considered to be a more timely and less productive approach. Therefore participants were approached directly during visits made to the wards by the researcher. This sample is therefore biased in the proportion of nurse-trained to other professional staff. Given that there are more wards for male patients, more than half of the questionnaires were administered to the male service and under half to the female service. Participants were split into two groups depending on the vignette that they received. Originally, it was hoped that questionnaires containing the female version would be sent to the female wards, and that the male versions would be sent to the staff on the male wards. However, this proved impractical because of the imbalance of male staff in the female service, and the small proportion of female staff in the male service, which meant that all versions of the questionnaire had to be sent to both services.

The results section provides details of demographic information about participants.
2.2 Procedure

Nurse Managers were approached to discuss recruiting participants. Following this, 11 specific wards were initially identified and the researcher visited each, to introduce herself and the project verbally, in an informal, standardised way. Participants were presented with an 8 page questionnaire, the first page explaining the study and providing the scenario. Vignettes comprised a brief history of the patient and classification. Details just prior to the aggressive incident were outlined, followed by a description of the aggressive behaviour. Having read through the vignette, participants were asked to rate which attributions they felt applied to the patient from a forced choice of 15 specific attributions, 3 general items (personal enduring, personal temporary, and external), and 7 items concerning perceptions of threat, responsibility, blame, controllability and stability. Participants were also given the opportunity of adding any further explanations themselves. Ratings were on a 7 point Likert scale, where 1 reflects very unimportant and 7 reflects very important. Following this, participants were also asked to indicate what action they would take if they were the member of staff in the vignette. 18 items were provided for each participant to rate how likely or unlikely their choice of each approach would be, on a 7 point Likert scale. An open question asking for any other strategies they would employ was also provided. In addition, they were asked to rate how supported they felt by colleagues and managers in dealing with such incidents.
Following completion of this section, the participants were required to rate 36 attitudinal items on a 5 point Likert scale. Finally, demographic details were requested.

Each ward was given 8-20 questionnaires, and participants were asked to return them in individual sealed envelopes which could then be placed in a labelled envelope in the office.

Of the wards visited, 6 were female and 18 were male. In order to maximise the number of respondents, a total of 24 wards were visited over a period of 5 months. This sometimes necessitated more than one visit to chase up non-returns.

2.2.1 Ethical Issues

Ethical approval was sought initially from Rampton Hospital’s ethical committee and also from Leicester University’s ethical committee (please see Appendix 1 for further details). Following approval being granted, consent from members of staff in the Secure Hospital was sought by expressing the voluntary nature of the study during the ward visits. It was pointed out that confidentiality and anonymity of responses would be maintained, both verbally to ward staff, and on the questionnaire itself. It was explained that the study was exploring staff views and management approaches of aggressive incidents, but no attention was drawn to gender or victim status.

Subjects were also told that a summary of the findings would be disseminated briefly to each ward, to the research interest group of the hospital, and to the Leicester University Centre for Applied Psychology as part of the course requirements.
Participants were asked to give their comments at the end of the questionnaire about their involvement.

2.3 Measures.

A three-part questionnaire was developed for the study. The first part consisted of a short story about an incident of aggression by a patient, attributional statements for the incident, and preferred management strategies. The second part explored attitudes to Special Hospital patients, and the third part requested demographic information.

2.3.1 Section One: Measurement of Attributions and Management Strategies

A case vignette approach was adopted using methodology developed by Star (1955, in Levey and Howells, 1995).

A literature review enabled theoretical perspectives and constructs (for example, the internal-external dimensions of attribution theory) to be considered.

Semi-structured interviews with four nurse managers enabled common scenarios involving violence and its management in the Hospital to be elicited. The interviews are described more fully in Appendix 2.

Two vignettes (one describing an act of aggression towards a member of staff, the other towards a patient) were constructed on the basis of the information from the interviews with the nurse managers and discussion with two Clinical Psychologists.
who worked in the hospital. They described a 32 year old in patient (either female or male) returning to the ward after an art session, arguing with a fellow patient, and using threatening gestures towards the member of staff or towards the other patient. Thus in all, four different vignettes were produced.

Questions concerning how supported staff felt were included in order to explore any interaction between perceived level of support, and preferred management approaches.

Attributions were coded on a scale of 1-7. Examples of such statements included: “She/ He is a violent woman/ man” and “She/ He has experienced a difficult childhood”. Statements about management strategies included: “Use physical restraint” and “Help him/ her explore his/ her feelings.” Face validity was assessed by consulting with four nurse managers in the Special Hospital and three Clinical Psychologists during the drafting of the questionnaire.

Construct validity (that is, whether the attributions reflected the proposed dimensions) was measured by asking 12 Trainee Clinical Psychologists and two qualified Clinical Psychologists to classify each statement according to the dimensions of internality, externality, responsibility, blame, controllability, perceived threat, or any other dimension, which they were requested to specify.

Of the items in the questionnaire, 25 out of an initial 57 items fulfilled the construct validity criteria of over 75% agreement as rated by trainee clinical psychologists. This compares with Vala et al., (1988) who obtained 100% agreement by 3 judges. These 25
items were reduced to 15 following further consultation with two clinical psychologists working at Rampton Hospital, and separating the more general items (for example: blame and controllability) into a separate section from specific ones. The general items comprised of; 7 statements reflecting perceived threats, blame and responsibility. For example, "how much of a threat do you feel this incident is to other patients?", was believed to reflect perceived threats, and "to what extent do you feel he/she is to blame for the acts?" was believed to reflect blame, as rated by 12 trainee clinical psychologists. A number of items were found to be ambiguous therefore requiring omission from the final version of the questionnaire. This can be found in Appendix 3.

Attribution theory has been criticised for the ambiguity that is produced by certain attributions; some statements do not fit into mutually exclusive categories. For example, "She is frustrated at being held in secure conditions" was perceived by some as an attribution of externality, but was also rated by some trainees as a reflection of internality.

An open question at the end of the section was also provided, in order to enable participants to generate their own explanations for the behaviour.

Management strategies were also coded by 6 Trainee Clinical Psychologists and 4 Assistant Psychologists (the latter group worked in the High Secure Hospital). Those which attained under 75% consensus by coding were excluded from the questionnaires. The management strategy items were reduced to 18 items for the final version of the questionnaire.
Factor analysis of attributions and management strategies enabled items to be further categorised according to the ratings from staff who participated in the study. This allowed for a more meaningful analysis according to this particular sample’s perceptions. These are recorded under ‘Results’.

Inter-rater reliability was tested by two independent raters scoring and entering the data from a sample of 15 questionnaires. Items were coded by use of acetates with scales of 1-7 for the attributions and management strategies, and on a scale of 1-5 for the attitudes. There was 100% agreement across the two raters.

There was no reason to anticipate that attributions or management strategies would not be constant over time, because the incidents of aggression in the vignettes were constant. However, given that real incidents of aggression occur in different situations and have different characteristics, one must be aware of the restrictions of making inferences from hypothetical scenarios.

2.3.2 Section two: Attitudinal Measurement

An adapted version of the Attitudes Towards Prisoners Scale (Melvin et al., 1985) was used in order to explore Special Hospital staff’s attitudes towards patients. The scale was modified by replacing the word ‘Prisoner’ to ‘Special Hospital Patient’ in all instances. Given the large number of questionnaire items, and consequently the larger number of participants required for factor analysis of these, pooling of data from the current study with data from the Horn and Hollin study was considered. However, as
Child (1975) points out, in the process of simplifying factors through factorial analysis, factors specific to one population may be obscured when pooling is applied.

2.3.3 Section three: Demographic Information.

Finally, information such as age, sex and qualifications, in addition to participants' past history of assault by patients, were sought, in order to investigate whether any interaction between these factors with the chosen attributions and management strategies existed.

2.3.4 Summary

In summary, a questionnaire developed by the researcher measuring attributions about inpatient aggression, perceived sense of support from colleagues, past assault history and management approaches was used. In addition, a modified version of the Attitudes Towards Prisoners Scale was employed in order to measure participants' attitudes to Special Hospital patients.

2.4 Design

An independent (unrelated) groups design was employed, with dependent variables as the attributions about the aggression, and the preferred management strategies, in addition to attitudes to Special Hospital patients. The independent variables were: the sex of patient, and the target of aggression ('victim status'). Participants were categorised on the basis of their sex, and the condition (questionnaire version). In total, there were eight groups according to these categories.
Table 2.4.1 – Design of the Study

<table>
<thead>
<tr>
<th>Questionnaire Version Vignette Figure (male/female) X Target (staff/patient)</th>
<th>Participants: Male / Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Staff Male Vignette Figure Staff Target</td>
<td>Female Staff Female Vignette Figure Staff target</td>
</tr>
<tr>
<td>Male Staff Male Vignette Figure Patient Target</td>
<td>Female Staff Female Vignette Figure Patient target</td>
</tr>
<tr>
<td>Male Staff Female Vignette Figure Staff Target</td>
<td>Female Staff Male Vignette Figure Staff target</td>
</tr>
<tr>
<td>Male Staff Female Vignette Figure Patient Target</td>
<td>Female Staff Male Vignette Figure Patient target</td>
</tr>
</tbody>
</table>

2.5. Statistical Analysis

The data for attributions, management strategies and attitudes were factor analysed in order to reduce the number of dependent variables. Factors were extracted using Principal Components Analysis and a varimax rotation. Please see the results section for more detail.

In all instances, (other than where data was non-numerical) the dependent variables were treated as interval data.

In order to check the dispersion of the data, graphical representations, such as histograms were initially employed. Given that some of the dependent variables were not normally distributed (for example, the ‘Victimisation’ dimension had a kurtosis of
.958, and skewness of -.746) further statistical tests were undertaken in order to test for the legitimacy of employing Analysis of Variance tests. Homogeneity between the eight groups was tested using Cochran's C, which demonstrated non-significance for the majority of attributional and management strategy items. Use of the ANOVA model (as opposed to non-parametric equivalents such as Kruskal-Wallis) would allow for more power and reduce the possibility of type I errors. Therefore, a series of 3-way Analysis of Variance tests were undertaken, in order to explore any differences in the attributions and management strategies as rated by the eight groups with each of the different vignettes.

In order to explore any association between attitudes, attributions and management strategies, a Pearson's product moment correlation coefficient was utilised. The use of the Pearson, rather than the nonparametric equivalent (that is, the Spearman rank correlation) was chosen due to the loss of power that can be incurred by using nonparametric tests (Howell, 1997).
3. RESULTS

3.1. Demographics

The 118 participants comprised of qualified and unqualified ward staff.

Of these, 17.8% (N = 21) of staff were unqualified, whilst 44.1% (N = 52) indicated that they had a nursing qualification, either as a registered mental nurse (RMN) or a registered nurse in mental handicap (RNMH). 34.7% (N = 41) were RMN trained, 17.8% (N= 21) had an RNMH training. A small percentage of staff stated that they held both RMN and RNMH qualifications (5.9% ; N= 7). 4.3% (N = 5) specified other qualifications (for example, diplomas in behaviour modification etc.).

Of these, 19.5% (N = 23) did not specify whether or not they were qualified.

Of these, 53.4% (N = 63) of staff were men and 46.6% (N = 55) were women. Their ages ranged from 24 - 59 years, with the mean age being 37.12 years (sd = 7.64).

Results are presented separately for attributions, management strategies and attitudes.
3.2. **Attributions**

3.2.1 **Factor Analysis**

In order to reduce the number of variables, it was necessary to undertake a factor analysis of specific attributions (that is, items 1 - 15). Factors were extracted using Principal Components Analysis and a varimax rotation. Five factors were extracted and the Scree test suggested that it would be appropriate to use all of these. However, factors three four and five were so conceptually ambiguous that they have been excluded from further analysis. The items which comprise factors one and two are presented in table 3.2.1 below, those for factors three, four and five are in Appendix 4.

**Table 3.2.1 Factors one and two for attributional statements, items, and factor loadings**

(the variance accounted for is in brackets).

<table>
<thead>
<tr>
<th>Factor 1 ('Victimisation') (24.5 %)</th>
<th>Factor 2 ('Internal -mad') (14.4%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.67*</td>
<td>2.16*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(Victimisation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(24.5 %)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>As an adult, she/ he has been the victim of a number of assaults.</td>
<td>0.78</td>
<td>She/ he has poor anger management skills.</td>
</tr>
<tr>
<td>She / he has experienced a difficult childhood.</td>
<td>0.76</td>
<td>He/ she was unable to communicate his/ her feelings appropriately.</td>
</tr>
<tr>
<td>She/ he is frustrated at being held in secure conditions.</td>
<td>0.65</td>
<td>She/ he is mentally ill.</td>
</tr>
<tr>
<td>His/ her mental state is deteriorating.</td>
<td>0.59</td>
<td></td>
</tr>
</tbody>
</table>

*Note: * = Eigenvalue.
The first factor, called “Victimisation” (four items loading above 0.5) accounted for just under one quarter of the variance. The maximum score on this factor was 28, indicating a belief that the aggressive behaviour is a result of past or current negative experiences. A low score, conversely, indicates a belief that the behaviour is not caused by such experiences.

The second factor which accounted for 14.4 % of the variance was called “Internal-mad”, on the basis of its items suggesting mental illness and poor coping skills. The maximum score for this factor was 21. A high score reflects a belief that the behaviour is a result of the patient being fundamentally mad and lacking skills with which to express or manage anger.

Perhaps surprisingly, the factor analysis did not yield an interpretable Internal “bad” factor. It is for this reason that the specific attributional statement “He /she is a violent man/woman” was retained for further analysis.

A number of other attributional statements were not included in the factor analysis because of their global nature, but were retained as separate variables. These were the dimensions personal temporary, personal enduring, and externality, together with stability, controllability, blame and responsibility items. Perception of threat was also retained as a separate variable. The means and standard deviations for these statements are given in the tables in the next section below.
3.2.2 **Hypothesis 1**

To explore staff’s attributions for violence in a Special Hospital setting.

Are different attributions made if people are told that the aggressor is male or female, and that the target is a patient or member of staff?

**Hypothesis 1.i.**

Irrespective of the target and the participants’ gender, staff will make equally high internal attributions for violence by a male and a female patient, but for different reasons. The female patient will be perceived as more mentally ill, and as more lacking in coping skills, compared to the male. The male patient will be perceived as a more violent person.

**Hypothesis 1.ii.**

Staff will rate victimisation explanations as more causal to the female patients’ behaviour than to the male’s.

**Hypothesis 1.iii.**

Given that males will be perceived as more violent, and as less mentally ill, they will be held as more responsible and more to blame for the behaviour.
Hypothesis 1.iv.

The aggressor will be perceived as being more threatening to staff, if a staff member is the target. In the patient as victim scenario, the aggressors' behaviour will be perceived as being more of a threat to other patients.

With respect to general attributional statements, the behaviour was seen as resulting more from internal enduring (Mean = 5.79) than internal temporary or external factors (Mean = 4.82 and Mean = 4.58 respectively). Table 3.2.2.a shows the mean responses and standard deviations for these three variables, divided by condition.

Table 3.2.2.a Mean responses (and standard deviations) for general attributions.

<table>
<thead>
<tr>
<th></th>
<th>General Attributions</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Internal temporary</td>
<td>Internal enduring</td>
<td>External</td>
<td></td>
</tr>
<tr>
<td>Participants' gender:</td>
<td>M (SD)</td>
<td>M (SD)</td>
<td>M (SD)</td>
<td></td>
</tr>
<tr>
<td>Female subjects N= 55</td>
<td>4.58 (1.70)</td>
<td>5.73 (1.28)</td>
<td>4.51 (1.66)</td>
<td></td>
</tr>
<tr>
<td>Male subjects N= 63</td>
<td>5.03 (1.95)</td>
<td>5.84 (1.38)</td>
<td>4.65 (1.70)</td>
<td></td>
</tr>
<tr>
<td>Patients' gender:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female patient N= 63</td>
<td>4.54 (1.95)</td>
<td>5.90 (1.30)</td>
<td>4.79 (1.80)</td>
<td></td>
</tr>
<tr>
<td>Male patient N= 55</td>
<td>5.15 (1.66)</td>
<td>5.65 (1.36)</td>
<td>4.34 (1.52)</td>
<td></td>
</tr>
<tr>
<td>Target:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff target N= 69</td>
<td>4.88 (1.76)</td>
<td>5.85 (1.06)</td>
<td>4.72 (1.48)</td>
<td></td>
</tr>
<tr>
<td>Patient target N= 49</td>
<td>4.73 (1.97)</td>
<td>5.69 (1.65)</td>
<td>4.39 (1.92)</td>
<td></td>
</tr>
<tr>
<td>Total N= 118</td>
<td>4.82 (1.84)</td>
<td>5.79 (1.33)</td>
<td>4.58 (1.68)</td>
<td></td>
</tr>
</tbody>
</table>
Mean scores on factor 1 ('Victimisation') were all well above the scale mid-point, suggesting that this was considered to be quite important in explaining the behaviour. Mean scores for factor two ('Internal-mad') were also well above the scale mid-point.

Table 3.2.2.b shows the mean responses and standard deviations for each of the two factors, divided by condition.

**Table 3.2.2.b Mean responses (and standard deviations) for Factors 1 and 2.**

<table>
<thead>
<tr>
<th></th>
<th>Factor 1: ('Victimisation')</th>
<th>Factor 2: ('internal-mad')</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (sd)</td>
<td>Mean (sd)</td>
</tr>
<tr>
<td>Participants' gender:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male staff N=63</td>
<td>21.41 (4.36)</td>
<td>17.98 (3.13)</td>
</tr>
<tr>
<td>Female staff N=55</td>
<td>21.36 (4.94)</td>
<td>18.65 (2.53)</td>
</tr>
<tr>
<td>Protagonists' gender:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male patient N=55</td>
<td>15.87 (4.22)</td>
<td>18.29 (3.06)</td>
</tr>
<tr>
<td>Female patient N=63</td>
<td>15.88 (4.96)</td>
<td>18.30 (2.73)</td>
</tr>
<tr>
<td>Target:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff N=69</td>
<td>20.86 (5.23)</td>
<td>18.43 (2.24)</td>
</tr>
<tr>
<td>Patient N=49</td>
<td>22.10 (3.55)</td>
<td>18.10 (3.60)</td>
</tr>
<tr>
<td>Total N=118</td>
<td>21.39 (4.62)</td>
<td>18.30 (2.88)</td>
</tr>
</tbody>
</table>

These hypotheses were tested by a series of three-way analyses of variance with patient gender, staff gender, and target of aggression as independent variables.

Use of the Cochrans’ C test initially allowed one to test for the legitimacy of using parametric tests, but also enabled further judgements about adopting certain probability
levels, when the homogeneity of variance test emphasised a more cautious approach to analyses. Thus, for the dependent variables where there was reason to suspect that the homogeneity of variance assumption could not be justified, it was decided to treat the main effects and interaction effects as being significant only if the probability of occurrence was 1% rather than 5%.

The first three analyses used scores on the general attribution measures (internal temporary, internal enduring, and external) as dependent variables. Consistent with hypothesis 1.i, there was no significant effect of patient gender (nor any other significant main effects or interactions) for any of these dependent variables.

In the next two analyses, testing hypothesis 1.i, scores on factor two (internal-mad) and the single attributional statement “she/he is a violent woman/man” were entered as dependent variables.

In contradiction to hypothesis 1.i, with factor two (internal-mad) scores as the dependent variable there was no main effect of patient gender (F = 17, df = 7, 110, p = .68). There was also no significant interaction between staff gender and patient gender (F = 4.34, df = 7, 110, p = .04), with Cochran’s C emphasising a more cautious level of significance.

The results of the second analyses using scores on ‘she/he is a violent woman/man’ as the dependent variable also failed to support hypothesis 1.i. There was no significant main effect of patient gender (F = .32, df = 7, 110, p = .57) nor any significant interactions. There was, however, a main effect of staff gender (F = 6.003, df = 7, 110,
Table 3.2.2.c Mean responses (and standard deviations) for single attributional statements

<table>
<thead>
<tr>
<th></th>
<th>‘Internal - Bad’&lt;sup&gt;+&lt;/sup&gt; She/ he is a violent woman/ man’</th>
<th>Mean</th>
<th>(sd)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participants’ gender:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female staff  &lt;sup&gt;N= 55&lt;/sup&gt;</td>
<td></td>
<td>5.14</td>
<td>(1.52)</td>
</tr>
<tr>
<td>Male staff &lt;sup&gt;N= 63&lt;/sup&gt;</td>
<td></td>
<td>5.79</td>
<td>(1.32)</td>
</tr>
<tr>
<td><strong>Protagonists’ gender:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female patient &lt;sup&gt;N= 63&lt;/sup&gt;</td>
<td></td>
<td>5.35</td>
<td>(1.58)</td>
</tr>
<tr>
<td>Male patient &lt;sup&gt;N= 55&lt;/sup&gt;</td>
<td></td>
<td>5.65</td>
<td>(1.28)</td>
</tr>
<tr>
<td><strong>Target:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff &lt;sup&gt;N= 69&lt;/sup&gt;</td>
<td></td>
<td>5.30</td>
<td>(1.45)</td>
</tr>
<tr>
<td>Patient &lt;sup&gt;N= 49&lt;/sup&gt;</td>
<td></td>
<td>5.75</td>
<td>(1.42)</td>
</tr>
<tr>
<td><strong>Total &lt;sup&gt;N= 118&lt;/sup&gt;</strong></td>
<td></td>
<td>5.49</td>
<td>(1.45)</td>
</tr>
</tbody>
</table>

In summary then, the results give little support for hypothesis 1.i. Consistent with hypothesis 1.i, there was no effect of patient gender on participants’ tendency to attribute violence to “internal temporary”, “internal enduring”, or “external” causes. When the more specific implications of hypothesis 1.i were examined, however, it gained no support. The gender of the vignette figure had no effect on the degree to which her/his violence was attributed to an internal inherent tendency to violence. The gender of the vignette figure also had no overall effect on the degree to which the factor representing “mental illness” was viewed as causing the violence.
With respect to hypothesis 1.ii, a further three-way analysis again using patient gender, staff gender and target of violence as independent variables and scores on factor one ("victimisation") as the dependent variable was undertaken. In contrast with hypothesis 1.ii, there was no main effect of patient gender ($F = .60, \text{ df} = 7,108, p = .44$). In addition, there were no other significant main effects or interactions.

Therefore, the findings revealed no support for hypothesis 1.ii.

In contrast to hypothesis 1.iii, there was no effect of patient gender on participants’ tendency to attribute responsibility or blame to the male vignette character ($F = 1.58, \text{ df} = 7,109, p = .21$) and ($F = .003, \text{ df} = 7,110, p = .96$), nor were there any other main effects of target or staff gender. There was, however, a significant interaction between patient gender and target with scores on responsibility ($F = 6.85, \text{ df} = 7,109, p < .01$).

Thus assignment of responsibility increased when the vignette figure was female, and the victim a member of staff (Mean = 5.47, $\text{ sd} = 1.41$) rather than a patient (Mean = 4.74, $\text{ sd} = 1.9$). However, responsibility increased more dramatically, but in the opposite direction, according to target, for the male vignette figure (Mean = 5.88, $\text{ sd} = 1.24$ in the patient as target scenario) compared with (Mean = 5.1, $\text{ sd} = 1.23$ in the staff as target scenario).

Similarly, ratings of blameworthiness varied as a function of an interaction between the target, and the aggressor’s gender ($F = 7.48, \text{ d.f.}= 7,110, p< .05$). That is, when the target was a staff member, and the aggressor female, more blame was assigned (Mean
Conversely, female patients who were aggressive towards other patients were regarded as less blameworthy (Mean = 4.1, sd = 1.7). Ratings of blame for the male protagonist did not vary according to the victim as either staff or patient (Mean = 4.37, sd =1.24 and Mean = 4.80, sd = 1.72 respectively).

In summary, there was no support for the hypothesis that the male vignette figure would be regarded as more blameworthy or responsible. In fact, the female figure was held as more to blame when the target was portrayed as a member of staff, whilst more responsibility was assigned to the male only when the target was depicted as a patient.

With respect to hypothesis 1.iv, using scores on perception of threat to staff as the dependent variable, there was no main effect of target upon scores (F = .86, df = 7,110, p = .36), which failed to support predictions. Similarly, there was no main effect of staff or patient gender, nor any significant interactions, with Cochran’s C suggesting a more conservative level of significance to be adopted.

The results of the second analysis using scores on perception of threat to other patients as the dependent variable, revealed a main effect of target, supporting hypothesis 1.iv. That is, there was a tendency for participants to perceive the aggression as more threatening to other patients when the target in the scenario was another patient (as opposed to a member of staff) (F = 4.66, df = 7,108, p < .05).

Tables 3.2.2.d and 3.2.2.e below show the mean responses for responsibility and blame, and for perceptions of threat.
### Table 3.2.2.d Mean responses (and standard deviations) for blame & responsibility.

<table>
<thead>
<tr>
<th></th>
<th>She/He was to blame</th>
<th>She/He was responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (sd)</td>
<td>Mean (sd)</td>
</tr>
<tr>
<td><strong>Participants’ gender:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female subjects</td>
<td>4.51 (1.48)</td>
<td>5.22 (1.41)</td>
</tr>
<tr>
<td>Male subjects</td>
<td>4.79 (1.61)</td>
<td>5.43 (1.56)</td>
</tr>
<tr>
<td><strong>Protagonist’s gender:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female patient</td>
<td>4.73 (1.61)</td>
<td>5.21 (1.65)</td>
</tr>
<tr>
<td>Male patient</td>
<td>4.58 (1.48)</td>
<td>5.48 (1.28)</td>
</tr>
<tr>
<td><strong>Target:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff target</td>
<td>4.80 (1.40)</td>
<td>5.32 (1.34)</td>
</tr>
<tr>
<td>Patient target</td>
<td>4.47 (1.74)</td>
<td>5.34 (1.69)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4.66 (1.55)</td>
<td>5.33 (1.49)</td>
</tr>
</tbody>
</table>

### 3.2.2.e Mean responses (and standard deviations) for perceptions of threat.

<table>
<thead>
<tr>
<th></th>
<th>Perceived threat to patients</th>
<th>Perceived threat to staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M (SD)</td>
<td>M (SD)</td>
</tr>
<tr>
<td><strong>Participants’ gender:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>5.45 (1.43)</td>
<td>5.42 (1.52)</td>
</tr>
<tr>
<td>Male</td>
<td>5.57 (1.40)</td>
<td>5.51 (1.58)</td>
</tr>
<tr>
<td><strong>Protagonists’ gender:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>5.70 (1.33)</td>
<td>5.54 (1.61)</td>
</tr>
<tr>
<td>Male</td>
<td>5.31 (1.48)</td>
<td>5.38 (1.48)</td>
</tr>
<tr>
<td><strong>Target:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff target</td>
<td>5.30 (1.56)</td>
<td>5.56 (1.47)</td>
</tr>
<tr>
<td>Patient target</td>
<td>5.83 (1.12)</td>
<td>5.33 (1.66)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5.52 (1.41)</td>
<td>5.47 (1.55)</td>
</tr>
</tbody>
</table>
In summary, results failed to support the predictions from hypothesis 1.i that staff would attribute the male patients' aggressive behaviour to an internal inherent tendency to violence, and for the female patient, that the same behaviour would be attributed to mental illness and poor skills. In addition, hypothesis 1.ii also received no support, in that gender of the vignette figure did not influence the degree to which his/her violence was attributed to victimisation experiences.

In terms of global attributions, results show that the personal enduring explanation was favoured more than the personal temporary or external one. However, there were no differences for this variable, according to staff or patient gender, or target.

Perhaps surprisingly, in contrast to hypothesis 1.iii, staff tended to attribute a greater degree of blame to the female vignette figure in the staff-as-target vignette, in comparison to the patient as-target in both the male and female patient vignettes. This may have implications for management approaches which will be explored later.

There was no main effect of gender on the degree to which responsibility was attributed to the male vignette figure, but the significant interaction effects between gender and target indicated that more responsibility was assigned to the male patient in the fellow patient-as-target vignette. This provided mixed, but inconclusive support for hypothesis 1.iii.

Results from the analysis of scores on perceived threat to staff as the dependent variable failed to support hypothesis 1.iv, in that there was no main effect of target, nor
any significant interaction. However, results from analysis of scores on perceived
threat to patients as the dependent variable were consistent with hypothesis 1.iv, given
that there was a main effect of target; perceived threat to patients was rated as higher in
the scenario where the patient was the target of aggression.

3.2.3 Additional Analyses

The table below gives the means and standard deviations for the remaining
attributional statements.

<table>
<thead>
<tr>
<th></th>
<th>Controllability</th>
<th>Stability</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Controllable by patient</td>
<td>Other situations</td>
</tr>
<tr>
<td></td>
<td>Mean (sd)</td>
<td>Mean (sd)</td>
</tr>
<tr>
<td>Participants’ gender:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female N=55; 55; 54</td>
<td>3.93 (1.72)</td>
<td>6.16 (1.03)</td>
</tr>
<tr>
<td>Male N= 63; 63; 63</td>
<td>3.81 (1.70)</td>
<td>6.17 (1.20)</td>
</tr>
<tr>
<td>Protagonists’ gender:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female N=63; 63; 62</td>
<td>4.11 (1.79)</td>
<td>6.29 (1.01)</td>
</tr>
<tr>
<td>Male N=55; 55; 55</td>
<td>3.58 (1.57)</td>
<td>6.04 (1.23)</td>
</tr>
<tr>
<td>Target:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff N= 69; 69; 69</td>
<td>3.68 (1.65)</td>
<td>6.19 (1.07)</td>
</tr>
<tr>
<td>Patient N= 49; 49; 48</td>
<td>4.12 (1.76)</td>
<td>6.14 (1.19)</td>
</tr>
<tr>
<td>Total N= 118; 118; 117</td>
<td>3.86 (1.70)</td>
<td>6.17 (1.12)</td>
</tr>
</tbody>
</table>
With respect to the patients' amount of control over their behaviour as perceived by staff, a significant interaction was found between staff and patient gender (F = 4.3; d.f = 7,110; p<.05). That is, male staff rated the female vignette figure as having more control of her aggression (Mean = 4.35, sd = 1.8), than the male figure (Mean =3.28, SD = 1.48). Conversely, there was a tendency for female staff to rate female patients as slightly less in control (Mean = 3.87, sd = 1.80) than male patients, (Mean = 4.00, sd = 1.62).

There was no main effect of target, staff or patient gender, for the estimated likelihood of future aggression occurring (F = 0.38, d.f = 7, 109, p = 0.77), (F = 0.15, df = 7, 109, p = 0.70) and (F= 0.19, df = 7, 109, p = 0.66). Also, there were no significant interactions.

These analyses also demonstrated no main effects of target, staff or patient gender, for the likelihood of occurrence in other situations. As shown in table 3.2.3, the means for these items suggested that respondents thought that the aggressive behaviour was likely to occur both in the future and in other situations.

3.2.4 Qualitative Analyses

Staff reports on attributions

At the end of the ratings for attributional items, in order to elicit spontaneous attributions, staff in each condition were asked to add any further explanations that they felt were important in describing the behaviour. Responses were classified into 7 categories.
1. Functional (that is, in order to gain something).
2. Skills based.
3. Interpersonal.
4. Intrapersonal.
5. Physical/medical.
6. Patients’ past history.
7. Other.

Twenty staff made comments, thus there were not enough for comparisons to be made between the eight subgroups. The most common attributional category comment was “Intrapersonal” (N = 6) followed by “Skills based” (N = 5).

The complete taxonomy of these qualitative results can be found in Appendix 5.

3.3 Management strategies

3.3.1 Factor Analysis

Factors were extracted using Principal Components Analysis and a varimax rotation in order to reduce the number of management strategy variables for further analysis. Six factors were extracted and on the basis of the scree test, factors 1 - 3 were retained. The last three factors are shown in Appendix 4. All three factors accounted for over 40 per cent of the variance. Table 3.3.1 below illustrates each factor.
Table 3.3.1 Factors for management approaches, items and factor loadings
(the variance accounted for is in brackets).

<table>
<thead>
<tr>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Controlling Approaches'</td>
<td>'Therapeutic Approaches'</td>
<td>'Avoidant Approaches'</td>
</tr>
<tr>
<td>(17.9 %)</td>
<td>(14.4 %)</td>
<td>(9.8 %)</td>
</tr>
<tr>
<td>3.21*</td>
<td>2.60*</td>
<td>1.77*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use physical restraint</td>
<td>0.86</td>
<td>0.71</td>
<td>0.88</td>
</tr>
<tr>
<td>Seclude the patient</td>
<td>0.84</td>
<td>0.65</td>
<td>0.71</td>
</tr>
<tr>
<td>Use P.R.N medication</td>
<td>0.62</td>
<td>0.61</td>
<td>-0.55</td>
</tr>
<tr>
<td>Impose a sanction</td>
<td>0.57</td>
<td>0.56</td>
<td>0.56</td>
</tr>
<tr>
<td>Identify a member of staff to spend some time with him/her</td>
<td>0.57</td>
<td>0.56</td>
<td>0.56</td>
</tr>
</tbody>
</table>

Note: * = Eigenvalue

High scores on each factor reflect a preference for that particular approach. Conversely, low scores for a particular factor suggest that this type of approach would not be considered to be very helpful in dealing with the violent incident.

The first factor, consisted of four items loading above 0.5. This factor was called 'controlling approaches' because it comprised of certain management approaches that...
used either physical (e.g. restraint, or P.R.N medication,) or punitive (e.g. impose a sanction) means of control. It accounted for 18% of the variance. The maximum possible score for this approach was 28, the minimum being 4.

The second factor, called 'therapeutic approaches', represented 14% of the variance, and consisted of five items loading at above 0.5. It includes approaches that involve talking to the patient, employing time-out or contacting a member of staff who had worked with the patient before the incident had occurred. The maximum and minimum possible scores were 35 and 5 respectively.

Factor three, (three items loading above 0.5) was termed 'avoidant approaches'. High scores on this factor reflected more distal approaches whereby staff would observe the patient or delegate another member of staff to spend some time with him or her. This factor accounted for nearly 10% of the variance. The maximum possible score for this approach was 21, the minimum being 3.

3.3.2 Hypothesis 2

To investigate the association between attributions for aggressive behaviour and management strategies.

Are certain attributions for aggressive behaviour associated with particular management approaches?
Hypothesis 2.i.

There will be an association between the attributions that staff make and their choice of management strategy.

Table 3.3.2.a below shows the mean scores and standard deviations for the three management approaches.

Means scores for factor 1 (‘Controlling approaches’) are below the scale mid-point, suggesting that this approach was not highly favoured amongst staff.

Mean scores for the therapeutic approach are above the scale mid-point, demonstrating that this was generally found to be more favourable.

Mean scores suggest uncertainty about the likely usefulness of the avoidant approach.

Staff rated the most useful ways of managing the protagonist’s aggression as being therapeutic (for example, encouraging the patient to think about the consequences of her behaviour) (Mean = 29.80, sd = 3.95). Those approaches considered as least useful were controlling, for example, physically restraining the patient (Mean = 11.77, sd = 4.86).
Table 3.3.2.a Mean responses (and standard deviations) for factors one, two, and three

<table>
<thead>
<tr>
<th></th>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>‘Controlling Approaches’</td>
<td>‘Therapeutic Approaches’</td>
<td>‘Avoidant Approaches’</td>
</tr>
<tr>
<td></td>
<td>Mean (sd)</td>
<td>Mean (sd)</td>
<td>Mean (sd)</td>
</tr>
<tr>
<td>Participants’ gender:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male staff N = 55</td>
<td>12.17 (4.90)</td>
<td>30.00 (3.64)</td>
<td>11.11 (2.76)</td>
</tr>
<tr>
<td>Female staff N = 62</td>
<td>11.42 (4.86)</td>
<td>29.63 (4.23)</td>
<td>10.64 (2.48)</td>
</tr>
<tr>
<td>Protagonists’ gender:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male patient N=63</td>
<td>12.08 (5.13)</td>
<td>29.73 (4.31)</td>
<td>10.92 (2.90)</td>
</tr>
<tr>
<td>Female patient N= 54</td>
<td>11.42 (4.56)</td>
<td>29.89 (3.53)</td>
<td>10.80 (2.26)</td>
</tr>
<tr>
<td>Target:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff N=69</td>
<td>11.35 (4.50)</td>
<td>29.80 (4.11)</td>
<td>10.68 (2.39)</td>
</tr>
<tr>
<td>Patient N=48</td>
<td>12.35 (5.33)</td>
<td>29.81 (3.75)</td>
<td>11.12 (2.90)</td>
</tr>
<tr>
<td>Total N=117</td>
<td>11.77 (4.86)</td>
<td>29.80 (3.95)</td>
<td>10.86 (2.61)</td>
</tr>
</tbody>
</table>

A series of two-tailed, Pearson’s correlation tests were undertaken in order to test hypothesis 2.i., with attributions and management strategies as dependent variables.

In the first set of analyses, scores from the therapeutic management factor were entered along with attributional factors and specific statements as dependent variables. Consistent with hypothesis 2.i, significant correlations were observed between therapeutic approaches and explaining the incident in terms of the patient being mentally ill and lacking in anger management and communication skills (‘Internal-mad’) \((r = .26, p < .01)\). Furthermore, when participants agreed with the statements that the behaviour was likely to occur in other situations and the internal enduring explanation, they were also more likely to choose therapeutic approaches \((r = .23\) and \(r\)
More perceived threat to patients was also significantly correlated with such approaches \( (r = .20, p < .05) \).

In the second set of analyses, scores on the avoidant management factor together with the attributional items were entered as dependent variables. Also in support of hypothesis 2.i, was the result that avoidant approaches were very significantly associated with agreement that the behaviour was likely to occur again in other situations \( (r = .32, p < .001) \) and to a lesser degree with the statement that the behaviour was likely to occur again in the future \( (r = .20, p < .05) \). In addition, the Internal-bad statement 'He/ she is a violent man/ woman' was significantly correlated with participants' choosing avoidant approaches \( (r = .21, p < .05) \).

The results from the third set of analyses using scores on the controlling management factor and the attributional items also supported hypothesis 2.i. Participants' preferences for controlling approaches correlated with agreement with the statement that the patient was to blame \( (r = .22, p < .05) \). Perhaps surprisingly, these approaches were inversely correlated with the internal enduring explanation \( (r = -.20, p < .05) \), so that less preference for controlling strategies was linked with being more likely to explain the behaviour in terms of internal enduring reasons.

There were no other significant correlations from these analyses.

Therefore, there was some evidence to support the proposal from hypothesis 2.i, that there would be an association between attributions and management strategies.
Consistent with hypothesis 2.i was the finding that choosing therapeutic approaches was very significantly correlated with agreement with the Internal-mad factor. In addition, the perception that the behaviour would occur in other situations was strongly correlated with avoidant strategies. Interestingly, the Internal-bad attribution correlated with avoidant, rather than controlling approaches, although there was a relationship between attributing blame and preference for controlling approaches to the incident.

Table 3.3.2.b details the correlations of all management and attributional factors, including specific attributional statements, and their levels of significance.
Table 3.3.2.b Relationship between agreement with attributional statements and management strategies for all participants.

<table>
<thead>
<tr>
<th>Attributions</th>
<th>Management Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Controlling</td>
</tr>
<tr>
<td></td>
<td>r</td>
</tr>
<tr>
<td>Victimisation</td>
<td>-.15</td>
</tr>
<tr>
<td>Internal-mad</td>
<td>-.10</td>
</tr>
<tr>
<td>Internal-bad</td>
<td>-.01</td>
</tr>
<tr>
<td>Internal enduring</td>
<td>-.20*</td>
</tr>
<tr>
<td>Internal temporary</td>
<td>.00</td>
</tr>
<tr>
<td>External</td>
<td>.03</td>
</tr>
<tr>
<td>Controllable by the patient</td>
<td>.08</td>
</tr>
<tr>
<td>She/ he was to blame</td>
<td>.22*</td>
</tr>
<tr>
<td>She/he was responsible</td>
<td>-.02</td>
</tr>
<tr>
<td>Perceived threat to staff</td>
<td>.14</td>
</tr>
<tr>
<td>Perceived threat to patients</td>
<td>-.12</td>
</tr>
<tr>
<td>Future occurrence</td>
<td>-.03</td>
</tr>
<tr>
<td>Occurrence in other situations</td>
<td>.10</td>
</tr>
</tbody>
</table>

*p<.05; **p<.01; ***p<.001; p<.1.

3.3.3 Hypothesis 3

Do staff employ different management strategies according to the patients' sex, and the target of aggression?

Hypothesis 3.i.

Staff's choice of management strategy will vary according to the gender of the vignette figure, and the target of aggression.
In order to test hypothesis 3.i, a series of three-way analyses of variance were undertaken, with staff gender, patient gender, and target of the aggression as independent variables.

Again, use of Cochran’s C allowed for testing the legitimacy of applying these analyses to the data, with significance only for the dependent variable “avoidant strategies”  
(C = .376, p = 0.000).

The first analysis used scores on factor one (controlling approaches) as the dependent variables. In contradiction to hypothesis 3.i, there were no significant main effects of patient gender, target (nor staff gender) in ratings of controlling approaches, nor were there any significant interactions.

In the second analysis, scores from the therapeutic approaches (factor two) were entered as dependent variables. In contrast to hypothesis 3.i, there was no main effect of staff or patient gender, or target. There was, however, a significant interaction between staff gender, patient gender and target (F = 4.16, d.f = 7,109, p < .05). That is, female staff, showed a greater degree of preference for this management factor in the staff-as-target scenario, where the vignette figure was a female patient (Mean = 30.80) compared with female staff in the patient-as-target condition (Mean = 26.80). Female staff were equally likely to prefer therapeutic approaches if the male patient’s target was either a member of staff or a patient (Mean = 30.15) (Mean = 30.70). Male staff indicated that therapeutic approaches were slightly more helpful if the target was a
patient in both female and male patient vignettes (Mean = 31.16) (Mean = 30.12). They viewed therapeutic approaches as being less helpful in the case of staff being the target of aggression by both genders (Mean = 29.3) (Mean = 28.8).

This suggests that when the vignette figure was a female patient who was aggressive towards another patient, this had a significant effect upon female staff's ratings on factor two, in reducing their ratings of this approach as helpful.

The results from the third analysis, using scores from factor three (avoidant approaches) as the dependent variable did not support hypothesis 3.i. There was no significant main effect of staff or patient gender, or target. Also, there were no significant interactions.

In summary, there is only limited evidence for hypothesis 3.i. That is, in the female patient vignette, more preference was indicated for therapeutic approaches but only when managed by a female member of staff and when the target was thought to be a member of staff. In contrast, in the female vignette condition with the patient-as-target, there was less preference for such approaches as rated by female staff.

Given that there were no differences in staffs' preferences for choosing controlling or avoidant approaches, according to the staffs' or the patients' gender, or the known target, there is generally little support for hypothesis 3.i.
3.3.4 Qualitative results

Management approaches

At the end of the second section of the questionnaire, open questions about what additional approaches staff would take, were asked. Again, responses were coded into four categories according to content and are listed below. Nineteen staff made comments. Results showed that the most favoured responses were those concerning direct contact with patients (\(N = 8\)), followed by “Alternative strategies” (\(N = 6\)).

1. Direct contact with patients.
3. Distal approaches.
4. Other.

Additional support

Staff were asked to describe what additional support would be helpful in dealing with violence and aggression at work. Twenty respondents made comments which are categorised below. The most frequent response category was “support from other staff members” (\(N = 10\)) followed by “Debriefing” (\(N = 5\)).

1. Training.
2. Debriefing.
3. Support from other staff.
4. Resources.

Again, the complete taxonomies of these results are shown in Appendix 5.
3.4 Attitudes

3.4.1 Factor Analysis

Finally, a factor analysis was conducted on the attitudes to Special Hospital patients scale, items 1 - 36. Ten factors were extracted using Principal Components Analysis and a varimax rotation. The Scree test suggested that it would be appropriate to use the first three of these. These three factors together accounted for 38% of the variance (Please see Appendix 4 for the later 7 factors, their items, and their factor loadings).

Table 3.4.1.a illustrates the first three factor structures.
Table 3.4.1.a Factors for attitudes, items and factor loadings

(the variance accounted for is in brackets).

<table>
<thead>
<tr>
<th>Factor 1</th>
<th>Factor 2</th>
<th>Factor 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Deviance'</td>
<td>'Normality'</td>
<td>'Positive Regard'</td>
</tr>
<tr>
<td>(26%) 9.33*</td>
<td>(7%) 2.36*</td>
<td>(5%) 1.93*</td>
</tr>
<tr>
<td>Patients in SH’s are always trying to get something from somebody 0.81</td>
<td>Most SH patients have the capacity for love 0.76</td>
<td>Most patients in SH are victims of circumstance and deserve to be helped 0.68</td>
</tr>
<tr>
<td>Patients in SH’s are just plain mean at heart 0.73</td>
<td>The values of most SH patients are about the same as the rest of us 0.62</td>
<td>I think I would like a lot of SH patients 0.65</td>
</tr>
<tr>
<td>SH patients only think of themselves 0.73</td>
<td>Most SH patients can be rehabilitated 0.59</td>
<td>Some SH patients are pretty nice people 0.62</td>
</tr>
<tr>
<td>Most SH patients are too lazy to earn an honest living 0.67</td>
<td>In general, SH patients are basically bad people 0.52</td>
<td>SH patients need affection and praise just like anybody else 0.53</td>
</tr>
<tr>
<td>SH patients are just plain immoral 0.66</td>
<td>Patients in SH’s are no better and no worse than other people 0.40</td>
<td>I would like associating with some SH patients 0.48</td>
</tr>
<tr>
<td>Give a SH patient an inch, and she/he’ll take a mile 0.53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients in SH’s should be under strict harsh discipline 0.48</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Special Hospital is represented by 'SH'. * = Eigenvalue*
**Factor 1** (Deviance) comprised of seven items loading above 0.4, and accounted for 26% of the variance. All items for this factor were reverse scored. Low scores (the minimum possible being 7) reflect an attitude that Special Hospital patients are immoral, and should be under 'strict harsh discipline' (item 30.6). A high score (the maximum possible being 35) indicates a belief that Special Hospital patients do not deviate from moral values. Mean scores on this factor were well above the half-way point, suggesting that in general, Special Hospital patients were not considered to be deviant. However, scores reflect a substantial difference to the way that male and female staff perceive patients according to this factor. Generally, male staff consider patients to be less moral than female staff in this study.

**Factor 2** (five items loading above 0.4) represents 7% of the variance. The maximum possible score on this factor is 25, suggesting a belief that Special Hospital patients are similar to people in general and that their behaviour can be responsive to therapeutic intervention. The lowest possible score is 5. Mean scores demonstrated that there was a tendency to regard Special Hospital patients as 'no better or worse' than non-Special Hospital patients, and that they are responsive to rehabilitation. Once again, female and male staff differed in the extent to which they viewed patients as being similar to people in general, with female staff tending to rate patients slightly more favourably on this factor.

**Factor 3** (five items loading above 0.4) accounting for 5% of the variance, contained items which represent a belief that Special Hospital patients need support and that interaction with them can be positive. This factor was called 'Positive regard'. The
highest possible score for this factor is 25, the lowest being 5. In addition, scores also reflected female staff's tendency to having more positive regard for patients than male staff.

Mean scores on this factor reflected a slight tendency for staff to regard Special Hospital patients in a positive way.

These responses from High Secure Hospital staff do not yield the same factor structures as those found in a recent study of the police and the publics' attitudes to offenders (Horn and Hollin, 1997). Firstly, using the same cut-off criteria as Horn and Hollin, the three factors did not comprise as many items as those in the police and public's attitude study. Despite factor one sharing some of the same items as the previous study, and representing the same basic concept, it includes fewer of these items. Factor two in this study is clearly a more neutral set of statements than the factor 2 of the Horn and Hollin study. This seems to be due to some of the more positive items from the second factor of the previous study falling into a separate dimension from the staff responses in the present study. The third factor in the current study represents those items which correspond to positive attitudes and a willingness to interact with Special Hospital patients.

Table 3.4.1.b below shows the mean responses and standard deviations for each of the three factors.
Table 3.4.1.b Mean responses (and standard deviations) for Factors 1, 2 and 3.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Participants</th>
<th>'Deviance' $M$ (sd)</th>
<th>'Normality' $M$ (sd)</th>
<th>'Positive regard' $M$ (sd)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1</td>
<td>Male $N=61$</td>
<td>15.87 (6.43)</td>
<td>15.87 (4.12)</td>
<td>15.87 (3.68)</td>
</tr>
<tr>
<td></td>
<td>Female $N=54$</td>
<td>24.58 (5.67)</td>
<td>16.00 (4.31)</td>
<td>17.22 (3.58)</td>
</tr>
<tr>
<td>Total $N=115$</td>
<td></td>
<td>23.18 (6.2)</td>
<td>15.76 (4.19)</td>
<td>16.50 (3.68)</td>
</tr>
</tbody>
</table>

3.4.2 Attitudes, attributions and management strategies

Hypothesis 4

Do staff with different attitudes to Special Hospital patients employ different attributions and different management strategies?

Hypothesis 4.i

There will be an association between specific attitudinal factors with certain attributions.

Hypothesis 4.ii

There will be an association between specific attitudinal factors with certain management strategies.
In order to test these hypotheses, a series of two-tailed Pearson's correlations were undertaken.

In this series of analyses, factor scores on the attributions, management strategies and attitudes were entered as the dependent variables.

In the first set of analyses, scores on the attitude factor positive regard and attributions were used as dependent variables. In support of hypothesis 4.1, positive regard was correlated with perceiving victimisation experiences (that is, factor one) as important in explaining the incident (\( r = 0.26, p < 0.01 \)). Also consistent with hypothesis 4.1, was the very significant correlation between perceiving the internal-mad items (factor two) as causal, and having positive regard for patients (\( r = 0.40, p < 0.001 \)). In addition, attributing blame was inversely correlated with positive regard (\( r = -0.24, p < 0.001 \)). There were no other correlations between positive regard and attributions.

The second set of analyses used scores on the deviance factor and attributions as dependent variables. In support of hypothesis 4.1, was the finding that scores on the deviance factor correlated with seeing the patients' behaviour as resulting from internal-mad causes, (\( r = .30, p < .01 \)); that is, when patients in general were regarded as less fundamentally bad, the more the use of the internal-mad factor as an explanation. The finding that agreeing with the internal enduring statement correlated with regarding patients in general as less deviant (\( r = .21, p = .05 \)) was also consistent with predictions. Finally, an inverse correlation was found between attributing blame and this factor (\( r = -0.21, p < 0.05 \)), providing further support for hypothesis 4.1, and
suggesting that when patients were viewed as being more deviant, greater was the degree of blame.

The final set of analyses used scores on the normality factor and attributions as dependent variables. In contrast to hypothesis 4.i however, factor scores on “normality” did not show any correlations with specific or general attributions.

These results show mixed support for the hypothesis that there would be an association between attitudinal factors and attributions, given that some correlations were found between certain attributions, positive regard and deviance, whilst there were no such relationships with the normality attitude factor.

Table 3.4.2.a shows the correlations of all attributions and attitude factors, and their levels of significance.
Table 3.4.2.a. Relationship between agreement with attributional statements and attitudes for all participants

<table>
<thead>
<tr>
<th>Attributions</th>
<th>Positive regard</th>
<th>Normality</th>
<th>Deviance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>r</td>
<td>r</td>
<td>r</td>
</tr>
<tr>
<td>Victimisation</td>
<td>.26**</td>
<td>.05</td>
<td>.04</td>
</tr>
<tr>
<td>Internal-mad</td>
<td>.40***</td>
<td>.03</td>
<td>.30**</td>
</tr>
<tr>
<td>Internal-bad</td>
<td>.06</td>
<td>-.11</td>
<td>-.15</td>
</tr>
<tr>
<td>Internal enduring</td>
<td>.10</td>
<td>.07</td>
<td>.21*</td>
</tr>
<tr>
<td>Internal temporary</td>
<td>-.05</td>
<td>.05</td>
<td>-.15</td>
</tr>
<tr>
<td>External</td>
<td>.17'</td>
<td>-.01</td>
<td>-.13</td>
</tr>
<tr>
<td>Controllable by patient</td>
<td>-.06</td>
<td>-.14</td>
<td>-.01</td>
</tr>
<tr>
<td>She/ he was to blame</td>
<td>-.24***</td>
<td>-.14</td>
<td>-.21*</td>
</tr>
<tr>
<td>She/ he was responsible</td>
<td>-.12</td>
<td>.04</td>
<td>-.07</td>
</tr>
<tr>
<td>Perceived threat to staff</td>
<td>-.10</td>
<td>.15</td>
<td>-.11</td>
</tr>
<tr>
<td>Perceived threat to patients</td>
<td>.10</td>
<td>.05</td>
<td>.02</td>
</tr>
<tr>
<td>Future occurrence</td>
<td>-.05</td>
<td>-.16'</td>
<td>-.10</td>
</tr>
<tr>
<td>Occurrence in other situations</td>
<td>-.02</td>
<td>-.07</td>
<td>-.03</td>
</tr>
</tbody>
</table>

*p<.05; **p<.01; ***p<.001; ’p<.1.

Hypothesis 4.ii was also tested by a series of Pearson’s correlations, with attitude and management strategy factors as the dependent variables.
Table 3.4.2. Relationship between attitude factors and management strategies for all participants

<table>
<thead>
<tr>
<th>Management Strategies</th>
<th>Attitudinal Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Positive regard</td>
</tr>
<tr>
<td></td>
<td>( r )</td>
</tr>
<tr>
<td>Controlling</td>
<td>-.21*</td>
</tr>
<tr>
<td>Avoidant</td>
<td>-.03</td>
</tr>
<tr>
<td>Therapeutic</td>
<td>.13</td>
</tr>
</tbody>
</table>

*\( p < .05; **p < .01; ***p < .001; ^p < .1.\)

In the first analysis, the controlling management strategy factor was entered as the dependent variable, along with the three attitude factors. Consistent with hypothesis 4.ii, significant inverse correlations were observed between all three attitudinal factors and controlling approaches. That is, the more positive regard held for patients, the less likely were participants to choose controlling strategies as helpful in the incident (\( r = -.21, p < .05 \)). In addition, viewing Special Hospital patients as less normal and more deviant was associated with preferring controlling strategies (\( r = -.28, p < .01 \)) and (\( r = -.21, p < .05 \)).

In the second and third series of analyses, attitude factors were entered as the dependent variables, along with the avoidant and therapeutic management factors. As demonstrated in table 3.4.2.b, and in contrast to hypothesis 4.ii, there were no
significant correlations found between these attitude factors and either avoidant or therapeutic strategies.

Generally, the hypothesis received limited support that there would be a relationship between management strategies and attitudes. It is evident that only ratings for controlling management strategies were associated with attitudes.

3.5 Additional Analyses

To investigate the association between demographic variables, the perceived level of support from colleagues and managers, and history of past attacks, with attributions, and management strategies.

Hypothesis 5.i.

There will be a difference between unqualified and qualified staff's preferences for attributions and management strategies.

Hypothesis 5.ii.

Age will also affect ratings of attributions and management strategies.

Hypothesis 5.iii.

There will be a relationship between perceptions about how supported one is in their work and the types of attributions and management strategies that are chosen.
Hypothesis 5.iv.

Past history of assault will affect participants' ratings of attributions and management strategies.

A series of t-tests for independent samples were computed, with attributions and management strategies as the dependent variables, in order to test predictions from hypothesis 5.i, that differences between groups of unqualified and qualified staff would exist.

Consistent with hypothesis 5.i, unqualified staff explained the incident more in terms of the internal enduring statement (Mean = 6.35, sd = .98) as compared with qualified staff (Mean = 5.56, sd = 1.22) ($t (93) = 2.93, p<.005$). In addition, unqualified staff also perceived the behaviour as more threatening to other patients (Mean = 5.96, sd = 1.28, compared with Mean = 5.19, sd = 1.37) ($t (91) = 2.46, p<.05$) and as more likely to occur again in other situations than were qualified staff (Mean = 6.57, sd = 1.03, compared with Mean = 6.03, sd = 1.00) ($t (93) = 2.36, p<.05$). Finally, unqualified staff were more likely to choose avoidant strategies than were qualified staff (mean = 11.92, sd = 1.32 as compared with Mean = 10.54, sd = 2.97) ($t (88.10) = 3.11, p<.005$), although the heterogeneity of variance using Levene's F test for the equality of variances was significant for this variable ($F = 6.04, p<.05$), emphasising a more cautious separate estimate of variance. There were no other differences in attributions or management strategies according to whether staff was qualified or not.
In testing hypothesis 5.ii, age was entered as the independent variable using Pearson’s $r$ correlations. This analysis used scores from attributions and management strategies as the dependent variables, and results showed that there was no relationship between age and ratings of attributions and management strategies, thus failing to support hypothesis 5.ii.

With respect to hypothesis 5.iii, Pearson’s correlations were employed, with scores on participants’ perceived sense of support by colleagues and managers entered as the dependent variables. Feeling supported by colleagues was significantly correlated with preference for avoidant approaches ($r = .20$, $p < .05$) and agreeing more with the Internal-bad attribution ‘She/ He is a violent person’ ($r = .19$, $p < .05$). Having a greater sense of support from managers also correlated with agreement with the externality statement ($r = .33$, $p < .05$). These findings provide some support for hypothesis 5.iii, although intuitively, and on face value, they might not reflect the expected specific correlations.

The results of the final analysis used scores on participants’ details of past assault by patients (in terms of frequency and severity of injuries), as the dependent variables. Given that no correlations were found between such experiences, attributions and management strategies, they did not yield any support for hypothesis 5.iv.

**In summary** then, these results provide some support for hypothesis 5.i, in demonstrating that being unqualified does have a relationship with choosing avoidant approaches and certain attributions. They also indicate that unqualified staff might be
more vigilant of potential aggression (perceived threat and likelihood of future occurrence), which might explain their preferences for more avoidant, distal strategies.

In contradiction to hypothesis 5.ii and 5.iv however, age and past experiences of assault were not found to be related to attributions and management strategies.

There was some limited evidence to support hypothesis 5.iii, that feeling supported by managers and colleagues would be associated with attributions and management strategies, although conceptually, the results from this analysis are not conceptually meaningful on first impressions.

3.6 Conclusions

In conclusion, there was insufficient evidence to support hypothesis 1.i, that staff would perceive the female vignette figure’s aggression as a result of mental illness and lack of communication skills, and that the same behaviour by the male vignette figure was caused by an inherent tendency to violence. Predictions from hypothesis 1.ii also were not supported, on the basis of the finding that no differences existed in perceptions of victimisation experiences as causal explanations according to the gender of the vignette figure.

In contradiction to hypothesis 1.iii, attributions of blame increased in response to the female vignette figure in the staff-as-target scenario, with no such effect for the male vignette figure.
With respect to responsibility as the dependent variable, no main effect of staff or patient gender on responsibility was found. There was a significant interaction between gender and target, however, which demonstrated that ratings of responsibility increased towards the male vignette figure in the patient-as-target scenario, with the opposite effect for the female vignette figure. These findings do not provide substantial support for hypothesis 1.iii.

Results also failed to support hypothesis 1.iv, that the vignette figure would be perceived as being more threatening to staff when a member of staff was the target. However, some support was found from the analysis using perceived threat to patients as the dependent variable, given that there was a main effect of target upon these perceptions.

Some evidence in support of hypothesis 2.i, was found, on the basis that all three management strategy factors were significantly associated with certain attributions.

As regards hypothesis 3.i, there was no evidence to suggest that management strategies would vary according to patient gender *per se*, on the basis of the finding that only therapeutic approaches differed according to an interaction effect of target, staff and patient gender.

The results from the analysis of attributions and attitudes provided quite substantial support for hypothesis 4.i, demonstrating an association between certain attributional factors and specific attribution items with both positive regard and deviance.
However, with respect to hypothesis 4.ii, less support was found, given that only controlling management approaches were associated with particular attitudes.

For the final group of hypotheses, there was some support for the proposal from 5.i that attributions and management strategies would vary according to qualifications. Hypothesis 5.ii and 5.iv were not supported on the basis that age and past experiences of assault were not found to be related to attributions and management approaches. Hypothesis 5.iii was supported by some significant correlations between perceived sense of support from colleagues and managers, and attributions and management strategies.
4. **DISCUSSION**

Results of the study are summarised and discussed in the context of the hypotheses previously outlined, and then in terms of their theoretical and empirical links.

Secondly, a methodological critique is presented, focusing on ecological validity, generalisability, floor and ceiling effects, and problems of measuring and categorising attributions. In addition, Type I and Type II errors are discussed.

Finally, implications for clinical practise and further research are considered.

4.1 Interpretation of findings.

4.1.1 Attributions

The use of factor analysis of attributions was useful to ascertain which items were conceptually meaningful to this particular group of participants. The first two factors, Victimisation and Internal-mad were clearly quite interpretable, and might be expected to be important attributions of High Secure staff. The fact that no Internal-bad factor emerged may have been due to the limited response set (that is, having only 15 specific attributions to rate) which might not have reflected what could comprise this dimension, or it might be the result of the fact that, for High secure Hospital staff, conceptions of aggression do not necessarily fall into a “bad” causal category. Alternatively, the item “she/ he is a violent woman/ man” alone might represent this. A range of attributions was rated by staff as important in explaining the aggressive behaviour. This finding is comparable with that of Meddings (1996) who found that
staff used a variety of attributions to explain a violent incident. This could be the result of methodological problems, which will be discussed later. Given that scores on factor two (internal - mad) were well above the half-way mark it is also apparent that these explanations were perceived by staff in the current study as important causes of the behaviour. This is similar to Gresswell's (1988) finding that overall, mental instability was the most popular explanation of offending behaviour by staff at Rampton.

These results show a tendency for staff to infer causality in a manner that is consistent with the fundamental attribution error, although the broad range of attributions that were used in this study may indicate that staff are taking into account a wide variety of variables, or perhaps are drawing from their own experiences of aggressive incidents.

There was limited support for hypothesis 1.i, only on the basis of the finding that internal enduring causes of aggression were rated as very important, regardless of the gender of the vignette figure. Contrary to hypothesis 1.i, was the finding that staff did not generally make different attributions according to the vignette figure's gender. The aggression of the female patient was not viewed as being more a result of mental illness or poor skills, nor was the male vignette figure's aggression perceived to be more a result of an internal inherent tendency to violence. Given that there was a main effect of staff gender, on ratings of the item "She/ he is a violent woman/ man", it is evident that male and female staff differed in their perceptions of this cause. With respect to hypothesis 1.ii, there was no support for the proposal that the factor representing "victimisation" would be rated as more causal in the female vignette.
figure's aggression. Given that a high proportion of female patients in the hospital under study have a history of being victims of past abuse, (Hemingway, 1996) this finding might be surprising. Given the complexities in attempting to link being victimised and using violence however, (Shaw, 1995), perhaps staff in this study are functioning in a more sophisticated manner by not making assumptions about such possible relationships. More alarmingly, could this reflect the staff's reluctance to "recognise the extent or significance of the women's' histories in contributing to their present mental state" (Dolan and Bland, 1996). However, given that the average ratings for both male and female staff were above the half-way mark, this is unlikely. Alternatively, it might reflect a recognition of past histories of abuse which may apply equally to understanding male and female patients' behaviours. What does seem apparent, is that usual gender stereotypes that have been mentioned in the context of other studies, might be mediated by the context of the Hospital environment. Consequently, victimisation experiences might be salient to explanations of both male and female patients' aggression.

With respect to attributions of responsibility and blame, hypothesis 1.iii received no support. There was no main effect of patient gender upon these attributions, but there were significant interactions between patient gender and target of aggression in both analyses. As Gresswell (1988) points out, interaction effects without main effects are unusual, but might imply that staff are taking into account the role of both gender and target as salient variables in attributing responsibility and blame. More complex are the findings that in the patient as-target, male vignette figure scenario, staff attributions of responsibility tended to increase, whilst this trend was shown in the opposite direction.
in the female vignette figure scenario. With blame, however, the female patient in the
staff target scenario increased such attributions, commensurate with the double
deviance hypothesis, that women who break gender role norms are viewed more
negatively. For the male patient, these attributions did not vary according to target.
Given that such perceptions may depend on internal rather than external attributions,
but that no significant differences were found across internal and external (global )
attributions, the basis of these results remain unclear. However, the increase in
assignment of blame on the basis of female patient and staff-as-target vignette, perhaps
indicates that behaviours that challenge gender role expectations may not necessarily
affect attributions of causality, but may lead to more sanctioning attributions in certain
circumstances (in this case, when a staff member is targeted).

In contrast to hypothesis 1.iv, no significant differences were found in participant’s
perceptions of threat to staff in general, across conditions that differed according to
target. Consistent with hypothesis 1.iv however, was the main effect of target on
perceptions of threat to other patients. These findings suggest that to High Secure
Hospital staff, the patient-as-target of aggression is more salient in the process of
considering the degree of threat to other patients. It might be that threat to staff is
processed according to other salient factors, which are beyond the scope of this study,
or that such perceptions concerning staff threat are quite high anyway, irrespective of
who the target is (a ceiling effect).

Additional analyses found a significant interaction effect between gender of staff and
of patient, in that male staff viewed the female patient as having greater control of her
behaviour, whilst female staff viewed the male patient as having greater control. This tendency to view persons of the same sex more positively in this instance, might be explained by social comparison theory (Festinger, 1954), whereby certain attributions are made in favour of people perceived as being more similar to oneself.

Qualitative analyses highlighted that the most frequent spontaneous attributions were intrapersonal (for example, “patient has difficulty trusting others”) followed by those relating to skills. This suggests that staff are still focusing on the patient by using more internal types of attribution, consistent with the fundamental attribution error. These factors might be particularly salient to the staff in understanding aggression, and highlight some of the problems of using forced choice questionnaires. It was interesting to note that no reference was made to power issues, patient autonomy and control, given the emphasis on these issues from some of the literature on maximum secure hospitals (Potier, 1993) although one respondent who commented on the male vignette figure mentioned the idea that the patient may no longer want to remain a victim.

**In summary**, the results suggest that, whilst mental illness and poor anger management skills (factor two) in addition to victimisation (factor one), and the internal-bad attribution are salient to staff in causal attribution, these factors are not applied differentially according to the patients’ gender or the target. This might be the result of methodological constraints, or that the category of gender is less salient in the Secure Hospital environment, because of the emphasis on diagnostic categories of psychopathology. This is particularly interesting given the finding by Lovelock (1996)
that staff perceived female patients in Rampton hospital differently to male patients, in terms of the former group being regarded as more complex, unstable, and having more psychiatric problems and negative past experiences than the latter. These different findings might have arisen because there were no male staff in Lovelock’s study. Nonetheless, in the current study, sanctioning attributions were found to vary, but only according to an interaction of gender of the patient and target, which implies that these variables in combination are more important when assigning blame and responsibility.

Findings on the blame items also hint at a possible gender bias towards females, as a possible result of expected behavioural norms. In addition, controllability varied according to patient and staff gender, and perceptions of threat to patients were influenced by the target of aggression as a salient variable.

These findings indicate that the context of the hospital setting might over-ride gender in the process of causal inference. In addition, perceptions about how much control a patient has for their aggressive behaviour might be the result of social comparison processes, which may influence attributions. Gender role expectations, in contrast, are indicated as more important in influencing sanctioning attributions, than causal inference, and are perhaps more central in the process of assigning blame, than actual internal-external distinctions. This would support Deaux’s (1976) assertion, that both the situational context and role expectations affect the process of attributional inference.
4.1.2 Management strategies

Factor analysis of management approaches revealed three main categories reflecting controlling, therapeutic, or avoidant styles. These are similar to those described by Apel and Bar-Tal (1996) whose factor structures represented violent responses (including the use of force if necessary), vigilant responses (avoiding contact with the patient), and therapeutic responses (including a consideration of the patients’ condition).

Hypothesis 2.i predicted that there would be an association between attributions concerning causes of aggression and preferred management strategies. There was some support for this prediction, especially so for the therapeutic approaches being highly correlated with the internal-mad factor. This result is to be expected, but is also perhaps quite positive, within the context of a High Secure hospital, which has sometimes been described as ‘counter-therapeutic’. In contrast to Meddings (1996), the internal enduring attribution was associated with therapeutic approaches and inversely associated with controlling methods. This might be the result of the use of different vignettes employed, or the fact that participants in Meddings’ study were working in hostels for the homeless where the emphasis on mental health problems might not be so strong. It would be interesting to explore what personal qualities staff in each of these settings equate with internal enduring attributions, and whether any differences fall into categories of internal-mad and internal-bad. Interestingly, the internal-bad statement correlated with avoidant, rather than controlling approaches. In fact, blame was the only attribution found to be associated with controlling approaches, which may have implications for the way that female patients are managed, given the previous
interaction effects for blame. Also, in contradiction to Apel and Bar-Tal (1996), who found that staff chose violent approaches with patients whose behaviour was viewed as more logical) was the finding that perceiving the behaviour as *less controllable* by the patient, did not correlate with therapeutic, nor any other management strategies. These authors’ findings might be the result of a methodological artefact, in that the behaviour in each vignette (arbitrary and non-arbitrary) was assumed to be uncontrollable/irrational or controllable/rational but was not directly described as such by these researchers. It might also be due to the fact that patients in Rampton Hospital who are viewed in this way, are thought to have personality disorders. Staff might find these patients particularly difficult to manage, but nonetheless, have experience of dealing with these patients in a non-controlling way. Thus the theoretical model of helping behaviour (Weiner, 1980, which asserts that when a person’s situation is viewed as being out of his control, more help is offered) could not be supported, given these results from the current study. Surprisingly, the very strong correlation between avoidant approaches and believing the behaviour would occur in other situations might reflect a tendency for staff to be more vigilant of a patient who is considered to be likely to behave aggressively on a regular basis. This implies that *consistency* information is perhaps important in influencing approaches that are adopted.

As with attributions, participants’ ratings of their preferred management strategies did not vary according to the patients’ gender alone. The significant interaction effect between staff gender, patient gender and target suggests that female staff were less likely to favour therapeutic approaches with the female vignette figure whose target was a fellow patient, whilst male staff were more likely to find this helpful if the target
was a patient and the vignette figure either male or female. This might indicate that female staff do not tolerate female patient aggression towards other patients, or find it more of a difficult problem to manage. Male staff, however, might have more difficulty in responding therapeutically when they are the targets of either male or female aggression (the latter being more consistent with Berkowitz’s 1983, proposal, that personal threat is more likely to result in aggression rather than helping behaviour). These findings are complex and again suggest that staff are taking into account both variables, or are drawing from their own particular experiences of working with patients. This then, may raise the question as to whether male and female staff hold a shared view of managing aggression and to what degree their approaches might differ under similar circumstances.

Given that there were no differences observed across the sub-groups in their preferences for controlling or avoidant approaches, this might be because these types of strategy were not generally viewed as useful by staff (i.e. a floor effect). It may, however, have been the result of the fact that the behaviour was not severe; it would be interesting to note whether differences did arise had the vignette described more violent behaviour.

With respect to the spontaneous management approaches offered by participants themselves, direct contact with the patient was the most popular, followed by offering the patient alternative strategies. However, given that only a small proportion of the total sample responded to this item, it is difficult to draw any conclusions from these findings.
In summary, some attributions correlated with management approaches. The fact that blame correlated with controlling approaches has treatment implications, particularly for female patients. However, results demonstrated that gender alone was not a salient factor that influenced staff's management preferences, but in conjunction with target, females who are aggressive towards other patients might be less likely to be treated therapeutically.

4.1.3 Attitudes, Attributions and Management strategies

Factor analysis of the attitude items revealed two conceptually similar factors to those from Horn and Hollin's (1997) study, in terms of 'Deviance' and 'Normality'. However, the factor in the current study was comprised of fewer items, compared to the previous study. Additionally, a third factor, reflecting positive regard, was extracted, which differs to the third factor of Horn and Hollin's study, which represented 'trust'. This might be the result of the more positive attitude items in this study falling into a separate factor, given that this study's participants might perceive some items (which originally constituted normality) as representing a separate, less neutral dimension, that is, positive regard. However, this might be due to the methodological artefact of using the label 'Special Hospital patients' in the current study, in contrast to that of 'offender' which might produce different structures for the attitude factors.

Consistent with the findings from Horn and Hollin's (1997) study, was the fact that participants generally scored well above the half-way point on normality and on deviance. In contradiction to Social Identity Theory (Tajfel, 1981) which would predict
that negative attitudes to outgroups occurs as a function of enhancing one's self-esteem, it seems that generally, staff held quite positive attitudes to patients. This is similar to Meddings' finding (1996) that participants generally hold positive attitudes to homeless people with mental health problems, but contrasts with those of Levey and Howells (1995), whose participants demonstrated high levels of social and psychological distance from people with schizophrenia. It might be that choosing to work with such groups is related to having more positive attitudes. As the contact hypothesis suggests, (Amir, 1969), contact with outgroups under positive conditions would foster more positive attitudes. These findings might, however, be the result of different labels employed in the scales and the vignettes, hence it is not strictly possible to compare these studies. Staff might have exercised caution in their responses, given possible awareness of media coverage or anxieties about the implications from stating their real views.

The strong positive correlations between positive regard and the internal-mad factor, was unexpected, given that internality presupposes responsibility and blame. However, given that attributions associated with mental illness items may mitigate against responsibility (Howells et al., 1983) this might explain these findings. More expected, was the association between viewing the behaviour as being caused by victimisation experiences, and having positive regard to patients in Special Hospitals. This is consistent with Meddings' (1996) finding that external attributions related to more positive attitudes to homeless people. The strong inverse correlation between blame and positive regard is also to be expected. Participants who viewed Special Hospital patients as deviant were less likely to use the Internal-mad factor as an explanation
(implying that deviance and mental illness are perceived as separate dimensions), and expectedly, were more likely to attribute blame. Thus it seems that agreement with some internal attributions correlate with more positive attitudes. This suggests that more attention needs to be given to the types of internal attributions before assumptions are made about the association between internality and sanctioning attributions. These findings are consistent with hypothesis 4.i that an association would exist between attributions and attitudes.

In terms of attitudes and management strategies, hypothesis 4.ii received mixed support. Whilst no association was found between attitudes and avoidant or therapeutic approaches, controlling approaches were linked to all three attitude factors. The strong inverse correlations between positive regard, normality, and deviance with the controlling management factor suggests that negative attitudes may influence staff's preferences for certain types of management strategy.

**In summary**, on the basis of the relationship between the attributions, attitudes and management strategies, it is evident that staff do strive to attain consistency across their beliefs and perceptions, particularly with respect to attributions and attitudes. Thus, the principle from Heider's balance theory, (i.e., that people attempt to achieve a balanced whole in their beliefs) could be tentatively applied to High Secure hospital staff in their attitudes, understanding and management of patients' aggressive behaviours.
4.1.4 Additional Analysis

In contrast to Meddings (1996), Crichton (1997) and Apel and Bar-Tal (1996), (who found that untrained staff preferred more punitive or violent responses), untrained staff in this study reported preference for more avoidant (rather than controlling/punitive) approaches, also perceiving the behaviour as more threatening to other patients than did qualified staff. This might be due to the fact that unqualified staff have not been given extensive training in models of understanding and managing aggression, or it might be due to their beliefs that qualified staff have more formal authority or responsibility in managing such incidents. This might therefore suggest the need for more extensive training in dealing with violence and aggression for unqualified staff. Equally, it might mean that such strategies are just as appropriate in some situations where a more distal approach is required. A study by Baxter et al., (1992) demonstrated that student psychiatric nurses were significantly more at risk from patient assault than any other nursing staff. Apel and Bar-Tal (1996) concluded from their study, that staff who respond therapeutically to some types of aggression (i.e., aggressive behaviour that is incongruent with the patient role), have more experience in dealing with aggression, or more specialist psychiatric training.

The differences in perceptions of threat in this study might be due to more hypervigilance by untrained staff, or, alternatively, more desensitisation to aggression by trained staff. It might be useful to investigate these differences further, perhaps by use of a qualitative methodology in exploring staff’s management preferences and perceptions of threat in greater depth.
Unexpectedly, and in contrast to Meddings (1996), there was (in the present study) no relationship between age and attributions or management strategies. However, Crichton (1997) and Levey and Howells (1995) did not find any age related differences in either attributions, attitudes or management strategies. In addition, no relationship was found between past history of assault by patients, with attributions or management strategies. This is consistent with the findings of Apel and Bar-Tal (1996) who found no significant relationship with staff’s personal experiences of being assaulted and their choice of management approach. The qualitative results indicated that most of the participants who commented on what type of additional support they required specified needing support from other staff (N= 10), by way of either rapid staff response, better communication, or recognition from higher management of the stresses placed upon them.

4.1.5 Summary

In summary, the overall pattern of results suggests that whilst causality attributions did not vary according to gender and target, attributions of responsibility and blame did. However, given that there were no main effects, only interactions, the variables of patient gender and victim status might not be very salient on their own, to staff’s attributions for aggression. This might mean that the context of the hospital environment might reduce the importance of gender and target in causal inference. However, these variables might be more salient than the hospital context, when staff assign blame and responsibility. Perhaps female aggression to staff is seen as more inconsistent with gender role expectations and thus more blameworthy. However, given the management findings, females who are aggressive to other patients may be
responded to less therapeutically in contrast to what one would expect from the patterns of attributions of blame. Also, it is evident that seeing patients as deviant, may have influenced assignment of more blame. Training also influenced some attributions and management strategies.

Given the high scores overall on the internal enduring statement, and the internal-mad factor, this might again be explainable within the context of the Hospital, where the ethos of the environment would emphasise the medical model, thus supporting the fundamental attribution error. This may also explain why there were no differences on these items according to gender and target, because the hospital ethos would skew these types of explanation. More speculatively, staff's caution in participating might have resulted in responses being socially desirable, which may also have undermined any gender differences, which might genuinely be held. If not consistent with the medical model, then staff may feel that their responses would lead to some degree of sanctioning by higher management.

Therefore, there might be a tension between people's actual attributions that they might apply outside of their working role, with those that are imposed by the hospital context.

4.2 The “Special” Hospitals

A large proportion of published literature on the High Secure Hospitals is morally driven, focusing on the therapeutic effectiveness of these facilities. The current study
has moved away from this type of debate, to explore psychological phenomena in staff. It is important on the basis that it raises the profile of gender as an area in need of research in relation to attributions and management of violence and aggression in a high secure hospital setting.

4.3 Problems of previous research that this study attempted to address

In terms of the methodological problems in attribution research, studies have been criticised in the way in which they have explored causal attributions. Furnham et al. (1983) highlight four main problems:-

1. The ‘limited answering set’ prohibits participants from expressing their natural responses and may lead to the fundamental attribution error being made. For example, if more internal than external attributions are provided by researchers, more dispositional attributions will be made. In this study, an attempt was made to offer participants a balance between external and internal attributions, in addition to the opportunity to give their own individual explanations.

2. The neglect of motivational criteria, which implies that more pre- and post-experimental briefing is needed. Whilst some attention was paid to this by approaching staff directly, and asking them to comment about the questionnaire at the end of it, the scope of this study did not allow for more detailed analysis.

3. The paucity of information provided to participants, by way of vignettes. They state that this could be overcome by providing more detail, and asking subjects to rate the degree of confidence that they have in each explanation, omitting and weighting
items accordingly. Given the task of recruiting a large number of participants, it was
decided to adopt a brief vignette to encourage a higher response rate. However, a
comments section at the end enabled participants to state how they felt about the
questionnaire in general.

4. The inattention to individual differences. Again, some attempts were made to
explore staff's differences according to age, gender and training, but the
questionnaire format did not allow for more detailed analysis.
Additional problems of attributional research is that often, blame and responsibility
have been used interchangeably (Holtzworth-Munroe, 1988). In this study, these
items were tested as separate variables. Whilst not strictly comparable with other
studies that used real life scenarios, the vignette approach allows comparison of
findings with other similar studies, for example, those of Meddings (1996), Crichton
(1997), and Gresswell (1988) who also adopted a vignette approach.

4.4 Methodological Issues

4.4.1 Difficulties Drawing Conclusions about Hypotheses

Some of the findings in this study were complex and difficult to interpret. Furthermore,
many of the hypotheses relied on the factor structures of several attributions,
management strategies and attitudes, rather than single attributional items.
Contradictory results for some hypotheses made it difficult to prove or disprove
proposals.
It would have been useful to have undertaken an extensive pilot study, in order to undertake factor analysis on a larger sample, had more time been available. This would have enabled further refinement of the questionnaire, and abandonment of ambiguous factors at an earlier stage. Conversely, exploring a smaller sample’s spontaneous attributions in greater depth would have provided a more contextual analysis of attributions and preferred management strategies.

4.4.2 Floor and Ceiling Effects

Participants’ responses were not widely dispersed, and tended to cluster at one extreme for many of the dependent variables. Given that floor and ceiling effects may have been present for some particular items (especially controlling management approaches, and the internal enduring attribution), these might have obscured the results. These effects need to be considered when making assumptions about the existence of interactions or main effects, and the possible relationships between the dependent variables, when there might have been floor or ceiling effects for each.

4.4.3 Type I and Type II Errors

A large number of hypotheses required statistical analysis. In order to reduce the possibility of Type I errors, a small series of Analysis of Variance tests were employed (as opposed to multiple procedures for each independent variable, such as t-tests), in order to avoid the occurrence of significant results purely as a consequence of chance (Howells, 1997). This is a particular issue for correlations, where the large number of dependent variables were tested. As Howells (1997) points out, a more conservative level of significance could be employed to deal with this problem.
The use of specific and global statements might have increased the chance of Type I errors, given the greater number of statistical tests required for these variables. Meddings (1996) however, suggests that this approach, (as opposed to employing just global items) is a more rigorous one. Despite the large number of participants, the high number of sub-groups meant that relatively few numbers were in each condition (the average number being 15). This might have led to Type II errors, whereby results which were actually significant did not appear to be so. This problem has also occurred in earlier studies; Crichton (1997) studied 576 participants, with an average of 18 in each condition and Gresswell (1988) recruited 41, with an average of 20 in each group.

4.4.4 Measurement and Categorisation of Attributions

A strategy was employed in developing the questionnaire by way of interviews with staff, and a literature search on attributions and violence and aggression in order to raise ecological validity.

However, experimentally elicited ratings meant that real-life relevance was uncertain and also, it is not entirely possible to say whether differences in scores were a consequence of actual preferences for management and attitudes. Reported preferences might be discrepant with actual preferences for management approaches. The ward milieu, management policies, and ward roles (especially on low staffed wards) might exert an influence on practise which would not be evident from responses. Also, participants might have wanted to make a good impression which may have influenced their responses. One way of dealing with this issue would have been to have used a
method employed by Rutter and Brown (1966) by asking staff to describe what they actually did the last time they dealt with an act of aggression. Whilst this might have helped to reduce the ambiguities between actual and perceived approaches, it might have been more threatening for staff because of the greater sense of being scrutinised. Apel and Bar-Tal (1996) employed a less threatening method by asking staff what would usually happen on their ward in such incidents, rather than focusing on the individuals' account. This might facilitate greater ecological validity. Gresswell (1988) suggests a more subtle method, by way of correlational checks (concerning the stated preferences for management approaches), based upon the rate of referral to psychology or psychologists' assessments of helpfulness of staff across different wards. The possibility does remain that findings were a consequence of real differences, but working from only limited information provided by the vignette might have resulted in the few additional comments on the qualitative items. Forgas et al. (1980) used real life aggressive incidents experienced by participants in exploring their attributions, which would increase ecological validity. Stratton et al., (1986) recommend a qualitative approach in eliciting respondents' spontaneous attributions. Attribution theory has been widely criticised in the way that it has conceptualised dimensions and causal processes. Firstly, the dimensions internality and externality are not mutually exclusive, given that some explanations can fall within both categories (for example, J failed to comply because he did not understand the request). Some items and factors were ambiguous and did not fit the attributional model. But by raising the theoretical validity, one would in effect, decrease the ecological validity. As Meddings (1996) points out, the attribution model may have its own limitations in that
peoples’ everyday explanations do not always fall into internal enduring, internal temporary and external dimensions. Had items been considered separately, as individual dimensions, rather than as factors, then other findings of a different nature might have emerged. However, the fact that variables were reduced into factors, helped to facilitate clearer results, and reduce the possibility of Type I errors.

4.4.5 Wider theoretical Issues in Interpreting the Results

The hospital culture and existing policies on management of aggression might have influenced the results. There has recently been a policy shift from seclusion to Level 3 observation. This type of observation is continual and means that patients who are on this level are accompanied by a member of staff at all times.

The possibility of mini-cultures existing on individual wards has also been mentioned (Boynton, 1980).

4.4.6 Response Rate and Generalisability

Generally, participants were co-operative. A response rate of approximately one third was returned, from the total number of questionnaires administered. Some members of staff that were approached indicated reluctance on the basis of the attitude scale and the perceived negative consequences of participating. There might have been differences between respondents and non-respondents, in that the latter might have held more negative attitudes, preferred more controlling approaches and chosen more blaming attributions.
Results from this sample may not generalise to those of staff who work in other secure hospitals. Nevertheless, this study does have a number of similar findings to those of Meddings (1996) in that mental illness attributions were viewed as important.

4.5 Practical difficulties

Unfortunately, no time was available to conduct a pilot study. This would have enabled further refinement of the questionnaire, including methods employed by Apel and Bar-Tal (1996) on actual staff responses.

4.6 Dissemination

A brief version of the findings will be made available to the wards who were sent questionnaires. Clinical implications and relevant sources of information will be included in each report.

In summary, the strengths of the study were that there were a large number of respondents, the questionnaire had good inter-rater reliability, and analysis followed rigorous quantitative procedures.

4.7 Clinical Implications

Some of the findings were ambiguous making it more difficult to draw certain clinical conclusions. However, a number of tentative suggestions can be made. The high rate of
agreement by staff on a variety of attributions, and the large clusters of responses around the Victimisation and Internal-mad factors, raise the question of whether staff share a clear conceptual model of understanding aggression across different patients and to what extent their approaches would differ under similar situations. Therefore, one implication is that staff, including management, could explore the level of consensus across peoples' perceptions, i.e. about individual clients.

The emphasis on mental illness may have positive implications in that it correlated with therapeutic responses. However, it might also result in other equally or more important factors being unrecognised and unaddressed. In the case of patients who behave aggressively because of certain injustices or real provocation, the underlying emotion might be undermined because of the tendency for staff to focus on internal-mad factors. Consequently, potentially real external causes including the environmental context might be unaddressed. Biaggio (1987) proposes that, in real-life situations, the multiple variables of anger and aggression must be taken into account. The suppression of anger may have negative psychological consequences (e.g. powerlessness, lowered self-esteem) for a patient.

The finding that male staff viewed the male patient potentially more positively on the basis of the perceived control of his behaviour (as did female staff with respect to the female patient), alludes to the possible benefits of same-sex staff working with male and female patients. However, this is tentative, given that these patterns of perceptions were not evident across other types of attribution.
Attributions of responsibility were moderately high across all subgroups, with the implications being that perhaps the patient was considered less in terms of the sick role per se, and more as a person with mental health problems who needed to develop his/her own sense of responsibility for his/her actions. Nonetheless, the fact that blame correlated with controlling approaches has implications for female patients who are aggressive towards staff (given the interaction effect between target and patient gender; for the female vignette figure, blame increased as a function of the target being a member of staff). This latter finding, may reflect the difficulties in managing inpatient conflicts. The usual emphasis in training on violence and aggression, often emphasises staff as targets, whereas an additional emphasis on interpersonal disputes between patients might be a useful part of workshops.

The findings that attributions and negative attitudes might be associated with certain management practises opens up the possibility of using attribution and attitudinal focused training in combination with more traditional training methods. For example, workshops might usefully explore staff's perceptions and explanations of real or hypothetical case presentations of male and female patients' challenging behaviours. This would facilitate the sharing of ideas and highlighting of any stereotypes or biases in attributions. As the qualitative findings demonstrated, some staff indicated that they would like more training and staff support in dealing with aggression and violence. Apel and Bar-Tal (1996) highlight the benefits of training and Whittington and Mason (1995) discuss the importance of recognising the role of stress on staff's appraisal and coping with violence and aggression. As demonstrated, specific training in therapeutic approaches may increase these methods by providing more response options (Apel and

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The research itself might have had beneficial effects upon the staff that participated. When members of staff are asked to consider several possible causes for aggressive behaviour, they are more likely to think about multiple solutions, which may help to facilitate positive practise.

Despite few differences found according to the patient’s perceived gender, this should not preclude the subject of gender issues from training. Seeman (1995) highlights the gender differences in the different treatment responses of people with schizophrenia, noting that what might be regarded as positive social contact in females might be perceived as intrusive by males (although individuals need to be treated as such, and not just on the basis of these crude categories). Doherty and Anderson, (1998) report from their conversational data on rape, that male victims are often viewed as being more rational than females, and that often, participants tend to focus on the victims’, and not the perpetrators’ behaviour, thus perpetuating a secondary cycle of victimisation.

4.8 Summary of Future Research

This study raises the question of whether quantitative methods are the most fruitful to employ when exploring attitudes and explanations of male and female patients’ aggression. The use of a more exploratory/qualitative methodology might increase the ecological validity. In addition, the use of videotaped or real life scenarios as Forgas et al.’s (1980) study employed, would enable participants to take account of the physical cues that might be noted in real life situations in their attributional processing. It is
possible that the use of a more serious incident of violence in the vignette might have resulted in different findings emerging. For example, one might speculate that, according to the double deviance hypothesis, blame might have increased across (all) female vignette figure conditions, given that gender norms would be violated to a greater extent.

With respect to gender issues, Shaw (1995) recommends that greater attention is paid to: - media images of women who use violence; the oversimplified and dichotomous explanations for women's violence; the male centred view of violence by women; the different meanings of the word violence according to different contexts; the problem with the links between being victimised and using violence; the problem of how we should treat or respond to women who use violence. It may also be useful to attend to male stereotypes in the hospital, through a qualitative analysis similar to that of Lovelock (1996). In addition, attitudes to both men and women might be useful to explore.

Meddings (1996) suggests a triangulation approach, whereby explanations for real life events through incident reports are compared with findings from the explanations around the vignette material. Greater attention could also be paid to the types of internal attribution and what the implications of these are, in order to explore further any gender based or other salient category explanations. Meddings (1996) outlines the benefits of conducting outcome research on clients whose behaviour was attributed and managed differently to establish the implications of certain attributions and management approaches. This would seem a worthwhile route for future research, in
that it would provide more information on any relationships that existed between certain attributions made by staff and actual behaviours of clients.

4.9 Conclusions

Attribution theory is offered as a way of exploring staff’s understanding and management of patient aggression, with attention to gender issues.

This study indicates that staff’s understanding of the causal factors in aggression are multi-dimensional, and that few causal attributions might vary according to the patients’ gender. In contrast, attributions of blame and responsibility were found to vary, with implications for management responses to aggression. However, only therapeutic responses were found to vary according to gender and target. Despite the few differences in staff responses across the conditions of gender and target, relationships were found between attributions, attitudes and management strategies, and are explainable within the framework of balance theory and the mitigation hypothesis.

This implies that explanations of aggressive behaviour may have important repercussions on the management of such behaviour.

Findings generally demonstrated that mental illness mitigated against the use of controlling approaches, whereas the double deviance hypothesis was supported by the effect of female patient label and the staff target condition, on attributions of blame.
Thus, different category labels might have different effects on attributions and/or management strategies, in that there might be more negative consequences from being labelled a female aggressor than an aggressor with a mental illness. Support for the contact hypothesis was also found.

Further studies exploring more personal, internal and contextual explanations in conjunction with outcome studies on patients’ progress, would be a next step in testing the importance of attributions in real-life situations.

Attribution focused training, with attention to gender stereotypes, differences and similarities across male and female patients may form part of the necessary induction to each member of staff. It might also be useful to consider the heterogeneity within the hospital environment. If each ward has a different culture, in addition to the different admissions criteria, then it might be more productive to target more individualised training to specific wards in order to maximise the benefits.

Greater attention in future research could be paid to the types of support offered to staff who are the victims of violence and aggression at work, and an evaluation of their effectiveness. A more in-depth, possibly qualitative, exploration of the types of support procedures that staff might find useful would also be beneficial. This area seems to be fundamental in enabling staff to cope with stressful experiences at work, and consequently, to be able to function at their optimum in the High Secure Hospital environment.
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PLEASE ENSURE ALL SECTIONS OF THIS FORM ARE FULLY COMPLETED.

RAMPTON HOSPITAL AUTHORITY’S APPLICATION FORM FOR THE
ETHICAL APPROVAL OF RESEARCH

HOSPITAL
Rampton
PROJECT
NO.

DATE:
04
09
97

NB See Appendix 1

TITLE OF PROJECT

Staff perceptions of violence- Implications for management approaches?

SECTION 1

PRINCIPAL RESEARCHER

NAME OF PRINCIPAL RESEARCHER
Julie Clarke

PRESENT APPOINTMENT/QUALIFICATIONS
Trainee Clinical Psychologist; BSc (Hons) PSYCHOLOGY

SUBJECT/DISCIPLINE
PSYCHOLOGY

Apologies for lack of boxes
Different system
SECTION 2

SUPERVISOR'S DETAILS

PROJECT SUPERVISOR (WHERE DIFFERENT FROM PRINCIPAL RESEARCHER)

FULL NAMES:
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Ronnie Saeland
Ms
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ADDRESS

Psychology Department Rampton Hospital.

TELEPHONE NUMBER:
ext. 7326

CURRENT POSITION:
Principle Clinical Psychologist.

SECTION 3

DETAILS OF PROJECT

N.B. Please attach a full research protocol, where relevant to this application form.

SUMMARY OF PROJECT (Maximum of 200 words)
The social construction of gender is salient to the way in which people evaluate others (Deaux, 1984: Travis, 1988). There is a wealth of literature on staff perceptions of violent incidents, many exploring the influence of diagnoses on attributions (Howells, 1983: Crichton, 1995). The aim of this study is to elicit staff's attributions and preferred management strategies, concerning a vignette of a violent incident. The independent variables involved will be:

(i) Staff attitudes to treatment.
(ii) Whether they believe the hypothetical person to be male or female.

As a pilot study, five staff interviews will initially be planned, in order to gain background information about ward events and scenarios of violent incidents, on which to base a realistic vignette, and elicit spontaneous attributions to be included in the questionnaire. Subsequently, a vignette will be administered to a random sample of staff (working on the male and female wards), who will then be asked to rate a number of attributional statements about the violent behaviour. Staff will also be asked to describe how they would manage such an incident.

Two different types of vignette will be used, one describing the person as male, the other describing the person as female.

The researcher will administer the questionnaire in a personal interview with the sample of ward staff (approximately 60 in total), who work at Rampton Hospital.

Additionally, a questionnaire concerning staff's attitudes towards treatment values will be administered (a 15-item version of Worell and Remers' 1992 "Counselling Values" questionnaire).

The interview will last between 30-40 minutes with each member of staff.

OBJECTIVES/HYPOTHESES OF RESEARCH PROJECT (where relevant)

The main objective of this project is to elicit staff attributions concerning violence by male and female patients, and their preferred approaches to managing these.

Hypothesis one will investigate whether more internal enduring attributions will be made about female aggression, in contrast to male aggression.

Hypothesis two will explore the existence of differences in management approaches, according to staff's beliefs about the gender of the person in the vignette.
Hypothesis three will be concerned with any differences in staff attitudes to treatment, and how these also might influence management approaches to violence.

SECTION 4  

PLANNING

NO. OF SUBJECTS  
See Below

NO. OF CONTROLS  
See Below

N.B. Please note in the boxes below whether all the subjects and controls are to be drawn from within the special hospitals.

NATURE AND METHODS OF SELECTION (subjects and controls where relevant - Maximum of 200 words)

There will be a random selection of 60 ward staff from Rampton Hospital. Half will be selected from the male wards, and half from the female wards.

No participants will be drawn from outside the hospital.

An information sheet about the study will be given to each member of staff. This will explain the purpose of the study, in which to explore staff attitudes to violence and how they manage such incidents. In addition, participants will be told that a written description of a patient will be given, and they will be asked to state honestly about how they would perceive the patient and respond to their behaviour. (Please see attached sheet).

Furthermore, subjects will be told that they will be free to withdraw from the study at any time, that confidentiality will be kept by way of anonymously coding their responses and that they will be sent a written summary of the project at its completion, and given the opportunity to comment on it.

DESIGN AND METHODS TO BE USED IN THE PROJECT  
(Maximum of 200 words)

Between subjects design - approximately 30 staff will be randomly selected from the female wards, half of whom will be administered
A vignette involving a female character, the remaining half will be given a vignette about a male. The same procedure will be employed with staff from the male wards. A list of attributional statements will be administered, and rated by way of a Q-sort (or a 7 point Likert scale). A questionnaire eliciting staff's preferred management approaches will be administered through a semi-structured interview.

Finally, staff will be asked to respond to a questionnaire concerning their attitudes towards treatment values. This procedure will be administered privately with each individual.

SECTION 5
DETAILS OF METHODS OF INVESTIGATION TO BE USED

<table>
<thead>
<tr>
<th>TYPE OF METHOD</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNSTRUCTURED INTERVIEW</td>
<td></td>
</tr>
<tr>
<td>SPECIFY AREAS OF INTEREST</td>
<td>NA</td>
</tr>
<tr>
<td>TYPE OF METHOD</td>
<td></td>
</tr>
<tr>
<td>ALREADY STANDARDISED STRUCTURED INTERVIEW</td>
<td>NO</td>
</tr>
<tr>
<td>SPECIFY</td>
<td>NA</td>
</tr>
<tr>
<td>TYPE OF METHOD</td>
<td></td>
</tr>
</tbody>
</table>
PSYCHOMETRIC TESTING  NO

SPECIFY

NA

TYPE OF METHOD

OTHER PSYCHOLOGICAL TESTING  NO

SPECIFY

NA

TYPE OF METHOD

URINE SAMPLES  NO

FREQUENCY

NA

TYPE OF METHOD
BLOOD SAMPLES NO

FREQUENCY
NA

QUANTITY
NA
BY WHOM (SPECIFY)
i.e. Researcher, hospital staff

TYPE OF METHOD

OTHER SAMPLES NO

SAMPLE TYPE
NA

FREQUENCY
NA

QUANTITY
NA
BY WHOM (SPECIFY)
i.e. Researcher, hospital staff

TYPE OF METHOD

OTHER TESTS NO
SPECIFY
(EG: NMR, CT SCAN, EEG)

NA

TYPE OF METHOD

OTHER METHODS YES

SPECIFY 1. Semi-structured interview; 15-20 attributional statements concerning the vignette will be administered. In addition, staff will be asked to describe their management approach to the incident in the vignette.

2. Questionnaire; staff will be asked to respond to 15 statements about treatment values, to elicit traditional/liberal attitudes to treatment.

SECTION 6

STATISTICAL ADVICE

ADVICE

1. HAVE YOU RECEIVED ANY STATISTICAL ADVICE ABOUT THE DESIGN OF THE PROJECT?

NO

2. DO YOU HAVE ACCESS TO STATISTICAL ADVICE OR SUFFICIENT SKILLS WITHIN YOUR TEAM?

YES

SECTION 7

RISKS
ESTIMATE BENEFIT, DISCOMFORT OR RISK TO SUBJECTS OR CONTROLS OF ANY PART OF THE RESEARCH
0=None, 1=Low, 2=Medium, 3=High

<table>
<thead>
<tr>
<th></th>
<th>SUBJECT</th>
<th>CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Risk</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>2. Discomfort</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>3. Side Effects</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>4. Benefit</td>
<td>2</td>
<td>NA</td>
</tr>
</tbody>
</table>

IF ANY OF THE ABOVE RATE GREATER THAN ZERO PLEASE INDICATE THE NATURE OF THE DISCOMFORT OR RISK AND THE SIDE EFFECTS THE PATIENT MAY ENCOUNTER. ALSO EXPLAIN WHAT SAFETY CONTROLS ARE TO BE USED TO PREVENT ANY HARM.

NA.

IS IT ANTICIPATED THAT THERE WILL BE ANY PERMANENT EFFECT ON THE PATIENT? PLEASE SPECIFY BELOW.

NA.

SECTION 8

CONSENT (where relevant)
PLEASE INDICATE FROM WHICH GROUPS CONSENT IS REQUIRED
Please tick relevant groups

PATIENT__
___

RELATIVE__
___

RMO__
___

APPROVAL REQUIRED__
___

HOSPITAL MANAGEMENT/SHSA__
___

OTHER (eg MHAC) WOMEN'S SERVICES MANAGER ✓
___

WHERE THE PATIENT OR RELATIVE IS TO BE APPROACHED FOR CONSENT
PLEASE SPECIFY THE EXPLANATION TO BE GIVEN AND THE CIRCUMSTANCES
(eg At interview with researcher and primary nurse present)

Please attach copies of both oral and written explanations to be used.

NA.

SECTION 9

FINANCIAL SUPPORT

HAS AN APPLICATION BEEN MADE FOR FUNDING?

NO
COST IMPLICATIONS: Please specify if there are any other costs involved with this project which are not covered by your grant. For example, these costs could include such items as additional nursing staff to escort patients.

NONE.

SECTION 10  
DATA COLLECTION

BRIEFLY DESCRIBE THE DATA STORAGE SYSTEM TO BE USED:

SPSS Database.

IF YOU ARE INTENDING TO USE COMPUTER SYSTEMS, HAS THE SYSTEM BEEN REGISTERED UNDER THE DATA PROTECTION ACT?

YES

PLEASE INDICATE HOW YOU WILL PROTECT THE CONFIDENTIALITY OF THE PATIENT:

Staff responses will be kept anonymous by use of coding the data yielded from each personal interview. Any reference to groups from the male or female wards will also be substituted by a coding system that will maintain anonymity. This information will be stored on a floppy disc in a locked cabinet in the psychology department.
SECTION 11  

EFFECTS ON HOSPITAL

WILL THE STUDY CAUSE CLINICAL PRACTICE TO BE CHANGED DURING THE DURATION OF THE STUDY?

NO

IF YES - PLEASE SPECIFY NATURE OF CHANGES AND GROUPS INVOLVED:

NA.

PLEASE SPECIFY ANY OTHER HOSPITAL INVOLVEMENT

NONE.

ARE OTHER SPECIAL HOSPITALS INVOLVED IN THE STUDY?

NO

SECTION 12  

DURATION OF THE PROJECT

PROPOSED START DATE:  November/December 1997

EXPECTED COMPLETION DATE:  July 1998

DURATION OF PERIOD DATA WILL ACTUALLY BE COLLECTED (in months)

3 months.
PLEASE ADD ANY ADDITIONAL POINTS THAT YOU THINK THE RESEARCH/Ethics COMMITTEE SHOULD CONSIDER WHEN EXAMINING YOUR PROPOSAL:
Exploring staff attitudes to treatment values and their attributions about violent behaviour will contribute to understanding the basis of current management approaches employed in such incidents. Any stereotypes held about gender and violence may help to inform training and recruitment procedures. This has implications for promoting positive practices on the wards, by raising staff awareness of their own values and how they impact upon their work. The women’s services manager fully supports this project and will facilitate efforts to obtain support for the study, with all staff members involved.

HOW DO YOU INTEND TO DISSEMINATE THE RESEARCH FINDINGS AND STATE WHERE THE DATA COLLECTED DURING THE STUDY WILL RESIDE:
The research findings will be disseminated to the women's services manager, and to the women’s service development group. The special hospital research interest group will be approached about a potential presentation of the results. A paper about this study will be submitted to Leicester University as part of the course requirements. Data collected during the study will be kept in a locked cabinet, in the Psychology Department.

ARE YOU DOING THIS AS EITHER A PRIVATE CONSULTANT OR AS COMPANY SPONSORED RESEARCH YES / NO. IF YES PLEASE GIVE DETAILS OF WHAT INDEMNITY ARRANGEMENTS YOU CAN OFFER THE HOSPITAL.
I am sponsored by Rampton Hospital, undertaking training in Clinical Psychology at Leicester University. I am on placement at Rampton Hospital for two days a week, from October 1997- September 1998.

I/we agree to comply with both the Ethics and Research guidelines set out in the accompanying notes to this application.
form. I/we further agree to adhere to any conditions deemed necessary by the Ethics Committee to protect the wellbeing and safety of special hospitals patients and staff.

SIGNATURE(S): [Signature]

DATE: 4/08/1994

© BLC, RESEARCH DEPT, APRIL 1994
ETHICAL MONITORING

Will this project be submitted for approval by another Ethical Monitoring body? [Yes No]

If so, which?

I HAVE SUBMITTED THE PROPOSAL TO RAMSTORVR HOSPITAL (6)

SUBMIT TO AN APPROPRIATE PSYCHIATRIC SETTING IN LEICESTER

Has approval been given? [Yes No]

Key areas of ethical concern

Please tick the relevant boxes. If any box on the right hand side is ticked, provide an explanatory note, together with any special precautions that are proposed, permission obtained, etc. Please use an additional sheet if necessary.

Will the research involve any of the following populations?

- Animals  
- Persons under the age of 16 years  
- Persons with special needs  
- Persons with mental disorders  
- Persons disadvantaged in any way  
- Detained persons

Will some sort of deception be practiced? [No Yes]

Will a full debriefing be given to subjects subsequent to the work being completed? [Yes No]

Will subjects be informed of their right to withdraw from the study at any point? [Yes No]

Will research records remain confidential to the researcher concerned? [Yes No]

Will research involve invasive procedures or the ingestion of drugs or chemical substances? [No Yes]

Are there any other matters which might arouse ethical concern to which the Committee's attention should be drawn? [No Yes]

Have you read the Ethical Principles document issued by the British Psychological Society? [Yes No]

(for completion on behalf of the Departmental Ethical Committee)

Approved by: ________________________ (Dr. A. Sunderland) Date: ________________

_____________________________(Dr. C. McCrea)

* All projects which involve work with patients must be submitted for approval by the local Medical Ethical Committee.
Outline the aims of the research

The social construction of gender is salient to the way in which people evaluate others (Deaux, 1984). There is a wealth of research on staff perceptions of violent incidents, many exploring the influence of diagnoses on attributions (Howells, 1983; Crichton, 1995). The aim of the study is to elicit staff's attributions concerning male and female violence, their preferred approaches to managing such incidents, and their attitudes to patients.

The independent variables will be

(i) whether staff believe the violent act to be carried out by a male or female

and

(ii) staff's attitudes to patients.

Hypothesis one will investigate whether more internal mental illness attributions will be made about female aggression, in contrast to male aggression.

Hypothesis two will explore the existence of differences in management approaches, according to staff's beliefs about the gender of the person in the vignette.

Hypothesis three will be concerned with any differences in staff's attitudes to patients, and how these might influence management approaches also.
APPENDIX 1

Subjects

Sixty staff in a secure setting will be randomly selected, half from the male wards and half from the female wards (if appropriate). No other participants will be drawn from outside the hospital environment.

An explanation of the study will be given to participants, in addition to the confidential nature of their responses, and their right to withdraw from the study at any time. Subjects will be debriefed after their participation in the study, and given the opportunity to comment on their involvement in it, and on the findings.

Briefly describe the procedure

An initial pilot study will be undertaken by way of five staff interviews, in order to gain background information about ward events and scenarios of violent incidents. This will enable a realistic vignette to be constructed, and help to generate a range of attributions for the semi-structured interview.

Subsequently, a vignette (concerning either a male or female hypothetical patient) will be presented to each participant. A list of attributional statements will then be administered, and rated by way of a 7-point Likert scale.

A questionnaire will be administered to elicit staff's preferred management approaches to the incident described in the vignette. Additionally, staff will be asked to respond to a list of statements concerning their attitudes to Special Hospital patients (based on an
adapted version of Melvin and Gramling and Gardener's (1985) Attitudes Towards Prisoners scale).

The questionnaire will take between 20-30 minutes to complete.

Data collected during the study will be kept in a locked cabinet, in the Psychology Department of the relevant setting at which the work is conducted.
APPENDIX 2

INTERVIEWS WITH NURSE MANAGERS

I'm planning to undertake a study on staff attitudes to violence, and the implications of this to training and the management of such incidents.

My interview with you today is completely confidential, but it will be used to help construct a story of a violent incident, and also with the design of a questionnaire.

1. Based on what you've experienced on the wards, could you please give me an example of a recent and severe act of violence.
   What were the long term and more immediate events that preceded it?
   Where did the incident occur?
   What was the injury to the victim?
   How was it managed?

2. Could you now give me an example of a less severe act of violence that happened recently in the hospital.
   What were the long term and more immediate events that preceded it?
   Where did the incident occur?
   What was the injury to the victim?
   How was it managed?

3. What are the possible explanations for these patients' behaviours?

4. How important would you say each of these are in explaining the patients' behaviour?
5. Could you please tell me about as many possible staff responses to violent incidents in general.

- prompts;

- what might be vigilant responses?

- what might be therapeutic responses?

- what might be the physical responses taken by staff?

- what punitive responses might be used?

6. Could you tell me about some of the daily activities of patients on the wards and in other areas of the hospital.

7. Can you tell me about the possessions that patients are allowed to keep in their rooms?

8. Which wards are you currently managing?
QUESTIONNAIRE

Thank you for agreeing to participate in this study about staff views on aggression in the hospital. This should take about 20 minutes. It is completely confidential, and you are not required to put your name on the questionnaire. It will be analysed by people outside the service, and a summary, but not individual responses, will be given to participants and managers. Please complete this form, and then the questionnaire which is attached. I would firstly like you to read the story below, and then answer the questions that follow.

**Story**

J is a 32 year old female/male patient, who was recently admitted to the hospital for offences of violence. S/he is classified as having a mental illness. J has had a very disturbed childhood, and during her/his adult life has been the victim of a number of assaults. Since her/his admission, s/he has regularly made threats to staff.

One day, whilst being escorted back to the ward from a morning art session, J argues with a fellow patient about some cigarettes that s/he lent to her. The member of staff intervenes and advises them to discuss this when they arrive back at the ward. J agrees to this, but a few minutes later, s/he suddenly becomes angry, kicks at the wall and shouts that no one can sort out her/his problems. S/he then turns towards the member of staff/other patient, and begins to make threatening gestures.

In real life, you would obviously have more information, but based on what you know from this story, and other information you have about people like J, please answer the following questions.

Below are some possible explanations for J’s behaviour.

For example, if you feel that her/his behaviour is a symptom of her poor anger management skills, you would place a tick on the line below as follows:

Very important \(\checkmark\) --- Very Unimportant

If you feel that poor anger management skills are not at all important in explaining her/his behaviour, you would indicate as follows:

Very important \(\checkmark\) --- Very Unimportant

However, if you feel neutral or unsure about how important or unimportant poor anger management skills are as an explanation, you would place a tick as follows:

Very important \(\checkmark\) --- Very Unimportant
SECTION A
Please indicate below, how far each statement might explain J’s behaviour

1. She/ He is frustrated at being held in secure conditions.
   Very Important --------------------------------- Very Unimportant

2. She/ He is impulsive
   Very Important --------------------------------- Very Unimportant

3. The other patient was provoking her/him
   Very Important --------------------------------- Very Unimportant

4. It was a culmination of events.
   Very Important --------------------------------- Very Unimportant

5. She/ He felt angry
   Very Important --------------------------------- Very Unimportant

6. Her/ His demands were not immediately met.
   Very Important --------------------------------- Very Unimportant

7. As an adult, she/ he has been the victim of a number of assaults.
   Very Important --------------------------------- Very Unimportant

8. Her/ His mental state is deteriorating.
   Very Important --------------------------------- Very Unimportant

9. She/ He resented the advice from the member of staff.
   Very Important --------------------------------- Very Unimportant

10. She/ He is a violent woman/man.
    Very Important --------------------------------- Very Unimportant

11. She/ He was unable to communicate her/ his feelings appropriately.
    Very Important --------------------------------- Very Unimportant
12 She/He was feeling wound up by the morning’s session.

Very Important ------------------------------------------------- Very Unimportant

13 She/He has experienced a difficult childhood

Very Important ------------------------------------------------- Very Unimportant

14 She/He is mentally ill.

Very Important ------------------------------------------------- Very Unimportant

15 She/He has poor anger management skills.

Very Important ------------------------------------------------- Very Unimportant

16 Do you have any other explanations for her/his behaviour?

The next few questions are about more general explanations of J’s behaviour.

17 Overall, would you say that this behaviour was likely to be a result of factors personal to him/her and enduring.

Very much so ------------------------------------------------- Not at all

18 Overall, to what extent would you say this behaviour was likely to be a result of factors personal to him/her and temporary?

Very much so ------------------------------------------------- Not at all

19 Overall, how much do you feel that this behaviour is likely to be a result of factors external to him/her?

Very much so ------------------------------------------------- Not at all

Now I would like you to indicate your responses to the following questions:

20 To what extent might J be likely to commit a similar act in the future?

Very likely ------------------------------------------------- Very unlikely

21 To what extent might J be likely to act similarly in other situations?

Very likely ------------------------------------------------- Very unlikely
22. To what extent might he/she be responsible for the act?

Very much so ------------------------------------------------------------- Not at all

23. How far do you feel that J is in control of his/her behaviour?

Very much so--------------------------------------------------------------- Not at all

24. To what extent do you feel he/she is to blame for the act?

Very much so--------------------------------------------------------------- Not at all

25. How much of a threat do you feel this incident is to other patients?

Very much so--------------------------------------------------------------- Not at all

26. How much of a threat do you feel the incident is to other members of staff?

Very much so--------------------------------------------------------------- Not at all

Now I would like to ask you about how you might handle the situation with J. If you were the member of staff in the story, what action would you take?

27. Adopt de-escalation techniques (e.g. give him/her body space)

Very likely--------------------------------------------------------------- Very unlikely

28. Use physical restraint.

Very likely--------------------------------------------------------------- Very unlikely

29. Use PRN medication.

Very likely--------------------------------------------------------------- Very unlikely

30. Seclude the patient.

Very likely--------------------------------------------------------------- Very unlikely

31. Encourage him/her to think of the consequences of his/her behaviour.

Very likely--------------------------------------------------------------- Very unlikely

32. Carry on as best you can as if nothing had happened.

Very likely--------------------------------------------------------------- Very unlikely

33. Identify a member of staff (who has a good relationship with J) to spend some time with him/her.

Very likely--------------------------------------------------------------- Very unlikely
34 Closely observe him/her for the next few hours
Very likely ---------------------------------------------------------- Very unlikely

35 Contact other members of staff for assistance
Very likely ---------------------------------------------------------- Very unlikely

36 Avoid contact with patient, and let other staff deal with him/her.
Very likely ---------------------------------------------------------- Very unlikely

37 Refer him/her to Psychology.
Very likely ---------------------------------------------------------- Very unlikely

38 Initiate a short period of time out.
Very likely ---------------------------------------------------------- Very unlikely

39 Change the care plan
Very likely ---------------------------------------------------------- Very unlikely

40 Impose a sanction (e.g. suspend an activity)
Very likely ---------------------------------------------------------- Very unlikely

41 Talk to the staff member who ran the morning group that J attended.
Very likely ---------------------------------------------------------- Very unlikely

42 Help him/her to explore his/her feelings
Very likely ---------------------------------------------------------- Very unlikely

43 Recommend him/her for anger management training
Very likely ---------------------------------------------------------- Very unlikely

44 Contact the RMO.
Very likely ---------------------------------------------------------- Very unlikely

45 Do you have any other strategies that you would use (please specify) ..........................

46 How supported do you feel by colleagues in dealing with incidents such as the one in the story?
Very Supported-------------------------------------------------------Not at all Supported

47. How supported do you feel by managers in dealing with such incidents?
Very Supported-------------------------------------------------------Not at all Supported

X X √
48 What additional support would you find helpful in dealing with incidents such as these?

SECTION B
Now I would like to ask you about your attitudes to patients in Special Hospitals. Please rate how much you agree or disagree with the following statements.

1. Patients in Special Hospitals are different from most people.
   Strongly agree-------------------------------strongly disagree

2. Only a few Special Hospital patients are really dangerous.
   Strongly agree-------------------------------strongly disagree

3. Special Hospital patients never change.
   Strongly agree-------------------------------strongly disagree

4. Most patients in Special Hospitals are victims of circumstance, and deserve to be helped.
   Strongly agree-------------------------------strongly disagree

5. Patients in Special Hospitals have feelings like the rest of us.
   Strongly agree-------------------------------strongly disagree

6. It is not wise to trust a Special Hospital patient too far.
   Strongly agree-------------------------------strongly disagree

7. I think I would like a lot of Special Hospital patients.
   Strongly agree-------------------------------strongly disagree

8. Bad hospital conditions just make a Special Hospital patient more bitter.
   Strongly agree-------------------------------strongly disagree

9. Give a Special Hospital patient an inch, and s/he'll take a mile.
   Strongly agree-------------------------------strongly disagree

10. Most Special Hospital patients are stupid.
    Strongly agree-------------------------------strongly disagree

11. Special Hospital patients need affection and praise just like anybody else.
    Strongly agree-------------------------------strongly disagree

12. You should not expect too much from a Special Hospital patient.
    Strongly agree-------------------------------strongly disagree

13. Trying to rehabilitate Special Hospital patients is a waste of time and money.
    Strongly agree-------------------------------strongly disagree
14. You never know when a Special Hospital patient is telling the truth

Strongly agree---------------------------------------------strongly disagree

15. Patients in Special Hospitals are no better and no worse than other people

Strongly agree---------------------------------------------strongly disagree

16. You have to be constantly on your guard with Special Hospital patients

Strongly agree---------------------------------------------strongly disagree

17. In general, Special Hospital patients think and act alike.

Strongly agree---------------------------------------------strongly disagree

18. If you give a Special Hospital patient respect, s/he'll give you the same

Strongly agree---------------------------------------------strongly disagree

19. Patients in Special Hospitals only think about themselves.

Strongly agree---------------------------------------------strongly disagree

20. There are some Special Hospital patients I would trust with my life

Strongly agree---------------------------------------------strongly disagree

21. Patients in Special Hospitals will listen to reason.

Strongly agree---------------------------------------------strongly disagree

22. Most Special Hospital patients are too lazy to earn an honest living.

Strongly agree---------------------------------------------strongly disagree

23. I wouldn't mind living next door to an ex-Special Hospital patient.

Strongly agree---------------------------------------------strongly disagree

24. Patients in Special hospitals are just plain mean at heart.

Strongly agree---------------------------------------------strongly disagree

25. Patients in Special Hospitals are always trying to get something from somebody.

Strongly agree---------------------------------------------strongly disagree

26. The values of most Special Hospital patients are about the same as the rest of us

Strongly agree---------------------------------------------strongly disagree

27. I would never want one of my children dating a Special Hospital patient.

Strongly agree---------------------------------------------strongly disagree

28. Most Special Hospital patients have the capacity for love.

Strongly agree---------------------------------------------strongly disagree

29. Special Hospital patients are just plain immoral.

Strongly agree---------------------------------------------strongly disagree
30. Patients in Special hospitals should be under strict harsh discipline.
   Strongly agree---------------------------------------------------------------strongly disagree

31. In general Special Hospital patients are basically bad people.
   Strongly agree---------------------------------------------------------------strongly disagree

32. Most Special Hospital patients can be rehabilitated.
   Strongly agree---------------------------------------------------------------strongly disagree

33. Some Special Hospital patients are pretty nice people.
   Strongly agree---------------------------------------------------------------strongly disagree

34. I would like associating with some Special Hospital patients.
   Strongly agree---------------------------------------------------------------strongly disagree

35. Special Hospital patients respect only brute force.
   Strongly agree---------------------------------------------------------------strongly disagree

36. If a patient does well in the Special Hospital, s/he should be let out early.
   Strongly agree---------------------------------------------------------------strongly disagree

SECTION C
Now I would like to ask you some questions about yourself.
1. How old are you? ..............
2. Are you male/female? .............
3. What formal qualifications do you have for your job? ..................................
4. If you have been the victim of a patient's aggression, please rate how frequently this has occurred.
   Very frequent---------------------------------------------------------------Not at all
5. At its most severe, please rate the severity of your injuries.
   Very serious---------------------------------------------------------------Not at all serious.

Thank you very much for completing this questionnaire.
Please put it into the sealed envelope and then into the labelled envelope in the office. If you have any additional comments you'd like to make, feel free to attach an extra sheet or use the space overleaf.
APPENDIX 4

Factor Analyses of Attributions, Management Strategies and Attitudes.

Additional factors for attributions, items and factor loadings (the variance accounted for is in brackets).

<table>
<thead>
<tr>
<th>Factor 3</th>
<th>Factor 4</th>
<th>Factor 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>(10.3%)</td>
<td>(9.1%)</td>
<td>(6.8%)</td>
</tr>
<tr>
<td>(1.55*)</td>
<td>(1.36*)</td>
<td>(1.02*)</td>
</tr>
<tr>
<td>Her/ his demands were not immediately met 0.80</td>
<td>The other patient was provoking her/ him 0.73</td>
<td>She/ he was feeling wound up by the morning’s session 0.79</td>
</tr>
<tr>
<td>She/ he felt angry 0.71</td>
<td>She/ He resented the advice from the member of staff 0.62</td>
<td></td>
</tr>
<tr>
<td>It was a culmination of events 0.68</td>
<td></td>
<td></td>
</tr>
<tr>
<td>She/ He is impulsive 0.67</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: * = Eigenvalue.

Additional factors for management strategies, items and factor loadings (the variance accounted for is in brackets)

<table>
<thead>
<tr>
<th>Factor 4</th>
<th>Factor 5</th>
<th>Factor 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>(7.6%)</td>
<td>(6.5%)</td>
<td>(6.1%)</td>
</tr>
<tr>
<td>(1.37*)</td>
<td>(1.16*)</td>
<td>(1.10*)</td>
</tr>
<tr>
<td>Refer him/ her to Psychology 0.84</td>
<td>Recommend him/ her for anger management training 0.55</td>
<td>Carry on as best you can as if nothing had happened 0.88</td>
</tr>
<tr>
<td>Change the care plan 0.71</td>
<td>Contact the RMO 0.53</td>
<td>Contact other members of staff for assistance -0.53</td>
</tr>
</tbody>
</table>

Note: * = Eigenvalue
Additional factors for attitudes, items and factor loadings (the variance accounted for is in brackets).

<table>
<thead>
<tr>
<th>Factor 4</th>
<th>Factor 5</th>
<th>Factor 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>(4.9%) 1.76*</td>
<td>(4.8%) 1.73*</td>
<td>(4.4%) 1.58*</td>
</tr>
<tr>
<td>If a patient does well in the SH, she/he should be let out early 0.71</td>
<td>Patients in SH’s have feelings like the rest of us 0.73</td>
<td>I would never want one of my children dating a SH 0.75</td>
</tr>
<tr>
<td>There are some SH patients I would trust with my life 0.69</td>
<td>You should not expect too much from a SH patient 0.68</td>
<td>Only a few SH patients are really dangerous patient 0.60</td>
</tr>
<tr>
<td>You never know when a SH patient is telling the truth 0.53</td>
<td>Patients in SH’s are different from most people 0.51</td>
<td>I wouldn’t mind living next door to a SH patient 0.51</td>
</tr>
<tr>
<td>Patients in SH’s will listen to reason 0.41</td>
<td>It is not wise to trust a SH patient too far 0.49</td>
<td></td>
</tr>
<tr>
<td>Bad SH conditions just make a patient more bitter - 0.45</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factor 7</th>
<th>Factor 8</th>
<th>Factor 9</th>
<th>Factor 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>(4%) 1.43*</td>
<td>(3.6%) 1.31*</td>
<td>(3.3%) 1.18*</td>
<td>(3.1) 1.1*</td>
</tr>
<tr>
<td>You have to be constantly on your guard with SH patients 0.73</td>
<td>Most SH patients are stupid 0.76</td>
<td>SH patients respect only brute force 0.79</td>
<td>In general, SH patients think and act alike - 0.78</td>
</tr>
<tr>
<td>SH patients never change 0.43</td>
<td>Trying to rehabilitate SH patients is a waste of time and money 0.59</td>
<td>If you give a SH patient respect, she/he’ll give you the same 0.45</td>
<td></td>
</tr>
</tbody>
</table>

Note: * = Eigenvalue; SH = Special Hospital
## Appendix 5 Table 1  Complete taxonomy of spontaneous attributions

<table>
<thead>
<tr>
<th>Explanation</th>
<th>Condition according to gender of the vignette figure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>1. Functional.</td>
<td></td>
</tr>
<tr>
<td>“To get his own way”</td>
<td>3</td>
</tr>
<tr>
<td>“To gain attention”</td>
<td></td>
</tr>
<tr>
<td>“To gain reassurance”</td>
<td></td>
</tr>
<tr>
<td>“Learned behaviour”</td>
<td></td>
</tr>
<tr>
<td>2. Skills based.</td>
<td>2</td>
</tr>
<tr>
<td>“Jenny lacks coping skills/ has poor understanding”</td>
<td></td>
</tr>
<tr>
<td>“Patient has poor ability to deal with the situation”</td>
<td></td>
</tr>
<tr>
<td>“Patient lacks social skills”</td>
<td></td>
</tr>
<tr>
<td>“Unable to express needs appropriately”</td>
<td></td>
</tr>
<tr>
<td>“She’s unable to deal with the situation in an appropriate way”</td>
<td></td>
</tr>
<tr>
<td>3. Interpersonal.</td>
<td>1</td>
</tr>
<tr>
<td>“Personality clashes between patient and staff”</td>
<td></td>
</tr>
<tr>
<td>“Poor relationship with intervening staff”</td>
<td></td>
</tr>
<tr>
<td>“Staff and patient may not get along”</td>
<td></td>
</tr>
<tr>
<td>4. Intrapersonal</td>
<td>3</td>
</tr>
<tr>
<td>“Patient finds it difficult to trust others”</td>
<td></td>
</tr>
<tr>
<td>“She has low self-esteem”</td>
<td></td>
</tr>
<tr>
<td>“Fear response/fight/flight reaction”</td>
<td></td>
</tr>
<tr>
<td>“The last straw for Joe, he no longer wants to be a victim”</td>
<td></td>
</tr>
<tr>
<td>“Powerlessness and difficulty accepting the situation”</td>
<td></td>
</tr>
<tr>
<td>“He may be afraid of something; he may be feeling out of control of his life”</td>
<td></td>
</tr>
<tr>
<td>5. Medical/physical</td>
<td>2</td>
</tr>
<tr>
<td>“Drug abuse”</td>
<td></td>
</tr>
<tr>
<td>“Medication may need changing; he may feel physically unwell”</td>
<td></td>
</tr>
<tr>
<td>6. Past history</td>
<td>-</td>
</tr>
<tr>
<td>“Patients’ past history”</td>
<td></td>
</tr>
<tr>
<td>7. Other.</td>
<td>1</td>
</tr>
<tr>
<td>“Not enough information”</td>
<td></td>
</tr>
<tr>
<td>“Difficult to make judgements on the basis of limited evidence”</td>
<td></td>
</tr>
</tbody>
</table>

Appendix-XXXI
Table 2

Complete taxonomy of spontaneous management strategies

<table>
<thead>
<tr>
<th>Management strategy</th>
<th>Condition according to gender of the vignette figure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>1. Direct contact with the patient.</td>
<td>4</td>
</tr>
<tr>
<td>“One to one session with named nurse”</td>
<td></td>
</tr>
<tr>
<td>“Encourage patient not to lend cigarettes”</td>
<td></td>
</tr>
<tr>
<td>“Problem solve with patient”</td>
<td></td>
</tr>
<tr>
<td>“Discuss after with patient”</td>
<td></td>
</tr>
<tr>
<td>“Explore other ways of coping with patient”</td>
<td></td>
</tr>
<tr>
<td>“Teach patient to use appropriate strategies”</td>
<td></td>
</tr>
<tr>
<td>“Talk to Jenny afterwards”</td>
<td></td>
</tr>
<tr>
<td>“Explore alternative strategies with patient”</td>
<td></td>
</tr>
<tr>
<td>2. Alternative strategies.</td>
<td>4</td>
</tr>
<tr>
<td>“Offer alternative strategies”</td>
<td></td>
</tr>
<tr>
<td>“Use of snoezelen”</td>
<td></td>
</tr>
<tr>
<td>“Encourage use of punch bag/relaxation”</td>
<td></td>
</tr>
<tr>
<td>“Offer alternative activities, e.g. relaxation/snoezelen”</td>
<td></td>
</tr>
<tr>
<td>“Relaxation methods”</td>
<td></td>
</tr>
<tr>
<td>3. Distal approaches.</td>
<td>1</td>
</tr>
<tr>
<td>“Determine risk factor and initiate appropriate levels of observation”</td>
<td></td>
</tr>
<tr>
<td>“Complete a functional analysis”</td>
<td></td>
</tr>
<tr>
<td>“Timeout”</td>
<td></td>
</tr>
<tr>
<td>4. Other.</td>
<td>1</td>
</tr>
<tr>
<td>“Depends on patient and what feedback they give”</td>
<td></td>
</tr>
<tr>
<td>“Lack of information in story to answer”</td>
<td></td>
</tr>
</tbody>
</table>
Table 3

Complete taxonomy concerning the type of support staff would like in dealing with violence and aggression.

<table>
<thead>
<tr>
<th>Additional support required</th>
<th>Condition according to the gender of the vignette figure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>1. Training.</td>
<td>1</td>
</tr>
<tr>
<td>“C &amp; R” training</td>
<td></td>
</tr>
<tr>
<td>“Training”</td>
<td></td>
</tr>
<tr>
<td>“More training”</td>
<td></td>
</tr>
<tr>
<td>2. Debriefing.</td>
<td>2</td>
</tr>
<tr>
<td>“Post incident discussions”</td>
<td></td>
</tr>
<tr>
<td>“Debriefing after the incident”</td>
<td></td>
</tr>
<tr>
<td>“Debrief”</td>
<td></td>
</tr>
<tr>
<td>“Debriefing”</td>
<td></td>
</tr>
<tr>
<td>3. Support from other staff.</td>
<td>5</td>
</tr>
<tr>
<td>“Support staff present in making the appropriate decision”</td>
<td></td>
</tr>
<tr>
<td>“Multi-disciplinary team support”</td>
<td></td>
</tr>
<tr>
<td>“Rapid staff response”</td>
<td></td>
</tr>
<tr>
<td>“Clarification and support”</td>
<td></td>
</tr>
<tr>
<td>“More communication from other staff”</td>
<td></td>
</tr>
<tr>
<td>“Higher management to recognise what stresses are placed on ward staff dealing with these situations”</td>
<td></td>
</tr>
<tr>
<td>“Better communication with other staff”</td>
<td></td>
</tr>
<tr>
<td>4. Resources.</td>
<td>-</td>
</tr>
<tr>
<td>“Greater staffing levels”</td>
<td></td>
</tr>
<tr>
<td>“More facilities for crisis intervention”</td>
<td></td>
</tr>
</tbody>
</table>

Appendix-XXXIII