Acknowledgements

I would like to gratefully acknowledge the contributions of my research supervisors, Fred Furniss and Andrew Papadopoulos and all of those people in the host NHS who have helped me in the research process or participated in this research.
Challenging behaviour in older adults:
A study of care staff attributions and management.

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Submitted in partial fulfilment of the degree of
Doctorate in Clinical Psychology,
University of Leicester,
Challenging behaviour in older adults:
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Objectives. The aim of this study was to explore the application of Weiner's attributional theory of motivation and emotion to care staff working with older adults with challenging behaviour. The research aimed to examine the effect of challenging behaviour type and dependency levels on attributions; and the role of optimism and positive affect as mediators for willingness to care for and change patients' behaviour. The study further aims to investigate associations between attributions and management of challenging behaviour by care staff, including abusive and depersonalising actions.

Design. A two-factor repeated measures design was used to examine the relative effect of dependency and challenging behaviour upon ratings of attributional dimensions, affect, optimism, and two variables of care staff behaviour. Correlations and path analysis were employed to examine the role of affect and optimism upon the care staff behaviour variables. ANOVAs and correlations were used to examine the effect of challenging behaviour type and dependency upon management strategy use and correlations were used to examine relationships between attributions, affects and management strategies.

Method. The participants were 46 unqualified care staff working in specialist NHS mental health residential settings for older adults. Participants rated six vignettes of scenarios of challenging behaviour of older adults for attributions, affects, optimism, and willingness to care for and change the behaviour of the client. Care staff also rated the likelihood that they would use a variety of management strategies in response to the behaviour.

Results. Significant differences in attributions were found for different dependency levels and challenging behaviour types. Correlations and path analysis showed that caring for clients was inversely predicted by negative emotion, which was predicted by control. Willingness to change the client's behaviour was best predicted by optimism, which was inversely related to attributions of stability. Abusive strategy use was significantly higher for high dependency clients and was associated with negative affect.

Conclusion. The results are consistent with Weiner's attributional theory of motivation and emotion and are discussed in relation to previous research and the wider literature. Clinical implications of the research in the areas of staff training and selection are discussed, as are suggestions for future research.
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1 INTRODUCTION

Longer life expectancies coupled with improved healthcare for chronic illnesses in recent years have led to an increased population of adults aged over 65 years and will in the future lead to even greater numbers of older people who are vulnerable or dependent and requiring residential care. Due to growing numbers of older people, there will also be a larger number of people with a dementia illness in the future. The national prevalence rate of dementia is estimated to be between 4 and 7 per cent (Jagger & Lindesay, 1993). Many people with dementia will require formal or informal care at some point in their illness and this task of providing formal care services has a significant impact on our health care delivery systems (Pajk, 1984). Traditional approaches to care of older people are often inappropriate or have mixed efficacy for managing care of people with dementia. It has been established that for institutions and for informal carers the greatest burden of care arises not from cognitive impairment and what the person can no longer do; but from challenging behaviour, what the person has started to do (Stokes, 2000). Increased understanding of the significance of the relationship between caregiver's interactive approaches and the behavioural responses of a person with dementia will facilitate the development of research based management techniques.

1.1 Residential Care for People with Dementia.

Implementation of Community Care policy in the United Kingdom has led to a greater proportion of adults over 65 years old being supported within their own homes or those of their carers and the closure of many long-stay beds in psychiatric and general hospitals (Baillon, Scothern, Neville & Boyle, 1996). These services have been re-provided by residential and nursing homes run by local authorities and by the private sector. Between 67% (Mann, Graham & Ashby, 1984) and 87% (Harrison, Savla & Kaftetz, 1990) of the residents of local authority Part III residential homes have been shown to be suffering from dementia to some degree. Dementia thus represents one of the most common clinical syndromes affecting older people and is over-represented amongst those living in institutional settings.
However it does not appear that the presence of dementia per se is the crucial factor influencing admission to an institution. Several studies have investigated the cause of entry into residential care for people with dementia and have found that levels of stress and wellbeing felt by the main carers are the most important predictors of the breakdown of home support (Jerrom, Mian & Rukanyake, 1993). Other studies have found that families are more likely to request institutional care because of the effects of behavioural disturbance than because of intellectual impairment in itself (Barnes & Raskind, 1980; Chenoweth & Spencer, 1986; Silver & Yudofsky, 1987). Once admitted into residential care, behavioural disturbance is often the reason for transferring the older person to another institution or to hospital (Mace, 1990). In fact, one study has shown that challenging behaviour is the most common reason for psychiatric referral, treatment with psychotropic drugs and hospitalisation (Steele, Rouner, Chase & Folstein, 1990). This has resulted in remaining NHS services such as older adult mental health assessment wards and continuing care units caring for an increasing proportion of patients with dementia and presenting behavioural disturbance.

1.2 Challenging behaviour in dementia.

There are many different types of dementia with different causes but all dementias represent a global deterioration in the mental functioning, affecting cognition, personality and behaviour to differing degrees, in an otherwise alert patient (Lishman, 1987). During the course of dementia, the process of cognitive deterioration will be accompanied by behavioural changes although by no means all people suffering with dementia will develop challenging behaviours. The term ‘challenging behaviour’ encompasses a wide range of perceived difficulty, and although the term is often assumed to be describing an inherent feature of the person, challenging behaviour really refers to the interaction between a person and his/her environment. As such the behaviour of persons with dementia presents challenges to informal and professional caregivers by making the task of caring more difficult, interfering with effective communication and decreasing quality of life (Allen-Burge, Stevens & Burgio, 1999).
1.2.1 The relationship between challenging behaviour and organic impairment and medical conditions.

Despite the increased frequency of challenging behaviours amongst older people suffering from dementia (as opposed to other psychiatric conditions), it is not clear that those people with greater severity of cognitive impairment are also those who show most challenging behaviour. Kitwood discusses the shortcomings of a view of dementia symptoms in general as caused solely by organic brain damage, given the lack of strong and consistent correlations between the degree of dementia and the extent of neuropathology found post-mortem (Kitwood, 1997a, p24-25). Particular types of challenging behaviour have been linked to damage in particular regions of the brain, (e.g. an association has been found between parietal lobe pathology and wandering, (De Leon, Potegal & Gurland, 1984) and between frontal lobe pathology and increased aggression and abnormal sexual behaviour (Lishman, 1987)). Challenging behaviour may also temporarily occur because of other medical conditions of the person. For example a urinary tract infection may lead to delirium and as a result, to challenging behaviour whilst the infection remains. But to expect a simple relationship between deterioration of brain tissue and behaviour would be to ignore other important factors such as the environment or personal interactions as precursors to challenging behaviour. This view has been supported by a study that investigated the relationship between the level of cognitive impairment and challenging behaviour (Martin, McKenzie & Ames, 1994). The study used the Rating Scale for Aggressive Behaviour in the Elderly (RAGE) (Patel and Hope, 1992) to measure levels of challenging behaviour and the Mini Mental State Exam (MMSE; Folstein, Folstein & McHugh, 1975) to measure severity of dementia in residents of nursing homes. The study failed to find any relationship between cognitive impairment and aggressive behaviour, this is consistent with other longitudinal research into challenging behaviour indicating that aggressive behaviour once present is likely to persist over the course of the dementia (Keene et al., 1999). Thus any explanation of the aetiology of challenging behaviour must take psychological and environmental variables into account as well as neuropathological factors.
1.2.2 The psychological understanding of challenging behaviour.

Challenging behaviour can be explained in psychological terms as the attempt by the person with dementia to communicate a personal need (Stokes, 1996). Usually a person develops from a child to an adult and learns to communicate and meet his/her needs in a sophisticated and mature manner. As dementia progresses this sophistry is lost and the person may resort to crude or inappropriate ways of communicating these needs and desires. The need for emotional security and physical safety may be particularly high for dementia sufferers as they can find themselves in a world they do not understand. The communication of this need may manifest as demanding behaviour or a desire to be close to carers at all times. In situations where the person feels threatened, aggression may be the behaviour they use to communicate their fear and to prevent further actions on the part of the carer. Some behaviour may be a repetition of antisocial behaviours performed prior to the person’s illness, now out of context and without the motivation that formerly accompanied them. Sixsmith, Stillwell and Copeland (1993) demonstrated that in supportive, person-centred residential settings, temporary improvements in cognitive and functional abilities and a reduction in social disturbance were observed. Those people who had previously been labelled as having aggressive or anti-social behaviour, anxiety and chronic restlessness, were those who improved most. This study provides more evidence that psychological and social factors exert a powerful influence on challenging behaviour.

1.2.3 Topography of challenging behaviour in dementia.

Research into challenging behaviour in dementia has been hampered by the lack of topographical description of the behaviours under investigation (Patel & Hope, 1993; Stokes, 2000, p17). There are various ways of categorising challenging behaviour: Allen-Burge et al., (1999) refer to behavioural excesses where the performance of a behaviour is problematic (e.g. disruptive vocalisation) and behavioural deficits where the non-occurrence of a behaviour is problematic (e.g. lack of feeding skills). Hope, Keene, Fairburn, McShane, and Jacoby (1997) refer to three behavioural syndromes: overactivity, aggressive behaviour, and psychosis. Of greatest concern (Patel & Hope, 1993) is the propensity to label a behaviour but not define further the causes or context of the behaviour leading to a number of distinct behaviours of different aetiology being classified using the same label. For example ‘toiletting difficulty’ may be used as the
label for such distinct behaviours as forgetting where the toilet is and aggression during toileting. Stokes (2000) argues that if labels are used the group of staff involved should all agree with reference to a particular individual patient what the label describes and the possible causes and function of such behaviour.

Despite the above difficulties of categorisation, some research has been carried out exploring the prevalence of challenging behaviours occurring in dementia. Studies (e.g. Jackson, Templeton & Whyte, 1999; Martin et al., 1994) have identified higher rates of challenging behaviour amongst residents of nursing homes and psychiatric wards than amongst those living in community settings. The most common behaviours appear to be aggressive behaviours (Burns, Jacoby & Levy, 1990b) and disruptive vocalisation (Cariaga, Burgio, Flynn & Martin, 1991).  In a British study of 178 patients clinically diagnosed with Alzheimer’s disease, 20% of patients exhibited aggressive behaviour likely to result in harm to other people. Aggressive behaviour was found to be more frequent amongst those older people in a psychiatric institution than amongst those living at home (Burns, et al., 1990b). Violent incidents, defined as acts of actual physical aggression involving physical contact were retrospectively studied by Shah (1995) and found to be relatively uncommon (29 incidents reported in 36 months) and committed by 18 per cent of patients in an acute psychogeriatric assessment ward. All of the incidents recorded were of minor severity, not resulting in any discernible injury. However, Eastley, MacPherson, Richards and Mian (1993) discovered a mean rate of 2.27 assaults by residents per member of staff per week in various types of settings. Freyne and Wrigley (1996) studied aggressive incidents on a long stay ward in the Republic of Ireland. They found that 89 per cent of incidents occurred during some form of nursing intervention, most usually while the person was being dressed or undressed or being washed. In a prospective, 10 year, English, study (Keene et al., 1999) it was found that most types of aggression are related to one another. Their longitudinal data showed that aggressive behaviour, in particular verbal aggression, occurs in most people at some stage during the course of dementia. There was some evidence of progression from verbal aggression to physical types of aggression, although there was wide variation. Aggressive resistance to care, physical, and verbal aggression are likely to persist until death.
Other challenging behaviours may stem from the psychiatric features of dementia, Burns, Jacoby and Levy (1990a) found that 16 percent of their subjects had delusions, the content of which was most commonly theft or suspicion. Such delusions can lead to difficulties in caring for the individual and to conflict between the older person and other patients and staff. Challenging behaviour has also been described in relation to disruptive vocalisation (Cariaga, et al., 1991) which is described as including loud requests for attention, chronic screaming, self-talk, negative remarks, and the use of obscenities. Eating difficulties (Burns et al., 1990b), sexual behaviour (Haddad & Benbow, 1993) and inappropriate walking or wandering (Rabins, Mace & Lucas, 1982) have also been described in the literature.

Souder et al (1999) conducted a study in the USA that examined the context in which various disruptive behaviours occurred. They found that almost half of the behaviours recorded started in the resident’s bedroom, and that behaviours rarely occurred during an organised activity or when proceeding to an activity. Most behaviours occurred during times of relative inactivity: sitting, walking or awaiting meals or medication. By contrast Ryden, Bossenmaier and McLachlan (1991) found that the majority of incidents occurred after a touch or invasion of personal space which occurred as part of the caregiving process, a finding supported by Burgener, Jirovec, Murrell and Barton (1992); and by Freyne and Wrigley (1996).

Challenging behaviour in the context of dementia is a common phenomenon that impacts upon members of staff, other residents and the person’s own quality of life. The range of behaviours that may be perceived by others to be challenging is large, however, the most common challenging behaviours appear to be physical and verbal aggression. Challenging behaviour can occur in any context but is most likely to occur when the person is receiving care and least likely to occur when the person is engaged in an activity.

1.3 Management of Challenging Behaviour in Dementia

Managing challenging behaviour has become an important part of the work of care staff working with older adults in nursing homes and NHS psychogeriatric wards. As seen
above, the range of behaviours that can be considered challenging is wide. Research into the management of such behaviours has been criticised for using vague definitions of the behaviour in question, reliance upon poorly selected controlled studies and the selection of patients into intervention groups (Lawlor, 1999); and methodological difficulties such as small samples and poor compliance of staff (Archibald, 1999). Interventions for challenging behaviour have fallen into two major categories: medical or pharmacological treatment; and psychosocial treatments.

A complete review of medical and pharmacological treatments for challenging behaviour in dementia is beyond the scope of this review. However a literature review by Furniss, Craig and Burns (1998) outlines the major issues in treating challenging behaviour with drugs. Furniss et al. revealed that neuroleptic medication is frequently used as treatment for challenging behaviour, particularly for behaviours such as 'overactivity', agitation and 'objectionable' behaviour. Such behaviours are often defined subjectively. The efficacy of such medication has not been established. They describe how neuroleptics are typically used for behavioural disturbance in the absence of psychotic phenomena, despite the significant side effects such as Parkinsonism, akathisia and constipation. Long-term use of neuroleptics has also been associated with a greater risk of recurrent falls, fractured neck of femur and an increased rate of cognitive decline. Burns (1993) reports several recommendations regarding antipsychotic medication use with older people. These guidelines include: the need for a full assessment of each individual of underlying environmental factors; that simple and safe behavioural interventions should be considered before medication is tried; that antipsychotic medications should be reserved for those patients with severe behavioural disturbance; and that medication should only be given for a short time and discontinued after resolution of the behavioural disturbance.

Psychosocial approaches to managing challenging behaviour in care settings have taken several different forms: specific approaches developed for specific problems; therapeutic activity programmes; behavioural analysis and modification; and person-centred care. Opie, Rosewarne and O’Connor (1999) have produced a systematic literature review of the efficacy of psychosocial approaches to behavioural disturbance in dementia and conclude that research into such treatments is often poorly designed
and reported. They found it easier to interpret the results of those studies that had examined a single behaviour or intervention and found evidence to support efficacy of activity programmes, music, behaviour therapy, light therapy, carer education and changes to the physical environment.

Specific approaches have mostly been described in the literature in the style of case study interventions. One example is the use of finger foods to promote autonomous feeding by residents with dementia (Van Ort & Phillips, 1995). Aggressive resistance during personal care can be minimised if the carer remains relaxed and smiling (Burgener et al., 1992). Another example is of a psychosocial intervention for wandering behaviour described by Stokes (2000). He suggests that when someone leaves a building observed, two staff members may intervene by the first carer joining the resident in a walk followed by the second asking if they would both return. Stokes suggests that this method may work through a trusting bond being established between the first carer and the resident and through the passage of time whereby the resident has forgotten their reason for leaving and may start to feel cold or tired and wish to return to the building.

Therapeutic activity programmes have attempted to reduce dementia-related problem behaviours by increasing engagement in pleasurable activities. Music, visual arts, ‘Snoezelen’ multisensory environments, and pet therapies have been used in this way. Lord and Garner (1993) report that a group of participants in a ‘big band’ music group showed greater subjective levels of enjoyment and social interaction than a group of residents who engaged in ‘standard’ recreational activities of drawing, painting and TV. Baker, Dowling, Wareing, Dawson and Assey (1997) contrasted two groups participating in eight Snoezelen sessions or eight ‘other’ activities. The Snoezelen group showed significant reductions in disturbed behaviour.

Behaviour modification follows on from behavioural analysis and involves the application of operant conditioning principles and procedures to modify behaviour. It is assumed that the challenging behaviour is unwittingly being reinforced either by the environment or the social situation following the event. Behaviour modification involves the withdrawal of the intrinsic or external rewards of a behaviour (such as
attention) to extinguish negative behaviours, and the reinforcement of positive
behaviour through rewards. Unfortunately there are few accounts of successful
behaviour modification interventions for individuals with dementia (Stokes, 2000). It
has been suggested that the profound learning deficit that characterises dementia may
interfere with the acquisition of new information contained in the intervention
programmes. An alternative to influencing the reinforcers of a behaviour is to control
aspects of the environment that are influential in triggering that behaviour. This is
known as ‘stimulus control’. There is some evidence to suggest that stimulus control
methods may be effective with people with dementia, for example covering a door with
a piece of material to prevent people from exiting the room (Namazi, Rosner &
Calkins, 1989). However, it is also widely recognised that staff of residential settings
rarely continue to maintain interventions such as behaviour modification or stimulus
control consistently and indefinitely (Moniz-Cook et al., 1998; Allen-Burge et al.,
1999). A further potential criticism of behaviour modification methods may come from
the lack of value accorded to the person by the application of such methods in the
absence of a person-centred understanding of the behaviour. Behaviour modification
alone does not attempt to meet the needs of the person with dementia, needs that may
be being expressed through their behaviour. If behaviour modification programmes
concentrate solely on the elimination of negative behaviour and the encouragement of
positive behaviour no attempt is made to understand the meaning of the behaviour for
the person. Behaviour modification techniques can be useful (for example the
avoidance of reinforcing unwanted behaviour by paying it unnecessary attention)
however, if used in isolation they are out of step with contemporary values (Stokes,
2000).

Kitwood and Bredin (1992) and Stokes (2000) advocate a person-centred approach for
managing challenging behaviour. Stokes (2000) suggests that first it is necessary to
operationally define the behaviour, then assess the need or function that is being
expressed or served. This may involve gaining information about the person’s life
history and personality to understand their motivation for the behaviour. The meaning
behind the person’s behaviour should be understood and resolved in any intervention.
For example it has been suggested that often the meaning behind aggressive resistance
during intimate care may be the misinterpretation of the care as a threat resulting in fear
The intervention is then devised. This will involve either an alternative means for the person to express their need, an alternative environment or stimulus that does not lead to the feelings aroused in the person with dementia that trigger challenging behaviour, or a different staff response aimed at helping the person understand what is going on around them. The art is in learning to manage behaviours so that they do not cause stress or anxiety for the identified patient, other clients or the staff themselves. This can mean that an intervention may simply entail the staff relabelling the behaviour to express the intent, needs and positive aspects of the person and to reduce the staff member’s stress associated with the behaviour. Kitwood (1997a; pp 103-112) emphasises how an organisation that cares for the clients in a person-centred manner will also be an organisation that cares about its staff and treats them as persons also.

1.4 The Relationship between Challenging Behaviour and Staff Stress.

Challenging behaviour is by definition difficult for staff to manage and most care staff have limited specific training in recognising the causes of behavioural problems (Baillon, et al., 1996). As the number of psychogeriatric wards decrease, staff in NHS settings and nursing homes for older people with mental health problems are facing increasing levels of aggression and behaviour disturbance by patients (Shah, 1995; Freyne & Wrigley, 1996; and Moniz-Cook et al., 1998). Some challenging behaviour will even represent workplace abuse of the care staff. Eastley et al., (1993) discovered high rates of assault (over 2 per week per member of staff) by residents in various types of residential settings managed by untrained staff without specialist support in assessment and management. The highest rates of assaults per member of staff were found in psychogeriatric hospital wards.

In other studies, resident aggression, and abuse of staff by residents has been found to be related to staff psychological disturbance. In a large study of 326 staff working in residential and nursing homes across England, Moniz-Cook, Woods and Gardiner, (2000) found that staff anxiety was associated with perceived management difficulty of 14 vignettes of challenging behaviour. McPherson, Eastley, Richards and Mian (1994) found that staff who experienced greater frequency of resident assault were more likely
to score at or above the ‘case’ cut off for psychological disturbance on the General Health Questionnaire. Freyne and Wrigley (1996) asked nursing staff of a 40 bed long-stay ward for people with dementia and associated behaviour problems how aggressive incidents impacted upon them. They found that although the severity of incidents was mild (no injury) or moderate (involving a superficial injury), in most cases the nurses rated themselves as ‘quite upset’ and found the aggressive behaviours ‘very difficult’ to cope with. This is consistent with research that has examined the relationship between challenging behaviour and the levels of stress and psychiatric morbidity amongst informal carers (Gilleard et al, 1984; Kinney & Paris Stephens, 1989).

Why is caring for older people with challenging behaviour so stressful? Kitwood refers to a model in depth psychology, first described in nursing by Isabel Menzies (1959, cited in Kitwood 1997a, p114). Menzies described how the organisational structures function to prevent the potentially overwhelming anxieties and strong emotions generated by close contact with illness and death from reaching consciousness. Defensive behaviours (such as task orientated care, distancing clients and using dehumanising labels) arise from avoidance of such feelings and the anxiety evoked by them, but conflict with the primary task of nursing and contribute little to long term reductions in anxiety. Steinmetz (1988; cited in Marriott, 1997) also comes to a similar conclusion, suggesting that carer’s perception of stress and the problems involved in providing social emotional support for an elder may be more difficult for carers than coping with caregiving roles that are more task orientated and practical in nature.

Moos and Schaefer, (1987) describe the influence on an individual member of staff as arising from two major systems: the environmental system and their personal system. The environmental system includes aspects such as the organisation of the home, its physical characteristics, policies and structures and the work social climate. The personal system encompasses work-related issues such as the type of job and the person’s work role and non-work factors such as the person’s personal resources and coping mechanisms. The environmental and personal systems are seen as interactive and appraisal of the various aspects of the systems is seen as the primary influence on the degree of tension and stress perceived by the staff member.
1.4.1 Burnout and the cognitive appraisal model of coping with stress.

Appraisal is a central concept in the model of psychological stress of Lazarus and Folkman (1984; p11). According to this theory stress is a 'particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her personal resources and endangering his or her well-being'. The cognitive appraisal model of stress is a transactional model, and represents a reciprocal relationship between cognitive appraisal and coping as mediators of stress. Novack and Chappell (1994) have found support for a cognitive appraisal model of burnout in staff working with older adults with challenging behaviours.

Burnout is a syndrome of emotional exhaustion, depersonalisation of clients and a reduced sense of personal accomplishment. (Maslach, 1982). Burnout often occurs among staff members who work closely and extensively with people who have severe social and health problems. It is sometimes thought to arise from intense involvement over a long period of time, perhaps with difficult clients, where improvements are limited or non-existent and where there is little support from colleagues and superiors (Maslach, 1982). Benbow (1998), in a review of the literature on burnout and professionals in old age psychiatry, points out that in common with other professions, nurses for older people with dementia and behaviour problems can suffer from burnout. Burnout is a concern for institutions not only because of its relationship with staff absence and turnover but also because it has negative consequences for the quality of care provided (Kitwood, 1997a, p107-109).

The relationship between burnout and challenging behaviour is complicated. In a study of Canadian nursing assistants (NAs), Chappell and Novack (1992) found that the proportion of clients with cognitive impairment and behavioural problems did not relate to the burden experienced by the NAs. Instead, those who lacked rewards in their job, who had fewer social supports and who had not been trained in working with cognitive impairment were more likely to experience burnout.

In a further study (Novack & Chappell, 1994) cognitive appraisal was used to explain the phenomenon of burnout. Burnout amongst the nursing assistants interviewed by Novack and Chappell (1994) was not explained solely in terms of external conditions.
(e.g. the type of patients in a caseload). Appraisal of the conditions and of patient behaviours was also an important contributor to burnout. A nursing assistant, who feels distressed by patient behaviours, even if those behaviours happen infrequently, will tend to feel chronic distress or burnout. As this feeling grows the nursing assistant will feel more distressed by the behaviours and will react more negatively to patients. Nursing assistants who found their work most unpleasant and those who had the strongest negative reactions to patient behaviours tended to depersonalise patients most. This may represent a way of coping with the perceived unpleasantness of the work. Depersonalisation probably affects patients more directly than other aspects of burnout leading staff to treat patients as objects and hurry through their work. This is not an inevitable consequence of working with cognitively impaired older people however. Nursing assistants who interpret the potentially disturbing behaviours and make positive self-appraisals about satisfaction and competence in their work will experience feelings of personal accomplishment and thus are less at risk of burnout. Partial confirmation of these results is reported by Rodney (2000). In a study examining the relationship of nurse stress and aggressive behaviour displayed by people with dementia, Rodney found that appraising the possibility of aggressive behaviour as threatening was related to an increase in nurse stress.

The effects of burnout upon the quality of care has been reported in a British study of workers in residential homes for the elderly. Jenkins and Allen (1998) found limited support for the hypothesis that staff burnout and distress would be associated with the quantity and quality of staff-patient interactions. Staff who reported higher levels on one subscale of the MBI (personal accomplishment; Maslach & Jackson, 1986) exhibited significantly more interactions with residents and staff who perceived involvement in decision making relating to their work showed significantly fewer negative staff-resident interactions.

Care staff for older adults may experience high degrees of challenging behaviour and physical aggression directed towards them. This is especially so in specialist settings for people with dementia and challenging behaviour such as psychogeriatric hospital wards. Challenging behaviour has been linked to increased psychological disturbance in staff and it is acknowledged that these staff can suffer from burnout. Burnout does
not appear to be directly associated with the incidence of challenging behaviour but is mediated by the appraisals that care staff make about incidents of challenging behaviour and their work in general. Burnout is a concern for providers of care for older adults because it may have an impact upon the quality of care given by a member of staff.

1.5 Quality of Care for People with Dementia

The quantity of activity and interactions within a home is a fairly immediate indicator of the quality of care. Woods and Britton (1985) provide a detailed review that draws attention to the very low levels of engagement which are often to be found in residential settings for the elderly. Interactions tend to focus around nursing tasks such as washing or dressing. However the quality of interactions is as relevant as the quantity and this consideration has led to developments in measurement of the quality of care for older people (Woods, 1996).

The quality of interactions between care staff and people with dementia and indeed between one person with dementia and another are not always of optimal quality. Suggested factors that may diminish the ability of nursing staff to manage disturbed patients and are indicators of poor quality care include: authoritarian attitudes and under-involvement of medical staff (Wilkins, Mashaih & Jolley, 1978, cited by Shah & De, 1998; page 36); increased vulnerability among staff in conflict (Atakan, 1995; cited by Shah & De, 1998; page 36); demoralisation and incompetence among staff with a high turnover (Beck, Robinson & Baldwin, 1992); poor communication between staff and between staff and patients, and lack of experience negative or inappropriate attitudes (Anderson, 1970).

Kitwood (1997a) suggests that optimal care is achieved through the carer’s perception of the person with dementia as a person who has needs that are common amongst all people, but is also unique in terms of interests, personality and life history (personhood). This will contribute to a person’s wellbeing. He also suggests that a ‘malignant social psychology’ a process in which the care environment or social interactions are harmful and damaging to personhood, surrounds people with a
diagnosis of dementia. Sometimes the quality of care is so poor that it may be defined as elder abuse. Both malignant social psychology and elder abuse are important issues in dementia care and in the management of challenging behaviour and will be considered below.

1.5.1 The relationship between challenging behaviour and Kitwood's dialectical framework of dementia and Malignant Social Psychology.

Kitwood (1997a) proposes that it is overly deterministic to believe that all of the behavioural disturbance associated with dementia comes about as a result of a neurological process, and instead believes, like other writers before him (e.g. Meacher, 1972; Gwilliam & Gilliard, 1996) that social psychology and other general arrangements in care settings can contribute to the dementing process. He suggests that 'malignant social psychology' surrounds people with a diagnosis of dementia and is detrimental to their well being. The use of the word malignant does not imply any negative intent on the part of the caregivers. Rather 'malignant' represents the detrimental effect upon the person.

Some of the more common aspects of malignant social psychology in formal care settings have been operationalised in Dementia Care Mapping (Kitwood & Bredin, 1992; Kitwood, 1997b). This is one method of monitoring the quality of care and interactions in a residential setting. Dementia Care Mapping is an observational method of describing the culture of care and allowing the systematic recording and crude quantification of common aspects of interactions and events in care settings that are enhancing or detrimental to residents.

Poor care exists when the person is treated as a disease, task, or commodity and is a significant contributor to the illbeing of the person. Seventeen elements of malignant social psychology are described by Kitwood and are assessed in Dementia Care Mapping: treachery; disempowerment; infantilisation; intimidation; labelling; stigmatisation; outpacing; invalidation; banishment; objectification; ignoring; imposition; withholding; accusation; disruption; mockery; and disparagement (See Appendix 1 for more details). Such acts are incompatible with personhood, are likely
to induce behavioural disturbance and are widely accepted as being undesirable within dementia care (Stokes, 2000).

Kitwood (1997a) argues that many problem behaviours associated with dementia can be traced to the caregiving relationship. The depersonalisation, disempowerment and stigmatisation of the person, via the malignant social psychology process, augments the effect of neuropsychological impairment and behaviour deteriorates. Both passive and active resistance to this process is likely on the part of the person with dementia. From the perspective of caregivers, both disengagement and overt hostility are likely to confirm their belief that the disease is responsible for the person's increasingly abnormal behaviour.

Some actions that may be defined as examples of malignant social psychology may be so detrimental to the person that they will also fall within the definition of elder abuse.

1.5.2 The relationship between challenging behaviour in dementia and elder abuse.

Elder abuse has been described as:

'A single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.'

_action on Elder Abuse,
1999.

This global definition is often built upon to describe a number of different categories of abuse including physical, verbal, sexual, psychological, and financial (See Appendix 1 for more details). The research examining dementia as a risk factor for elder abuse is inconclusive (see Wolf, 1997a). Some of this research will now be reviewed. In 1993, Meddaugh used an ethnographic field observation technique and interviews to assess interaction between staff members and residents of a nursing home with cognitive
impairment. This brought attention to subtle forms of psychological abuse including personal choice issues, isolation, and labelling. It was also found that those older people least able to influence their care due to degree of cognitive impairment, aggressive behaviour and physical dependence were most at risk from the observed abusive behaviour, supporting a link between dementia and elder abuse.

Homer and Gilleard (1990) interviewed British informal carers of elderly people referred to a respite service, but found no association between a diagnosis of dementia and abuse. They did find evidence to suggest that characteristics of dementia such as the presence of disruptive behaviour may be more important than cognitive impairment however. Another American study sent questionnaires to carers who called a dementia support telephone helpline (Coyne, Reichman & Berbig, 1993). It was found that carers who were abusive were caring for patients who had greater functional impairment than those carers who were not abusive, supporting a link between dementia and abuse. But, this study also suggested that aggressive behaviours of the patient put them at risk of abuse by their carers. Cooney and Wrigley (1996) interviewed carers of dementia sufferers attending a day hospital in Ireland. They found higher rates of abuse of the dementia sufferers by their carers than experienced by the general population aged over 65. However, levels of cognitive impairment or behavioural disturbance did not differentiate between those who were at risk of abuse and those who were not. The researchers speculated that the lack of association between abuse and the levels of behavioural disturbance may be due to a ceiling effect since all 26 patients studied were already in contact with a specialist service and were more likely to have had behavioural problems. Pillemer and Suitor (1992) compared caregivers who were violent with caregivers who feared they would become violent, and found that abusive carers reported that they experienced more disruptive behaviour from the victim.

Payne and Cikovic (1995) investigated the relationship of abuse and dementia from a different perspective, that of abuse reported to and successfully prosecuted by the authorities. They conducted a thematic content analysis of cases of elder abuse reported to the Medicaid Fraud Control Units in America. Incidents in the reports indicated that the violence was a result of typical interactions occurring between patients and caregivers, and that caregivers use precipitating events to justify their
actions. They did not find evidence of a link between dementia and abuse. This report gives an interesting account of why care givers say they have committed abuse but it must be remembered that much elder abuse goes undetected and unreported, it could also be argued that those suffering from cognitive impairment will be least able to report abuse. Therefore the results of official investigations or prosecutions may be unrepresentative of much of the abuse that goes on in residential settings.

The research into the relationship between dementia and elder abuse is inconclusive. However it appears that although dementia *per se* may not be a risk factor for elder abuse, challenging behaviour is. The presence of challenging behaviour, particularly aggression, may be associated with a greater risk of abuse of the person with dementia by both professional and informal carers.

1.6 Research into Elder Abuse Perpetrated by Staff of Residential Settings.

There has been no major study of the prevalence or incidence of elder abuse in residential centres in Britain. In the United States 10-11% of nursing home staff in the Pillemer and Moore (1989) survey admitted that they themselves had committed physically abusive acts. In the UK the extent of abuse in residential centres is unknown, but the existence of abuse has been well documented in the UK by organisations that investigate complaints and collate information for public bodies such as the Social Services Inspectorate (Phillipson & Biggs, 1995: 189). In the report of their large survey, Pillemer and Moore (1990) differentiated between different types of abuse and the associated risk factors involved and led the way for a more detailed understanding of elder abuse. They found that members of staff who are burned out, and who experience significant staff-patient conflict are at greater risk of depersonalising residents and committing abusive actions. In addition staff were likely to retaliate when patients were aggressive towards them. They concluded by suggesting that a greater understanding of conflictual relationships between the elderly residents and staff would be crucial in understanding elder abuse. Pillemer (1988) went on to describe a model of abuse in institutions that is shown in Figure 1, and also has support from British researchers Phillipson and Biggs (1995).
The poor quality of some staff-resident interactions observed in homes for older people and the rigidity of institutional life has been termed 'institutional elder abuse'. Decalmer (1993; p59) has defined institutional elder abuse as a situation where the environment, practices and rules of the institution are abusive in themselves. Investigations by the Social Services Inspectorate and reports of investigations into malpractice in residential centres have provided information about the varied nature of abuse within institutional settings. This has included poor standards of privacy, the dehumanisation of older people in hospitals and homes, and care practices which are insidiously abusive in addition to actual physical, verbal and financial abuse (Bennett & Kingston, 1993).

Studies of the characteristics of staff that are associated with elder abuse have focussed on direct care staff who have most contact with the older person. Pillemer and Moore (1990) reported in a further paper that they found no evidence that variables such as educational level, length of time working in a nursing home, or staff grade were related to maltreatment. However, levels of staff-patient conflict and levels of burnout were found to be related to acts of physical abuse. Levels of burnout and patient aggression were also predictors of psychological abuse. Younger staff and those who had more negative attitudes towards elderly people were more likely to engage in psychological abuse.
MacPherson et al. (1994) also found a relationship between patient aggression and patient abuse, where staff suffering greater levels of patient aggression and greater psychological disturbance were more likely to shout back at abusive residents.

Elder abuse prevention training programmes for staff currently focus upon abuse recognition and reporting, managing aggression from patients, and upon staff attitudes to abuse (Pritchard, 1992; Pillemer & Hudson, 1993; Goodridge, Johnston & Thomson, 1997). One effect of an abuse training programme reported by Goodridge et al. (1997) was to reduce staff reports of conflict while the level of patient aggression remained at pre training levels. The staff changed their attitudes about the aggression and no longer defined situations in terms of conflict – the programme provided staff with new paradigms with which to contextualise abuse.

Recently Shaw (1998) has presented findings from a qualitative research study about responses of nursing home staff to abusive acts of residents. A number of different professional staff groups were interviewed and types of documentation were analysed to develop a grounded theory of immunity on behalf of direct care staff to provoked and unprovoked abusive acts by residents. Immunity is described as a self-protecting mind set, essential in preventing reactions of direct care staff, which are detrimental to themselves or the elder person. Phases of developing immunity included a socialisation to abuse and information gathering phase; the development of an ideology of abuse including not taking abuse personally and making concessions to the illness of the elder person; and practising vigilance, intuition and having strategies to deal with aggressive behaviour. Immunity may never be developed by some staff or may be lost by others due to the stresses of caring that may erode staff resistance to abuse. This may lead to the abuse of nursing home residents. In order to investigate the explanations of staff for patient challenging behaviours, and how these might interact with management approaches and abuse, it is necessary to review theory and research on attributions.

1.7 Attributions

The current study employs aspects of attribution theory as a main framework to understand staff responses such as stress, poor care practice and abuse in the face of
challenging behaviour of older adults. Attribution theory is a collection of several theories concerned with the explanations, often called ‘ordinary explanations’ that people make about their own and others’ experiences in life.

Attribution theorists specify that as actors and observers we are motivated to find causes of events (Heider, 1958). These explanations of causes are attributions. Heider stated that people are equally motivated to make attributions about physical events such as an earthquake, as they are of social events such as the behaviour of another person. There are many attribution theories (see Kelley & Michela, 1980) that attempt to account for the different sorts of explanations that people make. However, all state that attributions are made in order that we may attempt to predict future outcomes.

Heider (1958) originally divided the types of attributions that people make into two different types: attributions that concern personal causes of events; and those that concern environmental causes of events. Personal attributions are those explanations that place the cause of an event with the person who performed the action. Environmental attributions are those explanations that specify the cause as an event or action not connected with the person in question. Over time Heider’s original terms of personal and environmental have been referred to in different ways including internal/external, dispositional/situational, and entity/situation (Antaki, 1982). To avoid further confusion Ross (1977) created an operational definition of internal (personal) and external (environmental) attributions that will be adopted in this thesis. Ross stated that external attributions are those “that do not state or imply any dispositions on the part of the actors beyond those typical of actors in general”. This draws upon the legal understanding of a ‘reasonable person’. If a reasonable person would have done what the actor has done then the cause cannot be deduced to be due to some particular dispositional cause, it is an external attribution. An internal attribution refers to a cause that is due to an individual distinguishing or unique personal characteristic. This dimension is called locus. Since Heider other dimensions of attributions have also been explored: for example stability (whether the cause is stable or variable over time), globality (whether the cause of the event will be present in many different situations) and controllability (the extent to which the cause of an event is perceived to be controllable) (Weiner, et al, 1971; cited from Weiner, 1974)). It has
also been suggested that Heider’s original distinction of internal/external should be expanded to a tripartite dimension representing: internal, external-personal (an attribution of the cause to the actions of another person(s)), and external-situational (an attribution of causality to circumstances or chance) (Kinderman & Bentall, 1996).

Attributions are not arrived at by chance. Jones and Nisbett (1972) state that a bias exists where we tend to assign external motives to our own actions giving importance to environmental differences in determining behaviour; but assign stable and internal motives to the actions of others, ignoring situational factors. This is known as the fundamental attribution error. Further biases have also been investigated, the most notable being a self-serving bias where actors make attributions which justify their own negative behaviour more often than they do for the negative behaviour of others (Kelley, 1972).

Different attribution theories (e.g. Jones & Davis, 1965; Kelley, 1967) provide explanations of why different types of attributions are made by people under different circumstances. However, a further facet of attributions is the effect that they have on a person’s subsequent behaviour. Theories that explicate the link between the attribution that a person makes about an event, their reaction to that event and their subsequent behaviour are called attributional theories.

1.7.1 Attributional theory

Attributional theories are models of the effects that attributions have on behaviour. There is no one attributional theory, although a number of self-sufficient theories have been proposed to explain certain types of events and behaviours (e.g. Weiner, 1974, 1979, and 1985; Abramson, Seligman & Teasdale, 1979).

Weiner (1974a) first proposed a theory of achievement motivation and emotion with achievement strivings as the theoretical focus. He later extended the use of this model to include other behaviours including helping behaviour (Weiner, 1980). The model of achievement motivation and emotion has been supported by research in the areas of both helping behaviour and achievement motivation (e.g. Meyer & Mulherin, 1980; Russell & McAuley, 1986). Weiner (1985) argues that it is the dimensional structure of
causal attributions: particularly locus, stability and control, which determine affect, expectancy and behaviour in achievement related contexts. It is also suggested that the causal dimensions will play a key role in the emotion process and in helping behaviour. Weiner’s (1985) full model is presented in Figure 2. (Linkages presented in the figure are also referred to in the text.)

Weiner suggests that when an event occurs (referred to as an outcome), an emotion will be experienced (referred to as an outcome-dependent affect, (linkage 1)) and a causal search undertaken (2) using information that is known about the antecedents. The causal search leads to a causal decision or attribution (3). Weiner states that in achievement related domains the causal attribution is biased towards a small number of attributions such as effort or ability, and may lead to a unique emotional reaction (4). The causal attribution may be classified along a number of attributional dimensions, for example locus of the cause, controllability of the cause and stability of the cause. Attributional dimensions have psychological consequences related to both expectancy and to affect. The stability of a causal attribution influences the expectancy of success (optimism, (6)). Locus of the attribution exerts an influence on self-esteem and pride (7). Controllability of the attribution influences social emotions such as guilt and shame if the attribution is made about one’s own behaviour (9) and other directed affects of anger and gratitude if the attribution is about another person’s behaviour (10). Finally expectancy and affect are presumed to determine action (linkages 11,12,13).

Weiner’s (1985) theory has been applied to many different situations including alcoholism (McHugh, Beckman & Frieze, 1979); crime and parole decisions (Carroll, 1978); depression (Abramson et al., 1978); loneliness (Peplau, Russell & Heim, 1979); and domestic violence (Frieze, 1979). Attributions may also exert an influence over other types of perceptions of behaviour for example moralistic judgements of blame or responsibility (Eiser, 1980). For example Staub (1996) has suggested that people may be motivated to attribute higher control of cause to a victim of an attack because by doing so they relieve themselves of responsibility to intervene and prevent or stop the attack.
Figure 2. An Attributional Theory of Achievement Motivation and Emotion, (from Weiner, 1985, p240).

Outcome Dependent Affect

- If positive, happy
- If unexpected, negative, or important
- If negative, frustrated and sad

Causal Antecedents

- Specific information
- Causal rules
- Actor vs Observer
- Hedonic Biases
- Etc.

Causal Ascriptions

- Achievement
  - Specific information
  - Ability
  - Effort
  - Strategy
  - Task
  - Luck
  - Etc.
- Affiliation
  - Physical characteristics
  - Personality
  - Availability of target
  - Etc.

Causal Dimensions

- Psychological Consequences
  - Cognitive
  - Self-directed
  - Pride
  - Self-esteem
  - Stability
  - Expectancy
  - (over time)
  - (over situation)
  - Relaxation
  - Surprise
  - Etc.
- Affective
  - Hopelessness
  - Hopefulness
  - Controllability
  - Intentionality
  - Self-directed
  - Pride
  - Self-esteem
  - Other-directed
  - Anger
  - Gratitude
  - Pity

Behavioural Consequences

- Actions
  - Helping
  - Achievement strivings
  - Parole decisions
  - Etc.
- Characteristics
  - Intensity
  - Latency
  - Persistence
  - Etc.
The two situations of most relevance to the care of older adults are achievement and motivation change (e.g. Weiner, 1974b; Russell & McAuley, 1986) and helping behaviour (Weiner, 1980; Meyer & Mulherin, 1980). The model explains that following a success or failure at a task, a causal attribution is made about the reason for the outcome. The stability of this causal attribution is felt to be of primary importance in leading to optimism or pessimism (expectancies) about future success, and feelings of hopefulness or helplessness. This expectancy leads to increased or decreased motivation when attempting the task on a subsequent occasion. In the case of helping behaviour, Weiner’s model predicts that the potential helper attempts to decide why help is needed. If the cause is uncontrollable, pity is experienced and help should be offered. If the cause is perceived as controllable, then the person is held responsible, anger is experienced, and help is withheld.

1.8 The Relationship of Attributional Theory to the Care Staff Behaviour.

Weiner’s (1985) model of achievement motivation and emotion as described above may be relevant to staff explanations of, and responses to, challenging behaviour of older adults. For example when a member of staff is involved in a challenging situation, they are likely to search for a cause of the event and to make an attribution. The model suggests the dimensional attributes (locus, stability, controllability etc.) of any perceived cause of a challenging behaviour will determine the emotional response and expectancy that the staff member experiences. This emotional response and expectancy will then determine the action that a member of staff subsequently takes.

A number of researchers have looked at the application of attribution theory in health and residential care situations. Many research studies have investigated the attributions of care staff for violent acts by psychiatric patients. Apel and Bar-Tal (1996) explored nurses’ ratings of explanations for predictable and unpredictable violence by a patient. They found that participants were more likely to rate mental illness as more important in the cause of unpredictable violence than of predictable violence, despite perceiving the latter event as more severe. Meddings (1996) investigated attributions of hostel staff for the violent behaviour of a homeless person with or without the label of schizophrenia. It was also found that the staff considered different explanations to be
important when the homeless person was labelled as mentally ill than when this label was absent. Staff who received a vignette stating that the person was mentally ill rated this explanation as most important above other internal enduring factors and external factors that were preferred by those hostel staff who were unaware of the mental health problems of the perpetrator. A further study in this area supports these findings, Crichton (1995) found that aggressive behaviour in a person with schizophrenia was attributed more to illness and perceived as necessitating medical treatment. By contrast, aggressive behaviour by a person with a diagnosed personality disorder was perceived as more controllable by the person and more deserving of punitive responses.

Attributional models may also provide useful models for exploring the responses of direct care staff in challenging staff-patient interactions and their association with poor care or abuse. Helping behaviour is an obviously important task of staff caring for older people with dementia. Such clients are likely to require help with many activities such as washing dressing, or eating. Care staff may also behave in ways that are achievement-orientated when they interact with clients. For example they may aim to change a challenging behaviour in some way, possibly through a planned intervention. Staff working with other client groups who show aggressive or challenging behaviour have begun to look to such models to understand staff responses to challenging behaviour and also to use cognitive behavioural interventions to produce change in the carer’s behaviour, cognition and emotion (e.g. Kushlick, Trower, & Dagnan, 1997).

In a direct test of Weiner’s model of helping behaviour, Sharrock, Day, Qazi and Brewin (1990) asked nursing staff about their attributions, affects, optimism and helping regarding the behaviours of one target patient in a medium secure unit. They interpreted their results as failing to support the attribution – affect – helping pathway and found instead that optimism was an important predictor of helping. Attributions of control and stability predicted optimism, which predicted helping. Emotional responses were not significantly associated with attributions or helping.

Another such study has been conducted with the carers of people with learning disabilities and challenging behaviour (Dagnan, Trower & Smith, 1998). Dagnan et al
also examined the application of Weiner’s attributional model of helping behaviour. Specifically the study examined the effect of carers’ attributions about hypothetical challenging behaviours upon their willingness to offer extra help to the client. The authors claim that their results support Weiner’s theory of helping behaviour. However in a path analysis they found that although the attributional dimension of controllability best predicted negative emotion, negative emotion inversely predicted optimism (optimism is not considered important in Weiner’s theory of helping behaviour) and optimism predicted helping behaviour. Staff who believed that the client was responsible for their challenging behaviour (an attribution of high control) were negatively affected emotionally and had less optimism about changing the behaviour (expectancy) and were less willing to offer extra help. Clearly the results of Sharrock et al (1990) and Dagnan et al. (1998) are similar in that they both found that optimism was significantly associated with helping. However, they have interpreted these results in different ways. This research has been furthered by Stanley and Standen (2000) who suggested that the observed role of optimism in helping may show that Weiner’s theory of achievement motivation is more appropriate in care settings. These authors report on a study that examined the relative effects of positive affect and optimism on propensity to help. They used a multi-factorial design with two levels of stability (high and low dependency clients) and three types of challenging behaviour (self-injury, destructiveness and aggression). The study showed that there was a significant relationship between affect and helping but not between optimism and helping, supporting Weiner’s theory of helping behaviour (1985). Their results suggest that positive affect best predicted the helping behaviour of carers overall. However they found that the relative importance of optimism is increased when the behaviour is perceived to come from a stable cause, and in this situation carers become more pessimistic and report being less willing to give help.

Research by Middleton and Forbes (1992) offers some support for the application of attribution theory to the care of older adults. They examined attitudes in a study of care staff of aggressive elderly people. It emerged that staff found it easier to cope psychologically with the aggressive behaviour of cognitively impaired elderly people than those without cognitive impairment because they did not hold the elderly person accountable for their actions and exonerated them from blame.
The relevance of attributions can also be seen when considering the study by Shaw (1998) discussed above. Shaw’s concept of immunity may represent a particular attributional style of non-abusing staff. This ‘immunity style’ accords external (the behaviour is a feature of circumstances and illness and not of the resident or the staff member) and uncontrollable (the behaviour is not the fault of the resident) attributions about aggressive behaviour of older adults. Shaw also identified two types of abusing staff members, the sadistic abuser and the reactive abuser. Sadistic abusers are said to repeatedly abuse residents, deny or blame others for their actions and feel no remorse. These concepts could be examined in terms of attributional dimensions of internal locus (the behaviour is a feature of the patient or was caused by other people) and high control (the patient has control over their behaviour). Reactive abusers are those staff who lose immunity suddenly and react abusively towards residents with impulsive or instinctive reactions. It may be that the different types of abusive staff have different attributional styles at the time of the abuse.

In another study conducted with care staff of people with learning disabilities, Whitehouse, Chamberlain and Tunna (2000) have investigated knowledge of and attributions about dementia related behaviour change. When a change in behaviour was attributed to dementia, care staff were most likely to view this as stable, global, uncontrollable and feel pessimistic about being able to change the behaviour, but reported that they would put in as much effort as possible. This study did not measure the reported emotions of care staff to each situation and thus cannot completely investigate the attribution pathway. However, it would appear that the study shows support for the earlier stages of Weiner’s model of helping behaviour (1985).

1.9 Summary
The number of people suffering from dementia is increasing. Often dementia is associated with challenging behaviours, and increasingly NHS psychiatric services are requested to assess and provide care for people with dementia who also present with challenging behaviour. Studies have shown relationships between appraisal of challenging behaviours and staff stress and staff psychological disturbance. Dementia may attract a malignant social psychology that can contribute to poor care and further behavioural disturbance. In addition, while research into dementia per se as a risk
factor for elder abuse has been inconclusive (Wolf, 1997a); challenging behaviours in dementia have been associated with increased risk of elder abuse by staff in several studies (McPherson et al., 1994; Meddaugh, 1993; Pillemer and Moore, 1990). Suggested mechanisms for elder abuse in institutions have included organisational factors, exogenous factors and staff characteristics. Characteristics of staff and of the relationships between staff and residents that increase the risk of elder abuse include: relationship factors such as conflict between the staff and the resident; and individual factors such as staff beliefs about the behaviour and depersonalisation of residents (Pillemer, 1996; cited from Glendenning, 1997b). Attribution theory may provide a way of explaining the beliefs and actions of care staff about challenging behaviour in dementia that lead to poor care practices such as examples of malignant social psychology and abuse.

1.10 Aims of the Current Study

The present study investigated the attributions of care staff about challenging behaviour of older adults with dementia. The effect of the client's level of dependency was examined, as was the effect of different challenging behaviours. The study also measured emotional reactions and optimism of care staff in relation to challenging behaviour. The study aimed to determine whether attributions were associated with care staff willingness to help care for client and their willingness to attempt to change the client's behaviour. In particular differential hypotheses arising from Weiner's (1985) theories of achievement motivation and helping were tested. The study also assessed the reported likelihood of staff to respond to challenging behaviour with abusive actions or actions indicative of malignant social psychology. The relationships between attributions and reported management actions were examined. The study collected information about demographic variables, care staff perceptions of support and the qualifications of the participants and examined associations between these factors and the dependent variables.
1.11 Methodological Issues

1.11.1 Research design.

The study aimed to compare participants' attributions for different challenging behaviours and dependency levels. Thus two experimental designs were appropriate: a between subjects design or a within subjects design. A within subjects design was preferred due to the smaller number of participants required and the avoidance of confounding the effects of variance due to subjects and that due to the experimental conditions. Order effects may influence the results in a within-subjects design. In order to minimise these it was decided to present all of the conditions in random order to the participants.

1.11.2 Methodological issues in attributional research.

As discussed above, attribution theory is a major field of study in social psychology and a number of different methodological techniques have been used to measure attributions and attributional style. There are two components to any such measure: the stimulus that elicits the attribution; and the means of coding or quantifying the attribution. Attributions may be elicited by a number of different types of stimuli, for example, experimental situations, written or video taped vignettes, or real life events. The real life event methodology was used by Sharrock et al., (1990) in their study of attributions about the challenging behaviour of a man with a learning disability. The attributional stimuli were several of the patient's frequently displayed behaviours that all participants in the study had witnessed. Alternatively the attributional stimulus may be hypothetical as in the case of the Attributional Style Questionnaire (Peterson et. al., 1982). A written description, or vignette, of an event is presented to the respondents with the instruction to vividly imagine themselves in this situation.

It would be unethical and impractical to place participants in an experimentally manipulated situation of challenging behaviour with an older adult client. Thus two methods of stimulating attributions were possible: real life events and vignettes. There are advantages and disadvantages associated with each method. In the former, there is greater validity of the responses since the participants have experienced the event directly happening to them. However, it is not possible to manipulate the stimulus
behaviours in any way in order to examine the effects of specific features of the stimulus situation. Measurement of attributions after a real event has occurred also causes problems of equivalence of stimulus between participants. Even in the type of real life events that Sharrock et al (1990) used it is not possible to ensure that the stimulus content or context of such events is identical for every participant. The disadvantages of vignettes concern the lack of ecological validity because they are essentially hypothetical situations for the participants. Participants may respond entirely differently to vignettes and to real life situations. However, the advantages are that the stimulus is entirely malleable to ensure identical presentation to each participant and to preserve distinct experimental conditions. This study aimed to test the effects of different challenging behaviour types and dependency level on attributions of care staff; and to validate elements of a theory still debated in the literature. It was therefore important to present each participant with identical stimuli. It is also important to consider the resource implications of the study, attribution theory has not been researched at all in relation to care staff of older adults and challenging behaviours in dementia. At such an early stage of research it is important not to waste resources in an overly time consuming or expensive study that may not produce clinically significant or relevant results. For these reasons vignette methodology was felt to be most appropriate for the current study. The study has attempted to address some of the concerns about validity by using descriptions of real incidents in the vignettes.

There are also many methods of measuring attributions, using closed and open questions, and discourse analysis. Most commonly, the attributional style has been measured by the Attributional Style Questionnaire (ASQ) (Peterson et. al., 1982). This assumes that to the extent that individuals show characteristic attribution tendencies, it is appropriate to speak of an attributional style (Peterson et. al., 1982). The ASQ provides hypothetical events for which respondents are invited by an open-ended question to generate a cause. Respondents then rate this cause on several closed question attributional dimensional scales. However the ASQ has been found to have psychometric shortcomings such as poor internal consistency (Cutrona, Russell & Jones, 1984) suggesting that the combination of the separate and distinct attributional dimensions to form a total attribution style score is not valid. A further criticism of the
ASQ has concerned face validity as discussed above because respondents rate hypothetical events (Hammen & de Mayo, 1980). Other researchers have suggested that assessing attributions for real life events may be a more valid indicator of attributional style (Cutrona, 1983; Norman & Antaki, 1988).

Discourse analysis also provides a method of coding attributions and attributional dimensions. Stratton et al., (1986) describe a method of coding attributions from qualitative data of a participant’s written or verbal discourse. They report adequate reliability, and because participants are free to describe their attributions using their own words this method has excellent face validity. However, it relies upon the researcher’s definitions of attributional dimensions that may be subject to rater subjectivity and show poor reliability for some items. Depending on how the data are coded and quantified this method of coding can be used to produce basic statistical analyses. However, data would only be at a nominal level because it is not possible to gain information about participants’ beliefs about the relative weight of different attributions for an event.

A modified version of the attributional style questionnaire was used in the present study. This gave benefits of using a popular measure allowing comparison between the present study and previous research; allowed participants to generate their own attributions about the cause of an event; and also ensured that information about the attributional dimensions of interest in the study was collected. The concept of attributional style was not considered important to the research aims, therefore the total score was not calculated and concerns about internal consistency could be dismissed. The Likert type scales for each attributional dimension ensured that detailed statistical analysis was possible.

1.11.3 Preserving favourable self-evaluation

Attribution theorists emphasise that people can provide a variety of explanations for a given event. Given this, how does the research participant decide upon which explanation they believe is the most likely cause? One probable way of deciding which causal explanations to emphasise is by making a meta-attributional inquiry, involving the participant considering why the researcher wishes or needs to know about their
causal perceptions (Kelley, 1983). Another way to decide which explanation to declare may be to emphasise those explanations that place the participant in a favourable evaluative light in the eyes of the researcher and the participant himself (Kelley, 1983). The present research has potential to elicit many causal explanations from participants that could lead to the participant making a negative evaluation of his or herself, or to the researcher evaluating the participant negatively. It is necessary to consider the role of a socially desirable response bias within this research. This may influence the results by reducing the likelihood that participants would ascribe internal attributions in response to negative or inappropriate staff behaviours described in the vignettes. For this reason, a measure of social response bias, the Marlowe-Crowne Socially Desirable Responding Scale (Short Form) (Reynolds, 1982), was included in the interview measures.

1.11.4 Measurement of care staff helping behaviour

In the studies of care staff behaviour referred to above (Stanley & Standen, 2000; Dagnan et. al., 1998, Sharrock et. al., 1990) helping has been assessed in different albeit similar ways. Sharrock et al. (1990) and Dagnan et al. (1998) asked a single question in which participants rated the question, “How much extra effort would you exert in helping this patient?” Stanley and Standen (2000) also asked their participants a single question, "As key worker for Client X, would this behaviour stimulate you to work harder or less hard on Client X's care programme?" Although at first sight the differences between the questions may seem slight, they may be significant. When confronted with a client's challenging behaviour, a member of care staff has a number of different potential actions to choose from. They may act to reduce the distress of the client, to reduce their own distress, to change the client's behaviour in the short or long term or to provide a prescribed nursing or medical intervention. Other alternatives also include actions taken in anger by the member of staff, in retaliation for a perceived injury, or unfortunately, those taken to deliberately harm the client. Optimism, important in achievement orientated theory, may also relate to the extent to which care or change can be delivered. Any study that examines an attributional theory must be clear about what the actions are that the attributions are expected to lead to. A particularly important distinction in the study of care staff behaviour is that between actions that may be described as helping or caring, such as those aimed at diminishing
the distress of the client and those actions aimed at changing the behaviour, particularly in the long term. The former may be best accounted for by Weiner's theory of helping behaviour, the latter by the theory of achievement motivation. As a consequence this study included separate questions addressing the distinction between care staff actions aimed at caring for the client and those aimed at changing the behaviour. Respondents were also asked two questions about their levels of optimism regarding caring for the client and changing the client’s behaviour.

1.12 Research Questions and Hypotheses

Research Question 1
Information about challenging behaviour type and dependency level will exert a differential effect upon attributional dimensions, affects, optimism, helping and behaviour and person evaluations.

Hypotheses:
Dependency level will exert a differential effect upon participants’:

1.1 causal attributions such that for vignettes representing clients with low dependency needs, causal attributions will be less internal in locus, less stable, less global and involve more control over the behaviour. Challenging behaviour type will exert a differential effect upon dimensions of causal attributions.

1.2 affects such that vignettes representing clients with low dependency needs will elicit more negative emotion and less positive emotion. Challenging behaviour type will exert a differential effect upon affects.

1.3 optimism regarding behaviour change and regarding care such that vignettes representing clients with low dependency needs will elicit more optimism regarding behaviour change and less optimism regarding care. Challenging behaviour type will exert a differential effect upon optimism.

1.4 helping such that for vignettes representing clients with low dependency needs care staff will be more willing to help change the client’s behaviour but less
willing to help care for the client. Challenging behaviour type will exert a
differential effect upon helping behaviours.

1.5 **person and behaviour evaluations** such that vignettes representing clients with
low dependency needs will elicit more negative person evaluations. Challenging
behaviour type will exert a differential effect upon evaluations.

**Research Question 2**
To investigate the applicability of Weiner’s model of helping behaviour and
achievement motivation to the management of challenging behaviour with older
adults.

**Hypotheses:**
2.1 As predicted by Weiner’s model of helping behaviour, propensity to care for the
client will be related to the attributional dimension of control and positive affect
rather than optimism regarding care.

2.2 As predicted by Weiner’s theory of achievement motivation, willingness to
change the behaviour will be associated with the attributional dimension of
stability, and the effect of affect will be mediated by optimism regarding
behaviour change.

**Research Question 3**
To investigate the management of challenging behaviour and the association
between attributions for challenging behaviour and management strategies.

**Hypotheses:**
3.1 Care staff will show a differential propensity to use the different types of
management strategy. Care staff will report that they are most likely to use
appropriate management strategies and least likely to use abusive management
strategies in response to challenging behaviour.
3.2 Client dependency and topography of challenging behaviour will differentially affect staff ratings of expressed intent to use MSP and abusive management strategies; such that staff will report less likelihood of using abusive and MSP strategies at higher levels of dependency.

3.3 There will be a positive relationship between willingness to care and appropriate management strategy use. There will be a negative relationship between willingness to care and abusive and MSP management strategies.

Research Question 4

To explore the relationship between training, familiarity with challenging behaviour and support at work; attributions and management strategies.

Hypotheses:

4.1 Student nurses and more highly trained staff (NVQ Level 3 staff) will make fewer internal attributions, show lower levels of negative affect and higher levels of positive affect towards the clients; and express less propensity to use abusive and MSP strategies than other staff.

4.2 There will be a positive relationship between feeling supported at work and helping and use of appropriate management strategies. There will be a negative relationship between feeling supported at work and expressed intent to use abusive/MSP management strategies.

4.3 Staff experiencing challenging behaviour regularly or continually will attribute lower levels of control, stability and negative affect, and higher levels of positive affect and helping behaviours than those staff who have less frequent contact with challenging behaviour. They will also express less intent to use abusive or MSP management strategies.
2 METHOD

2.1 Participants

The 46 participants in the study were (29) nursing assistants (Grades A and B) and (17) student nurses (Non-qualified) working in inpatient settings for older people (aged over 65 years) in a mental health trust in the West Midlands. 50 people were approached as participants for the study; the response rate was 92%. The sample was randomly selected from those unqualified staff working on older adult psychiatric wards and in older adult residential nursing homes run by the mental health trust. Ten participants were male (22%), and 36 were female (78%). Their ages ranged from 18 to 60 years with a mean of 37.2 years. (sd=12.57).

2.2 Measures

A structured interview was developed for the study. The interview was divided into four sections: demographic information; measurement of attributions about the challenging behaviour of older adults; measurement of preferred management strategies; and a measure of socially desirable responding. The measurement of attributions and management strategies was assessed using vignettes and questionnaires that were devised for the study. Information about the measures used in the study and their psychometric properties is presented below. A copy of the interview is available in Appendix 6.

2.2.1 Demographic and occupational information, and perception of support.

Participants were asked their age, gender, and qualifications for their job. They were also asked how many years they had worked as a carer of older people and when they had last attended training for their job and the topic. Participants were asked how often the people they cared for presented disruptive behaviour. Answers to this question were coded as ‘rarely’, ‘occasionally’, ‘regularly’ or ‘continually’. Questions about the participant’s perceptions of support to cope with challenging behaviours were also included to determine the level of satisfaction with existing support systems regarding difficult situations at work.
2.2.2 Measurement of attributions regarding older adult’s challenging behaviour.

No current instruments were available to measure attributions of challenging behaviour in older adult services. Attributions were assessed using a vignette methodology similar to that previously used by Dagnan, Trower and Smith (1998) with a group of care staff for people with learning disabilities and subsequently by Stanley and Standen (2000) also with care staff of people with a learning disability. Six vignettes were developed for the study each describing an older adult client and a member of staff involved in an incident of challenging behaviour. These were developed using the procedure discussed by Home (1994), involving literature review, interviews and pilot studies. The incidence and typology of behavioural disturbances amongst older adults with dementia was established through a literature review and from examination of 7 incident books from May 1998 to October 2000 of 4 wards for older adults in a psychiatric hospital. The incident books documented a total of 25 incidents where an abuse or injury occurred, or potential for injury had occurred as a result of a patient’s behaviour. These incidents included situations of personal care and administration of medication and those with no recorded or no discernible trigger. Injuries sustained ranged from no injury to serious physical injury (bruising, scalds and cuts). The mental health trust had also recently carried out an audit of abuse in the workplace of staff working with older adults. This audit identified the typologies of behaviour that most often resulted in abuse towards staff and the most common types of workplace abuse (Saffrey, 1999). For a summary of this survey see Appendix 2. The vignettes were devised to represent examples of the three most common precursors to abuse reported in the Abuse in the Workplace Survey: repetitive behaviours, toileting difficulties and verbal demands. Subsequently, interviews were carried out with five members of nursing staff (3 qualified nurses and two nursing assistants) who had worked with older adults with challenging behaviour for over five years, to allow enable realistic scenarios to be developed around each behaviour. These participants were later excluded from the major study. These interviews are described in more detail in Appendix 3.

The vignettes were based on typical aspects of real incidents as described by members of staff and the incident books. The vignettes represented three different behaviour
typologies: toileting difficulty, verbal demands and delusional behaviour; and two levels of dependency, mild or early language and memory difficulties with few requirements for personal care, and severe or advanced language, communication and memory problems with many requirements for personal care. The gender of the client and of the member of staff was disguised in all of the vignettes. Background information was kept to a minimum in the vignette to allow a variety of causal explanations to be generated by the participants. A pilot study of the vignettes was conducted with six ‘experts’ in the field of elder care who also rated the associated management strategies (see below).

Each vignette was followed by amended questions from the Attributional Style Questionnaire by Peterson et al (1982) to allow open ended identification of the perceived likely cause of the incident and attributions of locus, stability, globality, intent, and control. To test Weiner’s attribution theories, questions regarding the participant’s willingness to put extra effort into caring for, and changing the client’s behaviour; optimism about caring for and changing the client’s behaviour; evaluations of the vignette client and of the behaviour; and emotional response to each vignette, were also included for each vignette.

An example of the attribution questions included:

Is the cause of the client’s behaviour something to do with the client, or something about other people or circumstances?

Totally due to the client  7  6  5  4  3  2  1  Totally due to other people or circumstances

2.2.3 Measurement of management strategies to older adults’ challenging behaviour.

There was no existing measure of expressed intent to use specific management strategies in response to challenging incidents of older people. A measure was devised for this purpose. Between 24 and 34 management strategy items were drawn up for each vignette. These represented a variety of behaviours amongst which were examples of abusive behaviour, malignant social psychology and behaviours that were
neither abusive or MSP. The strategies were developed from actions detailed in incident books, interviews with experienced members of staff (see Appendix 3), from literature of psychological interventions in challenging behaviour in dementia (Stokes, 2000) and from literature on elder abuse (Glendenning 1997a, Glendenning 1997b).

For each vignette five strategies were required to represent abusive behaviour and examples of malignant social psychology, five representing malignant social psychology alone and five representing neither abusive behaviour or malignant social psychology (henceforth referred to as ‘Appropriate’ strategies). For the interview the fifteen management strategies for each vignette were listed in random order. The participant was asked to rate how likely they were to use each of the management strategies in the situation described in the vignette. This was done using a seven-point anchored scale (very likely to very unlikely). An example of the management strategy questions included:

How likely are you to:

Carry on as if nothing had happened? Very likely 7 6 5 4 3 2 1 Very unlikely

2.3 Validity and Reliability

2.3.1 Construct validity – Management strategies.

In order to ensure construct validity of this part of the interview it was necessary to classify the management style items as abusive, and as examples of malignant social psychology (MSP, Kitwood, 1997a). The management style items were rated by six ‘experts’, selected because they were experienced professionals working with older people in institutional care or workers in the field of elder abuse. The raters came from different professional backgrounds: clinical psychology, a charitable organisation (Action on Elder Abuse), nursing (2), occupational therapy and social work (Social Services Inspection Unit). Each rater received a postal questionnaire of the definitions of abusive behaviour and Malignant Social Psychology (Appendix 1), the six vignettes and proposed management strategies (Appendix 4). The definition of abusive behaviour was drawn from the definition given by Action on Elder Abuse (1999) and included in the government paper about abuse of vulnerable adults ‘No Secrets’. 

40
(Department of Health, 2000). The definition of Malignant Social Psychology was taken from Kitwood’s work on dementia and represents a social or environmental event that undermines and damages personhood and well being (Kitwood, 1997a). This definition is more inclusive than the definition of elder abuse. The raters were asked state whether each management strategy was an example of abusive behaviour (Yes/No/Don’t Know) and of malignant social psychology (Yes/No/Don’t Know) independently. The raters were also asked about the face validity of the vignettes and responses. All of the raters felt that the vignettes and responses were realistic and described events that could potentially happen in a number of different hospital and residential settings for older people.

Because the constructs of abuse and MSP were rated independently it was possible for a particular strategy to show 100% concordance for abusiveness but show disagreement amongst raters for MSP. For the final interview questions it was necessary to show that the raters agreed on both constructs of each strategy. Thus the table below displays the number of items where the agreement between raters for both constructs of management strategy was 6/6 raters (100%) and at least 5/6 raters (83%).

Table 1. Number and Percentage of Management Strategies Agreed Upon by the Raters to be Examples of Abusive Behaviour or Malignant Social Psychology or Neither.

<table>
<thead>
<tr>
<th></th>
<th>Abusive + MSP</th>
<th>Abusive + Not MSP</th>
<th>Not Abusive + MSP</th>
<th>Not abusive + Not MSP</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% concordance</td>
<td>19</td>
<td>0</td>
<td>3</td>
<td>12</td>
<td>34</td>
</tr>
<tr>
<td>Number of Strategies</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>20</td>
</tr>
<tr>
<td>Percentage</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
</tbody>
</table>

|                  | 48            | 0                 | 36                | 39                    | 123   |
| Number of Strategies | -             | -                 | -                 | -                     |       |
| Percentage       | -             | -                 | -                 | -                     | 73    |

The construct validation criterion of 100% agreement on both constructs of management strategy was achieved for 20% of the strategies. For each vignette five
strategies were required to represent abusive behaviour and examples of malignant social psychology ('Abusive' strategies), five representing malignant social psychology alone ('MSP' strategies) and five 'Appropriate' management strategies. To achieve the required number and proportions of different strategies it was necessary to extend the inter-rater reliability criterion to agreement between at least 5 out of 6 raters on both constructs (>83% concordance). This criterion was achieved by 73% of the strategies. From these, 15 management strategies for each vignette were chosen, with preference given to those strategies achieving the greatest inter-rater reliability. The final concordance between raters for the management strategies selected for the interview was 84%.

2.3.2 Face validity.

The perception that the participants and administrators have of the measure is known as face validity. Face validity concerns were addressed at several stages in the development of these measures. Initially the pilot interviews about challenging behaviour provided information about common challenging behaviours that the care staff face and about the possible ways of managing such behaviour. Subsequently after the measures were designed the five expert raters of management strategies were asked to comment upon realism of the vignettes and management strategies. Comments from participants during the data collection were favourable regarding the common and realistic description of the challenging behaviour vignettes. Face validity was weighed against the dangers that the participants are aware of the hypotheses of the study. The information and instructions given to participants was restricted to the investigation of the way people think about challenging behaviour, how it affects them and how they choose to manage it. Different management strategy types were not discussed with the participants although, inevitably some participants could easily discriminate some MSP and most abusive responses and made comments about the inappropriateness of these actions. In order to collect accurate data about feelings and actions that could potentially be viewed by the staff as unprofessional or negative; confidentiality was assured, names were not written on the data questionnaire and interviews were conducted in private rooms, wherever possible away from client spaces or offices on the ward. As described below the effect of a social response bias was assessed and found not to be significantly associated with any of the research variables.
2.3.3 Validity - Measurement of bias.

To assess the effect of a socially desirable responding bias on the participant’s responses the Short Versions of the Marlowe-Crowne Socially Desirable Responding Scale (Reynolds, 1982) was included in the interview. Participants are asked to rate a number of statements as true or false. An example of one of the questions from the scale is:

It is sometimes hard for me to go on with my work if I am not encouraged

True / False

2.4 Procedure

Ethical consent was obtained for the study from the Local Research Ethics Committee for the NHS Trust and the study was also approved by the University of Leicester Clinical Psychology Research Committee. The researcher contacted the ward/unit manager in all of the inpatient facilities of the trust and was provided with an up to date staff list including details of nursing grade. Participants were selected at random from these lists and the researcher visited the wards on a number of occasions to recruit participants personally to the study. Participants were given an information sheet at least 24 hours before the interview took place and at the time of the interview were asked to give their consent to participate in the study (see Appendix 5). All participants completed the same interview with the researcher, in a private room, during their normal working hours. Ten participants (out of 11 approached) agreed to complete the interview a second time for the purposes of measuring reliability of the measures.

2.5 Data Analysis

The attributional, affect, optimism, helping and management strategy variables for each vignette are measured using 7-point Likert scales and are ordinal variables. They are categorised and can be ordered in terms of more or less. Ordinal data is customarily analysed using non-parametric statistical tests. However, the summary variables that
are compiled from these have been analysed using parametric statistical tests, for use with interval or ratio data. The rationale for this treatment has come both from precedent and examination of the data. Bryman and Cramer (1990) and Clark-Carter (1997) suggest that most of the multiple item measures of ordinal data created by researcher may be treated as though they were interval data because these measures allow a large number of categories or values (over 20) to be stipulated. In the case of the summary variables in this study there are 37 values possible within the scale (scores may potentially range from 6 to 42. Other criteria for the use of parametric statistics have also been met by the data: variables are normally distributed, with no skewness or kurtosis. Assumptions of homogeneity of variance are also met for all variables, therefore the use of parametric statistics is appropriate.

Data analysis was conducted in four stages using SPSS 8 for Windows (SPSS Inc, 1998). Firstly, the effects of different challenging behaviour topography and client dependency upon attributions, optimism, affect and helping were examined. A series of two-way (2x3) within-subjects ANOVAs were performed. Main effects were studied in post hoc analyses using the Bonferroni method (described in more detail below).

Secondly summary variables were created for the attributional dimensions, affects, optimism, helping, evaluations, and management strategy responses by summing the scores on each variable across all six vignettes. The relationships between the summary attributional variables, affects, optimism and helping were examined using Pearson’s Product Moment Correlations and partial correlations. Tests were carried out to compare the correlated correlation coefficients between helping variables and affects and optimism to show evidence in support of the different attributional theories of care staff behaviour. Details of this procedure are given in Appendix 7. A path analysis was carried out for the two helping variables: Willing to Care and Willing to Change.

Subsequently the expressed propensity for participants to use different types of management strategy was examined. Pearson correlations were used to examine the relationships between these and helping and attributional and affect variables and the
effect of challenging behaviour type and client dependency was examined using two
way ANOVAs and post hoc analyses (described in more detail below).

Lastly, participants were grouped according to qualifications and frequency of contact
with challenging behaviour variables and significant differences in attributions, helping
and management strategy use were explored using independent samples t-tests.
Pearson’s correlations were carried out to explore the relationships between feeling
supported at work and expressed use of MSP or abusive management strategies.
3 RESULTS

3.1 Demographic Information

The 46 participants comprised unqualified staff working on the psychiatric wards and units for older adults of a mental health trust. The participants included student nurses of Diploma and Degree Nursing Studies courses, and nursing assistants, some of whom had gained Level 2 or Level 3 NVQ qualifications. The number of participants in each group is shown in Table 2. For the purpose of specific questions in the data analysis the participants were split into two groups on the basis of their qualifications those with no qualifications and those with Level 2 NVQ formed one group, and those with Level 3 NVQ or on nurse training programmes formed the second group.

Table 2. Qualifications and Frequency of Challenging Behaviour Experienced by Participants.

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Number of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>24</td>
<td>52.2</td>
</tr>
<tr>
<td>NVQ Level 2</td>
<td>3</td>
<td>6.5</td>
</tr>
<tr>
<td>NVQ Level 3</td>
<td>2</td>
<td>4.3</td>
</tr>
<tr>
<td>Nurse Training</td>
<td>17</td>
<td>37.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>46</td>
<td>100</td>
</tr>
</tbody>
</table>

All participants indicated their gender. Female participants made up 78.3% of the sample (N=36) and male participants 21.7% (N=10). Age was recorded by 45 participants. Ages ranged from 18 years to 60 years. The mean age was 37.2 years (s.d.=12.57).

Table 3 shows the frequency of challenging behaviour reported by participants in their working environment. The majority of the participants report experiencing challenging behaviour on at least a weekly basis. For the purpose of specific questions in the data analysis the participants were split into two groups on the basis of their contact with challenging behaviour. Those experiencing challenging behaviour regularly or
continually formed one group and those experiencing challenging behaviour rarely or occasionally formed the second group.

Table 3. Frequency of Challenging Behaviour in the Workplace Reported by Participants.

<table>
<thead>
<tr>
<th>Frequency of Challenging Behaviour</th>
<th>Number of Participants</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rarely (less than once a month)</td>
<td>4</td>
<td>8.7</td>
</tr>
<tr>
<td>Occasionally (at least once a month)</td>
<td>13</td>
<td>28.3</td>
</tr>
<tr>
<td>Regularly (at least once a week)</td>
<td>18</td>
<td>39.1</td>
</tr>
<tr>
<td>Continually (daily)</td>
<td>11</td>
<td>23.9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>46</td>
<td>100</td>
</tr>
</tbody>
</table>

Participants were asked about the last time they had received training about challenging behaviour. The majority of the sample (89.1%) reported having received no training at all in management of challenging behaviour. Two participants (4.3%) reported having training over the past year, a further two participants reported having received training over the past five years and one participant (2.2%) said they received training during their induction 16 years previously. Due to the small number of participants who reported having received training, no further analysis was carried out with this variable.

3.2 Validity and Reliability

3.2.1 Face validity of helping behaviours

To examine the independent nature of the two optimism variables, Optimism re Care and Optimism re Change; and the two helping variables, Willing to Care and Willing to Change, Pearson correlation coefficients were examined. Optimism re Care and Change did not show a significant degree of correlation ($r=.142, p>.05$). Willingness to Care and to Change did show a significant positive correlation ($r=.313, p=.034$). However, a paired samples t-test showed that the mean differences of participants' scores on the two variables were significantly different ($t(45)=2.275, p=.028$). Participants rated themselves as more willing to put extra effort into changing the behaviour than into caring for the client.
3.2.2 Measurement of social response bias.

Data from the short form of the Marlowe-Crowne Socially Desirable responding scale (SDS(13), Reynolds, 1982) was analysed. The mean score on the scale was 6.91 (s.d.=2.96). Pearson correlations (Kendall's Tau correlations where appropriate) were performed between the socially desirable responding scale total score and 22 other variables (attributional dimensions, affects, optimism, helping, evaluations, age, training, support and experience). The SDS(13) did not correlate significantly with any other variable, although the relationship between socially desirable responding and negative emotion ($r=.271$, $p=.069$) and optimism regarding care ($r=.255$, $p=.088$) were approaching significance. However, 22 correlations were performed and likelihood that these relationships may have occurred by chance is increased. It is unlikely that participants' responses on any measure were subject to marked social response bias (at least as assessed by the Marlowe-Crowne Scale (Reynolds, 1982)).

3.2.3 Test-retest reliability of the measures.

Test reliability was assessed in two ways: test-retest reliability and split-half reliability. Test-retest reliability measures the degree to which the measure produces the same results on the second occasion as on the first. A small sample of participants (N=10) agreed to complete the measure twice, with an interval of 5-6 weeks between the two questionnaire administrations. Pearson correlations were calculated for the summary variables of attributional dimensions, affect, optimism, helping, and management strategies. Kendall's tau-b correlation was calculated for qualifications, last training and frequency of challenging behaviour. Kline (1993; cited in Clark-Carter, 1997, p.337) suggests that a reliable measure will have a Pearson correlation of at least 0.8. The small number of participants completing the measure twice reduces the likelihood of demonstrating this degree of relationship and the results must be interpreted with caution. The test-retest correlations are shown in Table 4 below. In general this 'pilot' study of reliability shows promise that the measure is reliable from one occasion to the next.
Table 4. Test-retest Reliability Coefficients for Key Variables.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Correlation coefficient</th>
<th>Probability level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualifications</td>
<td>1.000</td>
<td>&lt;.0005</td>
</tr>
<tr>
<td>Last Training</td>
<td>1.000</td>
<td>&lt;.0005</td>
</tr>
<tr>
<td>Frequency of Challenging Behaviour</td>
<td>.840</td>
<td>.005</td>
</tr>
<tr>
<td>Locus</td>
<td>.622</td>
<td>.055</td>
</tr>
<tr>
<td>Globality</td>
<td>.498</td>
<td>.143</td>
</tr>
<tr>
<td>Stability</td>
<td>.443</td>
<td>.199</td>
</tr>
<tr>
<td>Control</td>
<td>.654</td>
<td>.04</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>.956</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Negative Affect</td>
<td>.772</td>
<td>.009</td>
</tr>
<tr>
<td>Optimism re Care</td>
<td>.778</td>
<td>.008</td>
</tr>
<tr>
<td>Optimism re Change</td>
<td>.504</td>
<td>.137</td>
</tr>
<tr>
<td>Willing to Change</td>
<td>.830</td>
<td>.003</td>
</tr>
<tr>
<td>Willing to Care</td>
<td>.908</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Appropriate</td>
<td>.780</td>
<td>.008</td>
</tr>
<tr>
<td>MSP</td>
<td>.878</td>
<td>.001</td>
</tr>
<tr>
<td>Abusive</td>
<td>.615</td>
<td>.059</td>
</tr>
</tbody>
</table>

3.2.4 Split-half reliability of the measures.

It is also possible to check that the test has items that are consistent with one another, by correlating performance on one half of the test with performance on the other half. Internal consistency was assessed for the summary attribution, affect, optimism, helping and management strategy variables. These variables were calculated by summing the responses from each vignette for each attributional dimension, affect, optimism variable etc. Split-half reliability was assessed using the Cronbach alpha reliability coefficient, which is the equivalent of having calculated all the possible split-halves. Kline (1993, cited in Clark-Carter, 1997; p337) has suggested that a reliable measure will have an alpha level of above .7. This criterion was met by the variables: Willing to Care (.77), Willing to Change (.81), Optimism re Change (.71), Optimism re Care (.75), Negative Emotion (.81), Positive Emotion (.72) and Abuse (.84). Alpha for the other variables was lower: Locus (.42), Globality (.47), Stability (.55), Control
(.55), Appropriate (.65), and MSP (.67). Conceptually, there are problems with calculating split-half reliability coefficients from this data set due to the deliberate manipulation of challenging behaviour type and dependency level in the vignettes producing variance in the dependent variables. The author would therefore suggest that the degree of relationships demonstrated by the split-half coefficients detailed above are adequate for this particular study.

3.3 Descriptive Statistics.

The mean scores and standard deviations for the attributional, affect, optimism and willingness to help, and management strategy variables are shown in Table 5.

Table 5. Mean Scores and Standard Deviations of Key Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locus</td>
<td>29.15</td>
<td>4.89</td>
</tr>
<tr>
<td>Globality*</td>
<td>-19.24</td>
<td>5.63</td>
</tr>
<tr>
<td>Stability</td>
<td>33.37</td>
<td>3.93</td>
</tr>
<tr>
<td>Control*</td>
<td>-28.04</td>
<td>5.66</td>
</tr>
<tr>
<td>Negative Emotion</td>
<td>15.67</td>
<td>7.03</td>
</tr>
<tr>
<td>Positive Emotion</td>
<td>29.87</td>
<td>7.15</td>
</tr>
<tr>
<td>Optimism re Change</td>
<td>27.89</td>
<td>5.71</td>
</tr>
<tr>
<td>Optimism re Care</td>
<td>36.89</td>
<td>3.68</td>
</tr>
<tr>
<td>Willingness to Change</td>
<td>35.57</td>
<td>4.76</td>
</tr>
<tr>
<td>Willingness to Care</td>
<td>33.52</td>
<td>5.57</td>
</tr>
<tr>
<td>Person Evaluation</td>
<td>14.35</td>
<td>6.70</td>
</tr>
<tr>
<td>Behaviour Evaluation</td>
<td>20.96</td>
<td>8.45</td>
</tr>
<tr>
<td>Appropriate response</td>
<td>167.41</td>
<td>16.69</td>
</tr>
<tr>
<td>MSP response</td>
<td>133.04</td>
<td>19.34</td>
</tr>
<tr>
<td>Abusive response</td>
<td>66.28</td>
<td>20.74</td>
</tr>
</tbody>
</table>
*The interview questions were phrased such that high levels of control and globality were rated as low scores. Control and Globality were therefore negatively scored in order that high scores indicated high control and globality of the attribution. For all other variables increasing scores indicated increased levels of: Internality of Locus, Stability, Negative Emotion, Positive Emotion, Optimism, Willingness to Care/Change, increasingly negative evaluations and increased likelihood of use (management strategies).

Participants’ mean ratings indicate that challenging behaviour was generally felt to be internal in locus, to be global rather than specific, to be stable over time, and to be relatively uncontrollable by the client. Challenging behaviours elicited low levels of anger and high levels of sympathy towards the client. The degree of negative evaluations of the vignette ‘clients’ was low and evaluation of the behaviour although slightly higher than evaluations of the person were also lower than the midpoint. Participants indicated that they were least likely to respond to challenging behaviour with abusive management strategies and most likely to respond with appropriate management strategies.

3.4 Research Question 1

Information about challenging behaviour type and dependency level will exert a differential effect upon attributional dimensions, affects, optimism, helping and behaviour and person evaluations.

To investigate the effects of behavioural topography and dependency level upon the dependent variables (attributional dimensions, affect, optimism and helping), a series of two way (2x3) repeated measures ANOVAs were conducted. In all the following analyses of variance the data met the criteria for ANOVA tests: the data was distributed normally, and the criteria for homogeneity of variance and sphericity of the data were met. Main effects were deemed to be significant if they were associated with a probability level of less than .05. In the case of significant main effects in the absence of an interaction, post hoc analyses involved unplanned pairwise contrasts and thus the probability level for significance was adjusted. The Bonferroni method (shown below)
was used to take account of the number of comparisons being made in order that the probability of a type I error for the family of contrasts remained at \( \alpha = 0.05 \).

The dependency factor only has two levels, thus a significant \( F \) ratio indicates that the main effect contrast of the two levels, high and low dependency, are significantly different at the indicated probability.

When examining the contrasts of challenging behaviour type, three means, one for each challenging behaviour type were involved. This gave a probability level for each comparison of

\[
p = \frac{\text{alpha}}{3} = 0.05 = 0.017
\]

When there was a significant interaction effect, the simple effects of dependency involved three comparisons comparing dependency type means for each challenging behaviour condition. To simplify the analysis and to decrease the number of pairwise comparisons to be made, the simple effects of challenging behaviour type were initially compared using a one way ANOVA at each level of dependency (recommended by Clark-Carter, 1997; p. 301). Probability for this test was set at \( p < 0.025 \). Then if only one level of dependency showed significant effects for challenging behaviour six within subjects \( t \)-tests were carried out for the simple effects analysis. Three \( t \)-tests comparing the effect of dependency level upon challenging behaviour type and three comparing different challenging behaviour types at one level of dependency. The adjusted probability level was set at \( p < 0.008 \). If both levels were significant, nine \( t \)-test comparisons were involved and the adjusted probability level was \( p < 0.006 \).

The means and standard deviations for each type of challenging behaviour and client dependency level are presented in Table 6.
Table 6 Mean Scores and Standard Deviations for Participants’ Ratings of Challenging Behaviour and Dependency.

<table>
<thead>
<tr>
<th></th>
<th>Toileting</th>
<th>Verbal aggression</th>
<th>Delusional</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Locus</td>
<td>3.98</td>
<td>4.61</td>
<td>4.78</td>
</tr>
<tr>
<td></td>
<td>(1.56)</td>
<td>(1.50)</td>
<td>(1.65)</td>
</tr>
<tr>
<td>Globality</td>
<td>-3.28</td>
<td>-3.76</td>
<td>-2.74</td>
</tr>
<tr>
<td></td>
<td>(1.86)</td>
<td>(1.70)</td>
<td>(1.81)</td>
</tr>
<tr>
<td>Stability</td>
<td>5.35</td>
<td>4.85</td>
<td>5.93</td>
</tr>
<tr>
<td></td>
<td>(1.08)</td>
<td>(1.32)</td>
<td>(1.18)</td>
</tr>
<tr>
<td>Control</td>
<td>-5.39</td>
<td>-3.43</td>
<td>-4.57</td>
</tr>
<tr>
<td></td>
<td>(1.42)</td>
<td>(1.67)</td>
<td>(1.85)</td>
</tr>
<tr>
<td>Negative</td>
<td>3.04</td>
<td>3.33</td>
<td>2.15</td>
</tr>
<tr>
<td>Emotion</td>
<td>(1.70)</td>
<td>(2.01)</td>
<td>(1.26)</td>
</tr>
<tr>
<td>Positive</td>
<td>5.22</td>
<td>4.65</td>
<td>5.39</td>
</tr>
<tr>
<td>Emotion</td>
<td>(1.59)</td>
<td>(1.88)</td>
<td>(1.77)</td>
</tr>
<tr>
<td>Optimism re</td>
<td>4.35</td>
<td>5.11</td>
<td>4.78</td>
</tr>
<tr>
<td>Change</td>
<td>(1.37)</td>
<td>(1.46)</td>
<td>(1.50)</td>
</tr>
<tr>
<td>Optimism re</td>
<td>6.04</td>
<td>6.33</td>
<td>6.20</td>
</tr>
<tr>
<td>Care</td>
<td>(0.89)</td>
<td>(0.73)</td>
<td>(0.93)</td>
</tr>
<tr>
<td>Willing to</td>
<td>6.07</td>
<td>6.17</td>
<td>6.09</td>
</tr>
<tr>
<td>Change</td>
<td>(1.31)</td>
<td>(0.82)</td>
<td>(0.89)</td>
</tr>
<tr>
<td>Willing to</td>
<td>6.07</td>
<td>5.17</td>
<td>5.93</td>
</tr>
<tr>
<td>Care</td>
<td>(1.14)</td>
<td>(1.61)</td>
<td>(1.20)</td>
</tr>
</tbody>
</table>

3.4.1 Hypothesis 1.1 - Dependency level will exert a differential effect upon participants’ causal attributions such that for vignettes representing clients with low dependency needs, causal attributions will be less internal in locus, less global, less stable and involve more control over the behaviour. Challenging behaviour type will exert a differential effect upon dimensions of causal attributions.

Significant main effects of challenging behaviour were found for locus, $F(2,90)=17.88$, $p<.0005$; no significant effects of dependency were found for locus. Post hoc contrast
analysis revealed that delusional challenging behaviours were perceived to be more internal in locus than toileting \( (p<.0005) \) or verbal challenging behaviour \( (p=.001) \).

No significant main effects for challenging behaviour or dependency were found for globality, however, there was a significant interaction effect, \( F(2,90)=3.19, p=.046 \). A one way ANOVA for challenging behaviour type at each level of dependency revealed significant effects for the level of low dependency only, \( F(2,90)=4.21, p=.018 \). Simple effects analysis showed that for low dependency vignettes toileting behaviours were perceived as more specific than delusional behaviours, \( t(43)=3.03, p=.004 \).

Significant main effects of challenging behaviour were found for stability, \( F(2,90)=12.33, p<.0005 \). There was also a significant main effect of dependency for stability, \( F(1,45)=10.06, p=.003 \). There was no significant interaction. Post hoc contrast tests showed that toileting problems were perceived to be less stable than verbal challenging behaviours \( (p=.003) \) and delusional behaviours \( (p<.0005) \). Stability was perceived to be greater in high dependency clients than low dependency clients \( (p=.003) \).

Significant main effects of challenging behaviour were found for control, \( F(2,90)=8.14, p=.001 \). There was also a significant main effect of dependency for control, \( F(1,45)=28.12, p<.0005 \) and a significant interaction effect between challenging behaviour type and dependency for control, \( F(2,90)=8.26, p=.001 \).

Post hoc contrast analysis revealed that high dependency clients were perceived to have less control than low dependency clients. Delusional behaviours were perceived to involve clients with less control than either toileting behaviours \( (p=.005) \) or verbal behaviours \( (p=.002) \). Simple effects analysis of the interaction showed that the main effect of dependency was due to low dependency clients being rated as having more control than high dependency clients in the toileting behaviour type \( (p<.0005) \). The effect of challenging behaviour type was examined using a one way ANOVA for the different behaviour types at each level of dependency. At both levels of dependency, challenging behaviour type exerted a significant difference upon the degree of control over the cause of the behaviour the client was judged to have (low dependency,
Simple effects analysis of challenging behaviour for high dependency clients revealed that verbal behaviours were perceived to involve more control than delusional behaviours ($t(45)=-3.05, p=.004$). For low dependency clients, toileting behaviours were felt to involve more control than verbal behaviours ($t(45)=-3.42, p=.001$) and delusional behaviours ($t(45)=-4.15, p<.0005$).

**3.4.2 Hypothesis 1.2** Dependency level will exert a significant effect upon affects such that vignettes representing clients with low dependency needs will elicit more negative emotion and less positive emotion. Challenging behaviour type will exert a differential effect upon affects.

A significant main effect of challenging behaviour was found for negative emotion, $F(2,90)=17.80, p<.001$. No significant effect for dependency existed. There was a significant interaction effect between challenging behaviour and dependency level. *Post hoc* contrast analysis showed that toileting behaviours elicited more negative emotion than verbal behaviours ($p<.0005$) and delusional behaviours ($p<.0005$).

Analysis of the interaction effect showed that simple effects of dependency on different challenging behaviour type were non-significant at the adjusted probability level. One way ANOVAs on challenging behaviour type at different levels of dependency revealed significant differences at both high ($F(2,90)=6.21, p=.003$) and low dependency ($F(2,90)=18.053, p<.0005$). Simple effects analysis for high dependency vignettes revealed that toileting behaviour elicited more negative emotion than verbal behaviours ($t(45)=3.16, p=.003$). For low dependency vignettes, significant differences were found between all three behaviours, toileting behaviour elicited significantly more negative emotion than both verbal ($t(45)=3.16, p=.003$) and delusional behaviour ($t(45)=5.10, p<.0005$) and verbal behaviour elicited more negative emotion than delusional behaviour ($t(45)=3.50, p<.001$).

Positive emotion did not demonstrate any significant main or interaction effects for either challenging behaviour or dependency.

**3.4.3 Hypothesis 1.3** Dependency level will exert a significant effect upon optimism regarding behaviour change and regarding care such that vignettes representing clients with low dependency needs will elicit more optimism.
regarding behaviour change and less optimism regarding care. Challenging behaviour type will exert a differential effect upon optimism.

Optimism regarding care demonstrated a significant main effect for dependency, $F(1,45)=7.55, p=.009$. No significant effect of challenging behaviour or interaction effects was found. Higher dependency clients elicited less optimism regarding their care from care staff.

Optimism regarding behaviour change demonstrated significant main effects for dependency $F(1,45)=8.92, p=.005$, challenging behaviour $F(2,90)=10.78, p<.0005$, and a significant interaction effect between challenging behaviour and dependency, $F(2,90)=3.128, p=.049$. Contrasts indicated that there was greater optimism regarding behaviour change for low dependency vignettes than in high dependency vignettes and that verbal behaviours elicited more optimism regarding changing the behaviour than delusional behaviours ($p<.0005$).

Analysis of the interaction simple effects revealed that the effect of dependency on challenging behaviour was due to the significantly higher levels of optimism regarding behaviour change for low dependency/toiletting behaviours than for high dependency/toiletting behaviours ($t(45)=2.804, p=.007$). One way ANOVAs of challenging behaviour type at each level of dependency indicated that there were a significant effects for challenging behaviour type in vignettes depicting low dependency clients only ($F(2,90)=9.72, p<.0005$). Tests of simple effects showed that delusional behaviour elicited less optimism regarding behaviour change than verbal ($t(45)=-3.03, p=.004$) and toileting behaviour ($t(45)=4.11, p<.0005$).

3.4.4 Hypothesis 1.4 Dependency will exert a significant effect upon helping behaviours such that for vignettes representing clients with low dependency needs care staff will be more willing to help change the client’s behaviour but less willing to help care for the client. Challenging behaviour type will exert a differential effect upon helping behaviours.

Willingness to care for the client demonstrated significant main effects for dependency ($F(1,45)=12.89, p=.001$) and for the interaction between dependency and challenging
behaviour \( F(2,90)=5.99, p=.004 \). Contrast analysis revealed greater willingness to care reported in response to higher dependency clients as predicted. Simple effects analysis of dependency upon challenging behaviour type showed that willingness to care was significantly higher in high dependency scenarios than in low dependency scenarios for toileting behaviours \( t(45)=4.01, p<.0005 \) and in verbal behaviours \( t(45)=3.58, p=.001 \). One way ANOVA of challenging behaviour type at each level of dependency showed that challenging behaviour exerts significant simple effects at the level of high dependency only \( F(2,90)=4.56, p=.013 \). However, when within-subjects t-tests were used to examine differences between pairs of challenging behaviour types these contracts were not significant at the adjusted probability level.

Willingness to change the behaviour demonstrated a significant main effect for challenging behaviour type only, \( F(2,90)=4.62, p=.012 \). Contrast analysis of the challenging behaviour means revealed that this effect was produced by toileting behaviours eliciting greater willingness to change the behaviour than delusional behaviours \( p=.014 \).

### 3.4.5 Hypothesis 1.5 – Dependency will exert a significant effect upon person and behaviour evaluations such that vignettes representing clients with low dependency needs will elicit more negative person evaluations. Challenging behaviour type will exert a differential effect upon evaluations.

A main effect of challenging behaviour was found for person evaluation, \( F(2,90)=8.95, p<.0005 \). Contrast analysis revealed that clients with toileting behaviours were evaluated more negatively than clients with delusional behaviours \( p=.001 \). No significant main effects for dependency or the interaction were found.

Evaluation of the behaviour demonstrated main effects for challenging behaviour type, \( F(2,90)=23.21, p<.0005 \) and for the interaction with dependency level \( F(2,90)=3.76, p=.027 \). Contrast analysis revealed that toileting behaviours were evaluated more negatively than delusional \( p=.004 \) and verbal behaviours \( p<.0005 \), and that verbal behaviours were evaluated more negatively than delusional behaviours \( p=.004 \).
The effect of dependency upon each challenging behaviour was not significant at the adjusted probability level. Evaluation of the one way ANOVAs for interaction effects of challenging behaviour revealed significant simple effects of challenging behaviour type for both low dependency scenarios ($F(2,90)=22.57, p<.0005$) and high dependency scenarios ($F(2,90)=4.15, p=.019$). For low dependency vignettes toiletting behaviour was evaluated more negatively than verbal behaviour ($t(45)=3.42, p=.001$), and delusional behaviour ($t(45)=5.81, p<.0005$); and verbal behaviour was evaluated more negatively than delusional behaviour ($t(45)=3.89, p<.0005$). For high dependency vignettes, toiletting was again evaluated more negatively than delusional behaviour ($t(45)=3.10, p=0.003$).

3.4.6 Summary

Within subjects (2x3) ANOVA's and post hoc tests were used to examine the effect of challenging behaviour type and dependency level upon the dependent variables of attributional dimensions, affects, optimism, helping, and evaluations of the person and behaviour. Hypotheses 1.1, 1.2 1.3, 1.4 and 1.5 were partially supported. Dependency level exerted significant effects upon ratings of some attributions, optimism, helping and evaluations. Low dependency level scenarios were perceived as less Stable; to involve less Control; elicited more Optimism regarding Care (counter to the hypothesis); more Optimism regarding Change and less Willingness to Care. Although no main effects of dependency were found for Globality, Negative Emotion and Behaviour Evaluation, interaction effects existed with challenging behaviour type for these variables indicating that dependency level did exert some effect upon participants' ratings. Challenging behaviour type exerted significant effects upon ratings of attributions, Negative Emotion, optimism, helping and evaluations.

Delusional behaviours were perceived as more internal in Locus, and were seen as involving less client Control than verbal or toiletting behaviours. Toiletting behaviours were perceived as less Stable; aroused more Negative Emotion; and received more negative ratings of Behaviour Evaluation than delusional and verbal behaviours. Vignettes of toiletting behaviours also received more negative Person Evaluations than delusional behaviours. Verbal behaviours elicited more Optimism re Change than delusional behaviours; and participants were more Willing to Change toiletting behaviours than delusional behaviours. Although main effects of challenging
behaviour were not observed for Globality and Willingness to Care there were significant interaction effects indicating that challenging behaviour did affect participants’ ratings on these dimensions.

3.5 Research Question 2

To investigate the applicability of Weiner’s models of helping behaviour and achievement motivation to the management of challenging behaviour of older adults.

To examine this research question ten summary variables were created by adding the scores for each of the six vignettes for each of the ten dependent variables. Subsequent analysis involved Pearson’s product moment correlations, partial correlations and comparison of the correlation coefficients for significant differences (formula shown in Appendix 7). The assumptions underlying the Pearson correlation were met by all the summary data variables: data is at least ordinal with over 20 different values in the scale; the scores in each variable are independent and all variables sampled are normally distributed.

Pearson correlations for all variables of interest to the models of helping and achievement motivation are shown in Table 6.
Table 6. Pearson Correlations Between Ten Dependent Variables.

<table>
<thead>
<tr>
<th></th>
<th>Locus</th>
<th>Global</th>
<th>Stable</th>
<th>Control</th>
<th>Negative Emotion</th>
<th>Positive Emotion</th>
<th>Optimism re Change</th>
<th>Optimism re Care</th>
<th>Willing to Change</th>
<th>Willing to Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global</td>
<td>.222</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stable</td>
<td>.068</td>
<td>.110</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>-.127</td>
<td>.022</td>
<td>-.226</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative Emotion</td>
<td>-.309*</td>
<td>-.044</td>
<td>-.018</td>
<td>.586**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive Emotion</td>
<td>-.053</td>
<td>-.145</td>
<td>.052</td>
<td>-.188</td>
<td>-.246</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optimism re Change</td>
<td>.019</td>
<td>.106</td>
<td>-.446**</td>
<td>.123</td>
<td>.073</td>
<td>.223</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optimism re Care</td>
<td>.133</td>
<td>.159</td>
<td>.077</td>
<td>-.354*</td>
<td>-.621**</td>
<td>.123</td>
<td>.142</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Willing to Change</td>
<td>.239</td>
<td>.200</td>
<td>-.301*</td>
<td>-.145</td>
<td>-.353*</td>
<td>.206</td>
<td>.658**</td>
<td>.420**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Willing to Care</td>
<td>-.008</td>
<td>-.011</td>
<td>.122</td>
<td>-.591**</td>
<td>-.682**</td>
<td>.215</td>
<td>-.009</td>
<td>.578**</td>
<td>.313*</td>
<td></td>
</tr>
</tbody>
</table>

* p<0.05 (2 tailed), ** p<0.01 (2 tailed)
3.5.1 Hypothesis 2.1 - As predicted by Weiner's model of helping behaviour, propensity to care for the client will be related to the attributional dimension of control and positive affect rather than optimism regarding care.

To test the predictions of Weiner's model of helping behaviour for the helping variable 'Willing to Care' Pearson's product moment correlations were calculated between the summary dependent variables for the model. Due to the numbers of correlations being calculated the probability level for significance was adjusted to \( p = .017 \) for the helping behaviour model and \( p = .008 \) for the model of achievement motivation. Negative emotion was used in the following analyses due to the absence of significant correlations between positive emotion and any of the other dependent variables.

Weiner's model of helping behaviour predicts that attributions of control predict affect and thus predict 'Willing to Care'. Partial correlations were also calculated to investigate if relationship between the attributional dimension of Control and 'Willing to Care' remained when mediating variables such as affect and optimism are controlled for. Weiner's model of achievement motivation predicts that attributions of stability predict affect, which is mediated by optimism and thus predicts helping. Partial correlations were also calculated to investigate if relationship between Stability and 'Willing to Care' remained when mediating variables such as affect and optimism are controlled for.

The model of helping behaviour shown in Figure 3 displays the significant \( (p < .017) \) associations between Control and Negative Emotion and an inverse relationship between Negative Emotion and 'Willing to Care'. However, when the partial correlation between Control and Willingness to Care, controlling for Negative Emotion is calculated, the inverse relationship between Control and Willingness to Care became non-significant \( (r = .323, p > .017) \).
Fig. 3 Models of Helping Behaviour and Achievement Motivation for Variable ‘Willing to Care’.

Helping

Achievement motivation

Key

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.578</td>
<td>Pearson correlation coefficients between two variables</td>
</tr>
<tr>
<td>0.095</td>
<td>Partial correlation coefficient between two variables.</td>
</tr>
</tbody>
</table>

* Correlation coefficient is significant at $p<0.017$
** Correlation coefficient is significant at $p<0.008$. 
The model of achievement motivation in Figure 3 shows that Willingness to Care was also significantly correlated with Optimism re Care (r = .578, p < .0005). However, Optimism regarding Care did not show significant correlations with the attributional dimension Stability.

In addition correlation coefficients between Negative Emotion and Willingness to Care and between Optimism regarding Care and Willingness to Care were compared using the method of Steiger (1980; cited in Clark-Carter, 1997, p525). This calculation tests for a significant difference between the two correlation coefficients. When the correlation coefficients are compared the correlation between Negative Emotion and Willingness to Care emerges as being significantly different to the relationship between Optimism regarding Care and Willingness to Care (t(43) = -6.46, p < .001).

A path analysis was carried out to examine the predictors of Willingness to Care. The model of Weiner (1986) shown in Figure 2 (page 24) was used to determine entry into the multiple regression analyses. Initially, Willingness to Care was regressed onto the variables preceding it in the model, Optimism re Care, Negative Emotion, Control and Stability. Subsequently those variables found to be significant predictors were regressed onto variables preceding them in the model. This process was continued until there were no significant predictors obtained or until the predictors obtained came from the attributional stage of the model. The results are presented in Figure 4.

The initial regression analysis for Willingness to Care was significant (F(41,4) = 13.18, p < .0005, R² = .563). Willingness to Care was significantly predicted by Control (an inverse relationship) and by Negative Emotion but not by Optimism regarding Care or by Stability. The subsequent regression analysis for Negative Emotion was also significant (F(43,2) = 11.936, p < .0005, R² = .357) and Control emerged as the attributional dimension that most predicted Negative Emotion. Caution must be taken in interpreting the results of this analysis because the sample size is below that normally required for regression analysis. However, power for the obtained effect sizes in both of the above analyses was above .89, indicating adequate power to avoid Type II errors (Clark-Carter, 1997, p631). The research hypothesis that variables in Weiner’s theory of helping behaviour will best predict Willingness to Care is supported.
3.5.2 Hypothesis 2.2 - As predicted by Weiner’s theory of achievement motivation, willingness to change the behaviour will be associated with the attributional dimension of stability, and the effect of affect will be mediated by optimism regarding behaviour change.

To test the predictions of Weiner’s model of helping behaviour for the helping variable ‘Willing to Change’ the same procedure was followed. Pearson correlation coefficients and partial correlation coefficients were calculated between the summary dependent variables for the model. The probability level was again adjusted to $p=0.017$ for the helping behaviour model and $p=0.008$ for the model of achievement motivation. The correlation coefficients between Negative Emotion and Willingness to Change and Optimism regarding Change and Willingness to Change were also examined for significant differences and a path analysis was carried out.
Figure 5. Models of Helping Behaviour and Achievement Motivation for Variable ‘Willing to Change’.

Helping

![Diagram showing the relationship between Control, Negative Emotion, and Willing to Change.](image)

Achievement Motivation

![Diagram showing the relationship between Stability, Negative Emotion, Optimism and Willing to Change.](image)

Key

<table>
<thead>
<tr>
<th>0.579</th>
<th>Pearson correlation coefficients between two variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.095</td>
<td>Partial correlation coefficient between two variables.</td>
</tr>
</tbody>
</table>

* Correlation coefficient is significant at \( p < 0.017 \)

** Correlation coefficient is significant at \( p < 0.008 \).

The above model of helping behaviour shows that there is a significant positive correlation between Control and Negative Emotion, and an inverse relationship between Negative Emotion and ‘Willingness to Change’ \((p < 0.017)\). The direct inverse relationship between Control and Willingness to Change is non-significant and partial.
correlations between Control and Willingness to Care controlling for Negative Emotion were also non-significant.

The model of achievement motivation shows Willingness to Change correlates significantly with Optimism re Change \((r=-.658, p=.0005)\) but not with Negative Emotion or Stability directly (at the requisite probability level). Partial correlations between Willingness to Change and Stability controlling for Optimism \((r=-.012)\) and for Negative Emotion \((r=-.329)\) were also non-significant. Optimism re Change showed a significant relationship with Stability \((r=.446, p<.002)\), but not Negative Emotion.

The correlation coefficients between Optimism regarding Change and Willingness to Change and between Negative Emotion and Willingness to Change were compared and this difference was found to be significant \((t(43)= 6.48, p<.001)\). Therefore Optimism regarding Change and Willingness to Change was significantly different to the relationship between variables Negative Emotion and Willingness to Change.

A path analysis was carried out to examine the predictors of Willingness to Change. The model of Weiner (1986) shown in Fig. 2 (page 24) was used to determine entry into the multiple regression analyses. Initially, Willingness to Change was regressed onto the variables preceding it in the model: Optimism for Change, Negative Emotion, Control and Stability. Subsequently those variables found to be significant predictors were regressed onto variables preceding them in the model. This process was continued until there were no significant predictors obtained or until the predictors obtained came from the attributional stage of the model. The results of these analyses are presented in Figure 6.
The initial regression analysis for Willingness to Change was significant \((F(41,4) = 11.597, p < .0005, R^2 = .531)\). Optimism regarding Change was the only significant predictor of Willingness to Change. The subsequent regression analysis for Optimism regarding Change was also significant \((F(42,3) = 3.790, p < .017, R^2 = .213)\). The standardised regression coefficients for Negative Emotion (-.262) and for Optimism regarding Change (.629) indicate that optimism accounts for a larger proportion of the variance in Willingness to Change than Negative Emotion. Optimism regarding Change also accounts for a larger proportion of the variance in Willingness to Change than the attributional dimensions of Stability and Control. Optimism was significantly predicted by Stability only. As noted above, caution must be taken in interpreting this analysis because the sample size is below that normally required for regression analysis. However, power for the obtained effect sizes in the above analysis was above .89 except for the regression of Optimism regarding Change which was at .77. A sample size of 50 would be necessary for an effect of size .20 to have power of .8 (Clark-Carter, 1997, p632). The research hypothesis that variables in Weiner’s theory of achievement motivation will best predict Willingness to Change is supported.
3.6 Research Question 3

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

This research question has been examined in three stages. Summary management strategy variables were created by summing the 30 scores for each management strategy (five scores for each type of strategy in each vignette). Descriptive statistics are presented which represent the expressed likelihood of using the different types of management strategies for each of the six case studies and the summary variables. Secondly, the effect of the independent variables of client dependency level and challenging behaviour type on likelihood of using Abusive and MSP management strategies are investigated using repeated measures two-way (2x3) ANOVA’s. Then the relationships between attributional variables, helping behaviours and Abusive and MSP management strategies are examined using Pearson correlations.

3.6.1 Hypothesis 3.1 – Care staff will report a differential propensity to use the different types of management strategy. Care staff will report that they are most likely to use appropriate management strategies and least likely to use abusive management strategies in response to challenging behaviour.

The means and standard deviations for Appropriate, MSP and Abusive management strategies on each vignette and the summary variables are shown in Table 7.

Appropriate management strategies received the highest scores for all vignettes except for low dependency/delusional behaviour where the mean score for appropriate management responses was the same as that for MSP responses. Abusive management strategies received the lowest scores for all vignettes. A one-way within subjects ANOVA was significant ($F(2,90)=459.20, p<0.0005$). Participants were more likely to use Appropriate strategies than both MSP ($t(45)=10.6, p<0.0005$) and Abusive strategies ($t(45)=23.5, p<0.0005$); and were more likely to use MSP strategies than Abusive strategies ($t(45)=28.04, p<0.0005$).
### Table 7. Mean Scores and Standard Deviations for Likelihood of Using Different Types of Management Strategies on each Vignette.

<table>
<thead>
<tr>
<th>Challenging Behaviour Type</th>
<th>Dependency Level</th>
<th>Mean (Standard Deviation)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Appropriate</td>
<td>MSP</td>
</tr>
<tr>
<td><strong>Toiletting behaviour</strong></td>
<td>High</td>
<td>28.61 (4.41)</td>
<td>22.35 (4.00)</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>29.07 (3.76)</td>
<td>20.98 (5.50)</td>
</tr>
<tr>
<td><strong>Verbal behaviour</strong></td>
<td>High</td>
<td>26.57 (4.06)</td>
<td>20.76 (6.11)</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>27.48 (5.37)</td>
<td>24.93 (5.46)</td>
</tr>
<tr>
<td><strong>Delusional behaviour</strong></td>
<td>High</td>
<td>30.48 (4.08)</td>
<td>18.80 (5.07)</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>25.22 (5.77)</td>
<td>25.22 (5.05)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>167.41 (16.69)</td>
<td>133.04 (19.34)</td>
</tr>
</tbody>
</table>

3.6.2 Hypothesis 3.2 - Client dependency and topography of challenging behaviour will differentially affect staff ratings of expressed intent to use MSP and abusive management strategies; such that staff will report less likelihood of using abusive and MSP strategies at higher levels of dependency.

Two way (2x3) within subjects ANOVAs were performed to examine the effect of dependency and challenging behaviour type on the expressed likelihood of Abusive and MSP strategy use. The procedure followed is described in Section 3.4.

A significant main effect of dependency was found for MSP strategy use, $F(1,45)=37.76, p<.0005$. Low dependency vignettes were more likely to elicit the use of MSP strategies than high dependency scenarios. There was also a significant interaction effect, $F(2,90)=21.55, p<.0005$.

A one way ANOVA at each level of dependency revealed that the effect of challenging behaviour was significant at both high ($F(2,90)=7.17, p=.001$) and low ($F(2,90)=11.59, p<.0005$) levels of dependency. Contrast analysis showed that the effect of challenging behaviour type was significant between high dependency vignettes for toiletting and delusional behaviour where toiletting was more likely to elicit MSP responses than delusional behaviour ($t(45)=4.671, p<.0005$). For low dependency vignettes, toiletting behaviour was less likely to elicit MSP responses than verbal ($t(45)=-3.53, p=.001$) and
delusional behaviour (t(45)=-4.61, p<.0005). The effect of dependency level was significant between verbal behaviours (t(45)=4.11, p<.0005) and delusional behaviours (t(45)=7.59, p<.0005). Low dependency/Verbal behaviours were more likely to elicit the use of MSP strategies than High dependency/Verbal behaviours and High dependency/Delusional were more likely to elicit the use of MSP strategies than Low dependency/Delusional scenarios.

For abusive management strategies, significant main effects were found for dependency (F(1,45)=14.76, p<.0005) and the interaction between dependency level and challenging behaviour (F(2,90)=5.95, p=.004). High dependency vignettes were more likely to elicit abusive responses from care staff than low dependency vignettes.

One way ANOVAs for challenging behaviour type at each level of dependency showed that significant effects were present for low dependency vignettes only, F(2,90)=8.59, p<.0005. Contrast analysis revealed that for low dependency scenarios, toiletting behaviours elicited less likelihood of using abusive management strategies than verbal behaviours (t(45)=-3.93, p<.0005) and than delusional behaviours (t(45)=-2.90, p=.006). The effect of dependency level revealed high dependency toiletting behaviour elicited significantly greater likelihood of abusive management than low dependency toiletting behaviour, (t(45)=4.96, p<.0005).

3.6.3 Hypothesis 3.3 – There will be a positive relationship between willingness to care and appropriate management strategy use. There will be a negative relationship between willingness to care and abusive and MSP management strategies.

Pearson correlation coefficients are calculated for the relationships between dependent variables of attributions, affect optimism and helping and the management strategy variables Appropriate, MSP and Abuse. These are shown in Table 8. Eight correlations were calculated for each management strategy therefore the significant probability level was adjusted to p<.006.
Table 8. Pearson Correlation Coefficients between Helping and Management Strategies.

<table>
<thead>
<tr>
<th></th>
<th>Appropriate</th>
<th>MSP</th>
<th>Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stability</td>
<td>-.009</td>
<td>-.245</td>
<td>-.291</td>
</tr>
<tr>
<td>Control</td>
<td>-.190</td>
<td>.165</td>
<td>.379*</td>
</tr>
<tr>
<td>Negative Emotion</td>
<td>-.427**</td>
<td>.034</td>
<td>.308*</td>
</tr>
<tr>
<td>Positive Emotion</td>
<td>.169</td>
<td>-.179</td>
<td>-.268</td>
</tr>
<tr>
<td>Optimism re Change</td>
<td>.287</td>
<td>.204</td>
<td>.115</td>
</tr>
<tr>
<td>Optimism re Care</td>
<td>.610**</td>
<td>.031</td>
<td>-.330*</td>
</tr>
<tr>
<td>Willing to Care</td>
<td>.530**</td>
<td>-.086</td>
<td>-.339*</td>
</tr>
<tr>
<td>Willing to Change</td>
<td>.492**</td>
<td>.278</td>
<td>.024</td>
</tr>
</tbody>
</table>

* Correlation significant at the p<.05 level  ** Correlation significant at the p<.006 level.

The results in Table 8 show that both helping variables Willing to Care and Willing to Change show a significant positive relationship with the likelihood of using appropriate management strategies. Other relationships between helping and Abusive and MSP management strategies were not significant at the adjusted probability level, although the inverse relationship between the variables Abuse and Willing to Care was approaching significance (r=-.339, p=.02). Negative Emotion was significantly inversely related to the likely use of Appropriate management strategies.

3.7 Research Question 4.

To explore the relationship between training, familiarity with challenging behaviour and support at work; attributions and management strategies.

The effects of training were compared by dividing the participants into two groups, those who were currently training as student nurses and those nursing assistants who had completed NVQ Level 3 training formed the ‘Trained’ group of staff and all others formed the ‘Untrained’ group of staff. Feeling supported at work (‘Support’) was measured by the sum of the three questions asking about the degree of support each participant felt that they received from their manager, colleagues and other agencies (i.e. social services, GP’s, residential facilities). The participants were also formed into
two groups on the basis of their familiarity with challenging behaviour, those who
reported experiencing challenging behaviour rarely or occasionally formed the
'Unfamiliar' group and those who reported experiencing challenging behaviour
regularly or continually formed the 'Familiar' group.

3.7.1 Hypothesis 4.1 - Student nurses and more highly trained staff (NVQ
Level 3 staff) will make fewer internal attributions, show lower levels of
negative affect and higher levels of positive affect towards the clients; and
express less propensity to use abusive and MSP strategies than other staff.

The 'Trained' and 'Untrained' groups of staff were compared using independent
samples t-tests for differences between the attributional dimensions of Control and
Stability; Positive and Negative Emotion; Optimism re Care and Change; Willing to
Care and Change; and management strategy variables Abuse and MSP. The means and
standard deviations of the two groups are shown in Table 9.

Table 9. Mean Scores and Standard Deviations of 'Trained' and 'Untrained' Care Staff
on Key Variables.

<table>
<thead>
<tr>
<th></th>
<th>Untrained Mean (S.D.)</th>
<th>Trained Mean (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>-29.25 (5.01)</td>
<td>-26.31 (6.19)</td>
</tr>
<tr>
<td>Stability</td>
<td>32.89 (4.11)</td>
<td>34.05 (3.64)</td>
</tr>
<tr>
<td>Positive Emotion</td>
<td>29.78 (7.22)</td>
<td>30.00 (7.25)</td>
</tr>
<tr>
<td>Negative Emotion</td>
<td>13.74 (6.02)</td>
<td>18.42 (7.58)</td>
</tr>
<tr>
<td>Optimism re Care</td>
<td>37.26 (3.79)</td>
<td>36.37 (3.55)</td>
</tr>
<tr>
<td>Optimism re Change</td>
<td>27.22 (6.02)</td>
<td>28.84 (5.25)</td>
</tr>
<tr>
<td>Willingness to Care</td>
<td>34.00 (4.96)</td>
<td>32.84 (6.42)</td>
</tr>
<tr>
<td>Willingness to Change</td>
<td>35.04 (5.56)</td>
<td>36.32 (3.32)</td>
</tr>
<tr>
<td>MSP</td>
<td>137.48 (20.67)</td>
<td>126.74 (15.71)</td>
</tr>
<tr>
<td>Abuse</td>
<td>67.15 (20.49)</td>
<td>65.05 (21.59)</td>
</tr>
</tbody>
</table>
Using an adjusted probability level of \( p < .005 \) to compensate for the ten \( t \)-tests being calculated, no significant differences between ‘Trained’ and ‘Untrained’ staff were found, although significant differences were found between the groups for negative emotion at \( p < .05 \) (\( t(44) = -2.33, p = .024 \)).

3.7.2 Hypothesis 4.2 – There will be a positive relationship between feeling supported at work and helping and use of appropriate management strategies. There will be a negative relationship between feeling supported at work and expressed intent to use abusive/MSP management strategies.

Pearson correlations were calculated between the total ‘Support’ variable; the two helping variables, Willing to Change and Willing to Care; and the two management strategies, MSP and Abuse. The probability level for significance was \( p < .0125 \). The correlations are shown in Table 10. Only the helping variable Willing to Change was significantly correlated with Support (\( r = .443, p = .001 \) (one-tailed)).

Table 10. Pearson Correlations between Support and Helping and Management Strategies.

<table>
<thead>
<tr>
<th></th>
<th>Willing to Change</th>
<th>Willing to Care</th>
<th>MSP</th>
<th>Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support</td>
<td>.443*</td>
<td>.167</td>
<td>.134</td>
<td>.217</td>
</tr>
</tbody>
</table>

* Correlation is significant at \( p < .0125 \)

3.7.3 Hypothesis 4.3 – Staff experiencing challenging behaviour regularly or continually will attribute lower levels of control, stability and negative affect, and higher levels of positive affect and helping behaviours than those staff who have less frequent contact with challenging behaviour. They will also express less intent to use abusive or MSP management strategies.

Differences between ‘Familiar’ participants (those staff experiencing challenging behaviour at least regularly) and ‘Unfamiliar’ participants (those staff experiencing...
challenging behaviour occasionally or rarely were examined using independent sample t-tests. The adjusted probability level for significance was $p<.008$ (one-tailed). Staff who are familiar with challenging behaviour reported significantly less likelihood of using abusive management strategies ($t(44)=2.55, p=.007$ (one-tailed)). The difference between groups for MSP management strategies was non-significant ($t(44)=1.66$, n.s.). There were no other significant differences between the groups on any attributional dimensions, affects, optimism, helping or evaluation variables.

Table 11 Means and Standard Deviations of Abuse and MSP Scores of Participants 'Familiar' and 'Unfamiliar' with Challenging Behaviour.

<table>
<thead>
<tr>
<th></th>
<th>Unfamiliar (S.D.)</th>
<th>Familiar (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control</td>
<td>-26.82 (6.88)</td>
<td>-28.75 (4.79)</td>
</tr>
<tr>
<td>Stability</td>
<td>33.18 (3.96)</td>
<td>33.48 (3.98)</td>
</tr>
<tr>
<td>Positive Emotion</td>
<td>29.18 (6.92)</td>
<td>30.28 (7.38)</td>
</tr>
<tr>
<td>Negative Emotion</td>
<td>16.35 (8.57)</td>
<td>15.27 (6.09)</td>
</tr>
<tr>
<td>Optimism re Care</td>
<td>37.00 (3.87)</td>
<td>36.83 (3.63)</td>
</tr>
<tr>
<td>Optimism re Change</td>
<td>28.88 (6.17)</td>
<td>27.31 (5.45)</td>
</tr>
<tr>
<td>Willingness to Care</td>
<td>32.35 (6.45)</td>
<td>34.21 (4.98)</td>
</tr>
<tr>
<td>Willingness to Change</td>
<td>35.59 (5.64)</td>
<td>35.55 (4.27)</td>
</tr>
<tr>
<td>MSP</td>
<td>139.12 (16.95)</td>
<td>129.48 (20.04)</td>
</tr>
<tr>
<td>Abuse</td>
<td>75.88 (23.30)</td>
<td>60.65 (17.09)</td>
</tr>
</tbody>
</table>
4 DISCUSSION

4.1 Interpretation of the Results

4.1.1 The effect of challenging behaviour topography and client dependency upon attributional variables, affect, optimism, helping and evaluations.

The results partially support hypotheses 1.1, 1.2, 1.3, 1.4, and 1.5. Participants used information about the client’s dependency level and about the challenging behaviour when rating attributions, affects, optimism and helping. Challenging behaviour type was shown to affect care staff of older adults’ ratings of the attributional dimensions of locus, stability and control; negative emotion, optimism regarding behaviour change; willingness to change the behaviour, person evaluation and behaviour evaluation. Dependency level also exerted effects on participants’ ratings: low dependency needs elicited ratings of less stability, greater control, greater optimism regarding change, less willingness to care for the client and, contrary to predictions, greater optimism to care. There was an interaction between dependency level and challenging behaviour type for the attributional dimensions of control and globality; negative emotion; optimism regarding behaviour change; willingness to care; and for behaviour evaluation.

Interaction effects indicated that whilst both independent variables, challenging behaviour and dependency level, influence participant’s beliefs about the cause of the behaviour and their motivation to intervene, one may moderate the effect of the other. For example in the case of the attributional dimension globality, the effect of challenging behaviour is only significant at the level of low dependency. There was only one variable where participant ratings were not influenced by challenging behaviour topography or dependency – positive emotion.

These results are mostly consistent with the literature in this field. For example, Stanley and Standen (2000) also examined the relative effects of dependency level and three different types of aggressive challenging behaviour (aggressive towards another client, destructive towards property and self-injurious behaviour) on the attributional ratings of carers of people with learning disabilities. The measure of optimism and helping used in the Stanley and Standen study closely relates to the measures of optimism and willingness to help regarding behaviour change used in the present
research. In common with the present study they found that challenging behaviour type exerted differential effects upon variables of control and stability, negative affect, and helping. By contrast to the current study they found that challenging behaviour type had an effect upon ratings of positive affect, but no effect upon optimism. In common with the present study a decreased dependency level elicited more control and less stability, and increased optimism. Results of the current study indicated that participants were less willing to care for clients with lower levels of dependency than those with high dependency needs. However, Stanley and Standen (2000), found that by contrast, dependency exerted a significant effect upon positive affect, and did not show an effect for helping. Stanley and Standen (2000) also found significant interaction effects for negative and positive affect, optimism and helping. The differences between the results of these studies may be due to variance in a number of aspects of the method. Aside from the alterations to measures of optimism and helping in the current study the participant groups care for different client groups and are likely to have different training and experiences that will affect their attributional responses. The vignettes in both studies were designed to show behaviour typical of the specific client group and thus vary considerably, depicting either clients with learning disabilities or older adults and different types of challenging behaviour. It may be that care staff for people with learning disabilities experience more variance in the degree of positive affect for the clients than do care staff for older adults for example. The results are sufficiently alike however to suggest that challenging behaviour topography and aspects of the client such as dependency needs influence the attributional, affective and intervention responses of care staff generally.

4.1.2 Applicability of an attributional model.
The results support hypothesis 2.1 and the application of Weiner’s model of helping behaviour for the expressed intention of participants to care for clients. There were significant relationships between control, affect and helping. As predicted, perceptions of increased client control over the cause of the behaviour were associated with increased negative emotion and decreased willingness to care for the client. When the model of achievement motivation was examined in relation to willingness to care for the client, although optimism was also significantly positively associated with willingness to care it was not associated with the attributional dimensions of stability.
Partial correlations indicated that attributions of Control were not directly correlated with Willingness to Care when Negative Emotion was controlled for. This suggests that the effect of attributions of control is mediated by negative emotion as proposed in the theory of helping behaviour. Comparison of correlation coefficients showed that the correlation between Willing to Care and Negative Emotion was significantly different to that between Willing to Care and Optimism re Care. Path analysis demonstrated that only Negative Emotion and Control significantly (inversely) predicted Willing to Care and thus were better predictors than Optimism and Stability. Attributions of Control significantly predicted Negative Emotion. The results suggest that care staff of older adults are likely to decide how willing they are to care for clients in the face of challenging behaviour on the basis of the degree of control they feel that the client has over the behaviour. This degree of control gives rise to negative emotion. The less control the client is believed to have over the behaviour, the less negative emotion experienced and the greater willingness to help.

With regard to willingness to change the client’s behaviour, the results support hypothesis 2.2, that the model of achievement motivation best accounts for the participants’ expressed willingness to change the behaviour of the clients. Willingness to Change the behaviour was inversely related to Negative Emotion and was positively correlated with Optimism regarding Change. Increased Negative Emotion was significantly related to increased degree of Control over the behaviour. Optimism regarding Change was inversely related to the perceived Stability of the cause of the behaviour. Partial correlations between Control and Willing to Change (controlling for Negative Emotion) and between Stability and Willing to Change (controlling for Optimism re Change) were non-significant indicating that optimism mediates between attributions and willingness to change the behaviour. Comparison of the correlated correlation coefficients between Willing to Change and Optimism re Change and between Willing to Change and Negative Emotion showed that these relationships were significantly different. Path analysis demonstrated that optimism was a significant predictor of willingness to change the behaviour whereas stability, control and negative emotion were not. However, Stability of the cause of the behaviour was a significant predictor of optimism. These results suggest that when faced with challenging behaviour, care staff may make attributions about the stability of the behaviour that are
associated with a degree of optimism regarding changing that behaviour. Care staff use the degree of optimism they have about the likely success of their actions to determine the degree of effort they are willing to put into changing the client’s behaviour.

Although the results have shown that significant relationships exist that support Weiner’s attributional model of achievement motivation and emotion, the research method did not allow the determination of the temporal order of the variables in the model. Therefore caution must be exercised in accepting the results as proof of Weiner’s model of helping and achievement related behaviour in caregiving situations.

Weiner (1974a) predicted that his attributional theory would generalise over a variety of situations. This study adds to the literature on attributional models of care staff behaviour, which has shown mixed support for both Weiner’s model of helping behaviour and achievement motivation. Brewin (1984) found that medical students were more likely to prescribe medication (interpreted as helping behaviour) when patients’ life events were seen as uncontrollable rather than controllable, supporting the theory of helping behaviour. Sharrock, et al. (1990) used path analysis to examine associations between attributions, emotions and behaviour in Weiner’s theory of helping behaviour for care staff of a medium secure unit for mentally disordered offenders. Hypothetical behaviours for a single target patient known to all participants were used as stimuli for the attributional dimension items only. Optimism and affect ratings were obtained for the patient, not the behaviours. In contrast to the current study, Sharrock et al. found that helping behaviour was related to optimism and therefore interpreted the results as not supportive of the theory of helping behaviour. Optimism was also significantly inversely related to attributions of control and stability. Sharrock et al (1990) suggested that care staff may habituate to problem behaviour and thus not show the affective responses that Weiner’s theory predicts motivate helping behaviour.

Dagnan et al. (1998) also used path analysis to find the best predictors of care staff helping towards a single learning disabled client’s challenging behaviours. They measured attributions, affect, optimism and helping for each of the client’s behaviours and also found that optimism was the best predictor of helping behaviour. Optimism
was inversely predicted by negative emotion and negative emotion was best predicted by the attribution of control. These authors interpreted this as supportive of Weiner's model of helping behaviour. Subsequently Stanley and Standen (2000) argued that, due to the significant relationship between optimism and helping, Dagnan et al.'s results may best be represented by Weiner's theory of achievement motivation.

Stanley and Standen (2000) attempted to clarify the relative roles of optimism and affect in an attributional model of learning disability care staff behaviour. Using vignettes they manipulated the stability of the cause of the behaviour of clients and described a broader range of challenging behaviours. Unlike the research conducted by Sharrock et al. (1990) and Dagnan et al. (1998) the results demonstrated the application of Weiner's theory of helping behaviour, with significant correlations between affect and helping but not between optimism and helping. However, their results did demonstrate that optimism becomes more important in scenarios when the cause of the behaviour is linked to a stable factor such as dependency level.

Care staff participating in the present study seem not to have habituated to challenging behaviour (or not at least to those presented within the vignettes). When care staff perceive that the client has a higher degree of control over the behaviour they are more likely to feel angry (negative emotion) and less likely to help to care for the client. By contrast, the intention to change a client's behaviour is based upon the staff degree of optimism about changing the behaviour, the level of optimism is inversely related to the degree of stability that the staff member perceives the behaviour's cause to have.

The results of the present study shed light upon the results of previous research. The present study has some major methodological differences to the research discussed above. One such change is the distinction between two helping variables: willingness to change the behaviour (interpreted as achievement related behaviour) found to be associated with attributions of stability and optimism; and willingness to care (interpreted as helping behaviour) found to be associated with attributions of control and affect. This distinction was introduced to specify more precisely the kind of action the member of staff was being asked about. The use of a single question asking how willing staff members are to help the client is likely to access the participant's
motivation for both behaviour change and willingness to care for the client. The present study demonstrates that the distinction between two helping behaviours, caring and changing the behaviour, is important in understanding the role of attributions of control and stability, affect and optimism.

This methodological change could possibly be one reason for the previously contradictory results with strong correlations of optimism with helping found by Dagnan et al. (1998) and Sharrock et al. (1990) and the correlation between affect and helping of Stanley and Standen (2000). Optimism was assessed by Sharrock et al. using a five point rating scale including items that were orientated to improving the patient’s mental health rather than their experience of the care. This was most similar to the optimism regarding behaviour change variable of the present study. However, assessing optimism about behaviour change in general is likely to be less accurate than collecting information about the degree of optimism regarding changing each behaviour. Helping was also assessed only once using a single question “How much extra effort would you exert in helping this person?” more akin to the variable ‘Willing to Care’ in the present study. These questions may have confounded two different beliefs of the care staff in the study: the belief that the behaviour could be changed and the willingness to care for the client regardless. Dagnan et al. (1998) assessed optimism and helping with regard to each behaviour rather than the client but again, although optimism items were orientated to behaviour change, care staff behaviour was assessed by an item asking about willingness to put extra effort into helping the client. This author would again argue that these results may have been produced because optimism and helping were insufficiently and contradictorily defined.

The method and results of Stanley and Standen (2000), are those most similar to the current study. The relationship between helping and affective responses is mirrored in the current study’s finding that willingness to care is most strongly related to negative affect. Stanley and Standen (2000) found a relationship between affect and helping despite the questions measuring helping and optimism being orientated to behaviour change. This is in direct opposition to the present study’s findings that motivation to change the behaviour is predicted by attributions of stability and optimism. However,
this author would argue that in answering the question regarding helping participants could (depending on their beliefs about care plans) be referring to both caring and behaviour change orientated tasks as discussed above. Due to the question construction they may also have confounded helping with affect. The helping question states:

"As key worker would this behaviour stimulate you to work even harder on X’s care programme?"

I would feel 1 2 3 4 5 6 7 8 9 I would feel
discouraged encouraged
and work less hard to work even harder

[Emphasis not present in the original].

The second major distinction between the research discussed above and the present study is the client and care staff group. The present study investigated the responses of care staff for older adults in response to challenging behaviours of older adults. It is possible that care staff of older adults may have different qualities, experiences and training from care staff for people with learning disabilities. These factors and those pertaining to beliefs about the causes of challenging behaviour of older adults could lead to different attributions about the cause of the behaviour from those made by carers of people with learning disabilities.

4.1.3 Management of challenging behaviours.

Participants reported that they were most likely to use appropriate management strategies in response to challenging behaviour and least likely to use abusive management strategies. The results showed that care staff do discriminate between responses that are appropriate, abusive and examples of MSP. To the author’s knowledge this is the first study to examine this question. Staff reported that they were likely to use different types of management strategies in response to different client challenging behaviours and dependency levels. Complex interactions between dependency and challenging behaviour exist for management strategies that were
examples of Malignant Social Psychology. High dependency level increased the reported likelihood of use of abusive management responses, counter to the predictions of the hypotheses. Several explanations may account for this finding. It is possible that care staff are less aware of the potential for their management actions to be abusive (and thus did not recognise abusive actions); or that the expert raters of the management strategies were especially sensitive to the abusive nature of the suggested management responses (and thus rated non-abusive strategies as abusive) with a more dependent client group. Alternatively it may be that clients with high dependency needs show behaviour which is more offensive to the care staff and thus they experience greater levels of negative emotion or anger towards the client leading to abusive management actions. The explanation for the finding is not clear from this study, however it is consistent with literature of elder abuse. In their literature review, Penhale and Kingston (1997) conclude that it appears that more vulnerable individuals are at an increased risk of being abused and that those individuals with dementia who become aggressive and/or violent may also be at increased risk of abuse occurring. Research has also found that healthier patients and residents receive more humane treatment from staff and that socially isolated residents and patients are at the greatest risk of abuse (Phillipson & Biggs, 1995: 192; Pillemer, 1988: 233).

The effect of challenging behaviour type on the likelihood of using abusive management responses was restricted to low dependency scenarios, where toileting behaviours elicited a greater likelihood of abusive management than verbal and delusional behaviours. A search of PsychInfo (2000) revealed no studies that examined the association between particular challenging behaviours and abusive responses of nursing staff, although two studies assessed the impact of different behaviours upon staff. Freyne and Wrigley (1996) found that nurses found it more difficult to cope with physical aggression than other challenging behaviours. Fisher, Fink & Loomis (1993) reported that surveys show that care staff generally find high frequency problems such as disorientation, incontinence and poor self-care easier to manage than low frequency episodes of verbal or physical aggression. Literature on family caregiving also suggests that those caring for people with dementia and challenging behaviour are more likely to fear hurting their relative with dementia than to actually commit abusive acts (Penhale & Kingston, 1997). The results of this study support the literature in the
learning disability field which finds that care staff distinguish between different challenging behaviours; choose different management strategies in response to different behaviours; and that not all of these behaviours would be seen as appropriate by other professionals (Hastings, 1996; Watts, Reed, & Hastings, 1997). Hastings and Remington (1994) suggest that inappropriate care staff beliefs about the causes of challenging behaviour might result in similarly inappropriate management of these behaviours on the part of care staff. Oliver, Hall, Hales and Head (1996) have found some evidence to confirm this with regard to self-injurious behaviour of people with learning disabilities. This study only found evidence of a weak association between abusive actions by staff and attributions of control, negative emotion, optimism regarding care, and willingness to care. The positive relationships between control over the behaviour, negative emotion and likelihood of using abusive management strategies, although not significant at the adjusted probability level, may bear further investigation.

4.1.4 Training, staff support and familiarity with challenging behaviour.

Qualifications for care work did not appear to have a significant effect upon participants' responses on attributional, affective, optimism, helping, and management strategy variables counter to Hypothesis 4.1. There are no other studies that have examined the relationship between care staff qualifications and familiarity of challenging behaviour with attributions, helping and management strategies for older adults. However, Dagnan et al (1998) found that their group of carers who had greater experience of challenging behaviour evaluated the person more positively and were more likely to report that they would help the client than those who were less experienced. Moniz-Cook et al. (2000) found that qualified care staff reported more difficulty in managing challenging behaviour than care assistants. This study replicated the finding of an Australian study (Snowden, Miller and Vaughan, 1996) who found that senior members of staff had differing views about the frequency of and disruption caused by challenging behaviour than the nurses or nursing assistants working most closely with the residents. Other literature suggests that poorly trained or untrained staff are more likely to abuse residents (Pillemer, 1988) and that trained staff are more likely to use less punitive and more talking/caring type management strategies (Crichton, 1995; Meddings, 1996). The differences between these studies and the
present may be due to the sample of participants; all of whom in the present study worked within a NHS mental health trust in specialist placements for older people with mental health problems. These settings included specialist dementia care units and the participant group, although 'unqualified', may have represented an already highly specialised and skilled section of the workforce. Dagnan et al (1998), Snowden et al. (1996), and Moniz-Cook et al. (2000) recruited qualified and unqualified staff from less specialist nursing and care homes. Thus a more heterogeneous knowledge of appropriate responses and perception of challenge may have been present amongst their participants than amongst the current participant group.

Feeling supported at work by managers, colleagues and other agencies was significantly associated with being willing to change the client’s behaviour, but showed no significant relationship with either abusive or MSP management strategy use. Thus the results only partially support hypothesis 4.2. The finding that feeling supported at work is associated with increased willingness to help change the client’s behaviour may be due to the reported practice of two members of staff managing clients with known challenging behaviours. In the pilot interviews, a two-person strategy was often mentioned as a way of preventing challenging behaviours especially with regard to personal care tasks. Two people working together to achieve a task is likely to increase feelings of mutual support with regard to managing challenging behaviour and may also lead to increased confidence and willingness to change the client’s behaviour. By contrast, Moniz-Cook et al. (2000) found a weak association between high supervisor support and the staff perception of greater difficulty in managing challenging behaviours. However, they suggested that this might have been due to the increased willingness of people who felt supported by a supervisor to admit difficulties with managing the behaviour.

The results only support a single aspect of hypothesis 4.3. The results demonstrate that staff members who are more familiar with clients who present challenging behaviour, reported being significantly less likely to use abusive management strategies. Care staff who come into contact with challenging behaviour more frequently might either have had greater knowledge about the appropriateness of particular management strategies, or have had greater restraint to avoid retaliation and abuse. Knowledge about abusive
and appropriate actions to take in the face of challenging behaviour might be delivered informally via other workers as situations occur, thus more frequent episodes of challenging behaviour give increased opportunities to learn how to manage behaviours appropriately. Alternative explanations are suggested by Sharrock et al. (1990) and by Shaw (1999). Sharrock et al suggest that carers who regularly experience challenging behaviour habituate to the behaviours and no longer experience negative emotions as a response to challenging behaviour. Shaw (1999) suggests that staff develop immunity to the negative emotions evoked by challenging behaviour. Immunity is said to involve the development of increased abilities to tolerate frustration or anger and to avoid the enactment of these emotions towards the clients. Shaw also suggests that not all care staff develop immunity and that care staff can lose their immunity under stressful circumstances.

4.2 Overall Relationship of Findings to the Literature in the Field

The study has extended the application of Weiner’s (1985) attributional model of achievement motivation and emotion to the care staff of older adults with challenging behaviour. The present study has confirmed findings by researchers in the field of attributional models of care staff intervention (e.g. Dagnan et al., 1998; Stanley and Standen, 2000) that Weiner’s model of helping behaviour can be used to explain the affects and caring behaviour of care staff in general in relation to challenging behaviour of clients. The study has also extended these findings and found that attributions of stability and optimism are related to the willingness of care staff to change the behaviour. The role of attributions in the care of older adults and the distinction between two forms of intervention: caring and promoting behaviour change, has not been previously considered. The author proposes that different attributional pathways as described by Weiner’s model, are required to account for these different behaviours.

Little research has previously been carried out examining the relationship between the topography of challenging behaviours in older adults and the subsequent beliefs and interventions of care staff. This study confirms the findings of Stanley and Standen (2000) that topography of challenging behaviour and other aspects of the client such as dependency level have an important mediating role in the behaviour of care staff. The
study also suggests that topography of the challenging behaviour of older adults should be considered in future research in the area of challenging behaviour.

The study has also examined the use of abusive actions and malignant social psychology by care staff in the management of challenging behaviour. The study shows that some care staff within the NHS, report that in certain situations they are likely to respond to challenging behaviour in an abusive or de-personalising manner. The study also shows support for the findings of research on elder abuse (Penhale and Kingston, 1997) that carers are more likely to use abuse those clients who have higher dependency needs. The study shows some tentative evidence that abusive actions may be related to attributions of increased control and negative emotion. This study has challenged the results of previous research that found that level of training was a significant factor in evaluation of behaviour (Moniz-Cook et al, 2000; Snowden et al 1996); intention to help the client (Dagnan, et al., 1998); and likelihood of abusing the client (Pillemer, 1996). The study suggests that at least within NHS specialist institutions for older people, it may be not be level of qualifications but feeling supported by colleagues, managers and other professionals that significantly affects attributional responses and willingness to help. This study also suggests that staff members who are more frequently exposed to challenging behaviour are less likely to respond with abusive management practices.

4.3 Clinical Implications

The clinical implications of this research are threefold. The research has implications for the application of psychological principles in areas of management of challenging behaviour of older adults with dementia, prevention of elder abuse, and provision of support to staff working with older people.

4.3.1 Staff training and selection - management of challenging behaviour

Archibald (1999) comments that in practice there are skilled approaches to managing challenging behaviour but often staff tend to be reactive, with little analysis of what is happening and why. Care staff do not engage in an exploration of what the person is trying to communicate and the reasons and meaning attached to behaviour are not
questioned. Where hands-on training is given to staff, thus creating awareness, and where a problem-solving approach and feedback are provided, some successes in outcomes are reported (Baltes, 1994; Hoeffer et al., 1997). However, even successful training programmes are often shown to produce only a temporary improvement in care staff practices (e.g. Moniz-Cook, et al., 1998; Campbell, Knight, Benson et al., 1991). Little attention has been paid to the reasons that interventions fail to be implemented or continued by care staff (Archibald, 1999). Attributional theory may provide a fruitful way of understanding care staff behaviour by examining the dynamic relationship between the carer, client and behaviour. This study has demonstrated that attribution theory can explain why care staff are more motivated to care for the client and to intervene to change the behaviour in some circumstances than in others. Attributional theory may also explain the motivations of a carer that are behind actions that serve to maintain or to reinforce the inappropriate behaviour of clients. Clinical psychologists are often asked to provide training and consultancy for care staff in dementia and management of challenging behaviour (Division of Clinical Psychology (DCP), 2000); and to contribute to the teaching programmes of student nurses. By introducing consideration of attributions made about challenging behaviour it may be possible for clinical psychologists to encourage greater degrees of helping and motivation to intervene to change client behaviour on the part of care staff. It may also be important for clinical psychologists to help care staff to consider explanations for challenging behaviour that are external in locus to the client such as the environment or the behaviour of others (including the staff member). However, Weiner (1988) points out that there are many other ways to use attribution theory to produce a change in the system apart from changing the attribution. Weiner’s (1988) suggestions include: alteration of the perceived outcome, modification of the causal antecedents; changes in causal meaning; and changes in the behaviour (of care staff). All such potential agents of change should be exploited to maximise the potential benefit to the causal attributions of care staff working with older adults.

Care staff should receive training that teaches them to attend to their attributions about challenging behaviour, and education about the abilities and motivations of older people with dementia. Training should also incorporate attributional retraining techniques that will enable the staff member to make less controllable attributions about
behaviour that will encourage them to feel more positively towards the clients and increase their motivation to care for them. When challenging behaviours are being targeted for change through the use of a planned intervention, it will be important for psychologists to address the attributions that care staff make about the stability of the behaviour and to increase the levels of optimism about successful intervention amongst the entire staff group. Training programmes that do not address the underlying attributional beliefs of care staff about stability of the cause of the behaviour and optimism regarding change, are likely to find that any changes in care staff management of challenging behaviour that are produced are undermined and eroded over time by the resurgence of responses to challenging behaviour that are driven by these attributions. Training that does not address attributions about the client’s control over the behaviour risks ignoring the potential for negative feelings to be aroused by a client’s behaviour and a decrease in the willingness of care staff to care for that client.

Clinical psychologists who are part of senior management teams can also be influential in policy that sets out criteria for staff recruitment (DCP, 2000). It may be important to assess the attributions and attributional flexibility of applicants for care posts regarding dementia and challenging behaviour. Those applicants who are less liable to attribute high levels of control to the client and whom are more accepting that the behaviour is liable to change will make more caring and motivated members of staff.

4.3.2 Staff training and selection – elder abuse prevention.

Attributional approaches may be vitally important in the prevention of elder abuse in institutions. Clinical psychologists have management responsibilities with regard to the protection of vulnerable adults and are in a position where they may be influential in service delivery and in investigation of abusive or poor care practices (DCP, 2000). No existing studies have intervened on staff’s emotional and cognitive reactions to physical aggression, and it has been suggested that negative reactions may continue to increase among staff over time leading to negative sequelae for residents (Allen-Burge et al., 1999). Research with staff caring for people with learning disabilities and mental health problems indicated that staff rarely blamed themselves for incidents of violence and that over time staff saw the cause of the behaviour as more internal to the client (Cottle, Kuipers, Murphy & Oakes, 1995). This study has found a tentative association
between attributions of increased control and negative emotion and an increased likelihood that care staff report intentions to act abusively towards the client. Training in elder abuse prevention should include accurate information that dispels beliefs in the abilities of clients with advanced dementia to actively control their behaviour. Coupled with training in the efficacious management of challenging behaviour, attributional retraining may help to prevent negative emotions and pessimism among care staff. This may hinder the formation of negative attitudes and practices that are neglectful and/or abusive. Apart from the direct effects upon attributions, training care staff to attend to their attributions about clients and behaviours may help to promote reflection on the meaning and causes of challenging behaviour. This is a step towards person-centred care within an organisation and away from task-orientated care, often associated with abusive practices (Counsel and Care, 1997 in Bright, 1997, p131).

Discussions between care staff and their supervisors about care staff attributions about client behaviours in general may also be used as a type of early warning system that the relationship between the member of staff and the client is not good. This kind of supervision may provide an opportunity for the staff member to express and explore their attributions about clients and for the supervisor to monitor and challenge negative attributions.

As discussed above, involvement of clinical psychologists in developing recruitment practices and policies offers the opportunity to screen the attributions of potential applicants. Recruitment of people who have the right personal qualities to work with older adults may be accomplished by taking account of the attributions made by applicants to interview questions about coping with challenging and aggressive behaviours of clients.

4.3.3 Reduction of stress and burnout amongst care staff of older adults.

Lawlor (1999) reports that over the next 25 years we will be facing a shortage of formal and informal care workers to deal with the increased number of people with dementia. It will therefore be important to develop staff training and continuing education procedures to aid with staff recruitment and retention. Staff find challenging behaviour difficult to cope with and frequently ask for training in management techniques. How can attribution theory and attributional approaches help to prevent staff stress? By
promoting a culture of care where the personal frustrations and stresses of caring for people with dementia are acknowledged and where care staff are encouraged by other professionals (such as nursing staff, psychologists and doctors) to explore a range of alternative attributions for the behaviour of clients. Cottle et al. (1995) suggest that promoting different attributions associated with positive affect, accomplishment and increased optimism for change would be beneficial. These alternatives should be modelled by other professionals and should include those attributions that accord less control and stability to the client’s behaviour. As found by Jenkins and Allen (1998) those staff who have sense of personal accomplishment in their work will be less prone to suffer from stress. Clinical psychologists often play a leading role in providing support to other staff through occupational health programmes and also through supervision. Cottle et al (1995) suggested that a critical period of a week to a month existed where staff in their study had increased levels of expressed emotion towards clients and higher levels of anxiety following a violent incident. It may be helpful to consider attributional approaches in the treatment of staff who present with stress and burnout that is primarily caused by occupational factors. Clinical psychologists might beneficially run or train others (e.g. senior nursing staff) to run a system of informal monitoring of staff reactions to and attributions about challenging incidents may be useful in identifying which staff may need further debriefing or support.

4.4 Critique of the Present Study

This critique of the study focuses on the adequacy of the methodology to answer the research questions. This issue was partly addressed before the study was designed by considering the issues discussed in the introduction. However, it is now possible to use the results of the study to draw further conclusions about the research method. Three areas in particular are considered: the likelihood of Type I and Type II errors; the validity and reliability of the measure; and the generalisability of the research.

4.4.1 Type I and Type II errors.

A Type I error refers to the likelihood that the null hypothesis was rejected when in fact it was correct. This occurs when findings, which are accepted as significant, have
actually occurred due to chance and no true difference or relationship exists. When a large number of statistical tests are used in the analysis of the results the likelihood of finding that some of these are significant (as determined by the probability level) is increased. The present study did use a large number of statistical tests, however, the study has also taken steps to prevent acceptance of significant results unduly. Whenever multiple statistical analyses were performed to test a single hypothesis the alpha level (the critical probability below which results are deemed significant) was reduced in proportion to the number of tests carried out. Thus the likelihood that the study has accepted the correct hypothesis for any of the research questions remains at 5%. This is considered acceptable within the research community.

A Type II error refers to the possibility that the null hypothesis was accepted when in fact it was incorrect. This occurs when there is a true relationship of difference between variables that has not been detected in the participant sample or by the statistical procedures. Sample size is important in reducing Type II errors. This study used a relatively small sample, although similar in size to comparable research, and may have led to Type II errors occurring. However, measurement of power can be used to assess the probability of avoiding a Type II error. Power for the analyses in this study where the null hypothesis was accepted was at 0.8 unless stated in the results. This provides an acceptable likelihood that the null hypothesis was not accepted incorrectly.

4.4.2 Validity and reliability.

Face validity concerns were addressed as discussed in the introduction, however, the results show that there may be some problems with the perception of the vignettes 5 and 6. Many of the attributional variables demonstrated interaction effects between challenging behaviour types and dependency levels that were located with vignettes 5 and 6. For an example see Figure 7.
Figure 7. Estimated Marginal Means for the Attributional Variable Control

Whilst these interactions may represent true differences in the way that dependency level and "delusional" challenging behaviour are perceived by care staff, it is also possible that the details of these vignettes did not accurately convey the dependency level or challenging behaviour type assumed by the research design. One way of improving the design of vignettes to ensure that they accurately portray the intended characteristics would be to have piloted the vignettes more extensively. The study went ahead with the five 'expert' raters having agreed on the face validity of the vignettes as part of the management strategy measure design process but this may not have been sufficient to ensure that they were free from such problems.

Convergent construct validity refers to the degree to which a measure is assessing some theoretical construct and may be assessed by comparison of the results of this study with those of previous studies testing similar constructs. The research assessing constructs most similar to this study is that by Dagnan et al. (1998); Stanley and Standen (2000); and by Whitehouse, Chamberlain and Tunna, (2001). The limited data analysis presented by Whitehouse et al. makes it difficult to make comparisons with the present study therefore only the results found by Dagnan et al. (1998) and by Stanley and Standen (2000) will be assessed.
Dagnan et al. (1998) used a sample of 40 care staff for people with learning disabilities and examined correlations between attributional variables, affect, optimism and a single variable of helping. They found significant correlations between control and negative emotion ($r = .52, p < .01$) and between negative emotion and helping ($r = -.53, p < .01$). They also found significant correlations between stability and optimism ($r = -.34, p < .05$) and between optimism and helping ($r = .79, p < .01$).

Stanley and Standen (2000) sampled 50 care staff of people with learning disabilities and examined the same correlations between attributional variables, affect, optimism and a single variable of helping. They found significant correlations between control and positive affect ($r = -.508, p < .01$) and between positive affect and helping ($r = .623, p < .01$). They did not find significant correlations between stability and optimism but did find a significant relationship between stability and helping ($r = .407, p < .01$).

The present study and those above were assessed for heterogeneity of effect sizes as recommended by Clark-Carter (1997; p.382). This involves examining the variation in the Fisher's transformed effect sizes ($r'$) to see if they are significantly different using the Chi square calculation.

Table 12. The Effect Size and Fisher's Transformed $r$-score for each Study.

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Control/ Affect Effect size ($r$)</th>
<th>Fisher's $r'$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present</td>
<td>46</td>
<td>.586</td>
<td>.672</td>
</tr>
<tr>
<td>Dagnan (1998)</td>
<td>40</td>
<td>.52</td>
<td>.576</td>
</tr>
<tr>
<td>Stanley (2000)</td>
<td>50</td>
<td>.508</td>
<td>.560</td>
</tr>
</tbody>
</table>

Weighted mean $r' = .6037$

Chi-square(2) = 0.307, 0.80 < $p < .90$. 

93
Table 12 (continued). The Effect Size and Fisher's Transformed r-score for each Study.

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Affect/Helping (Care)</th>
<th>Fisher's r'</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present</td>
<td>46</td>
<td>.682</td>
<td>.833</td>
</tr>
<tr>
<td>Dagnan (1998)</td>
<td>40</td>
<td>.53</td>
<td>.590</td>
</tr>
<tr>
<td>Stanley (2000)</td>
<td>50</td>
<td>.623</td>
<td>.730</td>
</tr>
</tbody>
</table>

Weighted mean $r' = .7241$
Chi-square(2) = 1.177, .30 < $p$ < .50

The three studies all show significant relationships between control, affect and helping and are not significantly heterogeneous with respect to the effect size of these relationships, this is evidence of convergent construct validity.

**Content validity** refers to the degree to which a measure covers the full range of behaviour of the construct being measured, in this case attributions about challenging behaviour and management strategies. The measure of attributions is broad and assesses not only those attributional dimensions thought to be of particular interest to helping behaviour but also the attributional dimensions of locus and globality. The measurement of affect is brief and might benefit from expansion to assess other emotions in addition to anger and sympathy. The management strategy measure appears to have floor effects for abuse and would benefit from expansion to the abusive management responses to include more subtle forms of abuse. Extra affect and abusive management items were excluded due to concerns about administration time, and in the case of abusive management strategies, inter-rater reliability, but may be useful additions to the research questions. There do not appear to be any redundant items in the measure. The two variables for helping and optimism, Willing to Change/Willing to Care and Optimism re Change/Optimism re Care are not separated in previous research but in view of the different pattern of responses to these variables, they do not appear to measure the same thing.
Reliability was assessed using the split half calculation and by assessing test-retest reliability. As discussed above, the measures demonstrated adequate reliability for both test-retest and split-half reliability. However, the test-retest reliability coefficients were based on a sample size which was very small (n=10) and would benefit from a larger number of participants completing the measure twice.

Overall, the measure demonstrated adequate validity and reliability, but would have benefited from additional pilot work into the vignettes, additional questions about abusive and MSP management responses and from a larger reliability study.

4.4.3 Response rate and generalisability of the research.

Generally, participants were co-operative and keen to participate in the research. A response rate of 92% was obtained for the main study and of 66% for the reliability study. Due to the high response rate in the main study, it is unlikely that the participant group showed any self-selection biases. The participants were approached in a random manner from staff lists that were provided by managers of older adult services within a single mental health trust. Results from the study may well generalise to other unqualified staff working within NHS specialist residential facilities for older adults with mental health problems.

The stimuli for measuring attributions in this study were vignettes. Vignettes have been criticised for their relative poverty of information compared to real life situations and the fact that participants will only be able to report their hypothesised responses, never their actual response to a real life situation. Most other attribution studies with clinical applications have used vignettes but a few studies have used alternative techniques such as memories of real incidents (e.g. Norman & Antaki, 1988). Observation methods and the use of participant’s memories are not without methodological criticism however, and do not allow the manipulation of independent variables such as dependency level. The written vignette is an extremely practical and time- and cost-effective way of undertaking initial research into the question of care staff attributions as this study has attempted to do. The results must be accepted with caution as only indicating general attributions, and attitudes towards management of
challenging behaviour and not interpreted as indicative that the attributions and management strategy likelihood reported is directly transferable to real life situations. The measurement of attributions is not predictive for any single individual. Results from this study may not generalise to other care staff working with older adults with challenging behaviour in other non-NHS, non-residential settings such as day services or private care homes.

4.5 Implications for Future Research

The results of this study show that further research into the attributions of care staff of older adults is justified and may drive clinical practices in the areas of managing challenging behaviour, abuse prevention and reduction of staff stress. Future research studies should investigate attributions and management of challenging behaviour of older adults using different methodologies and research designs to extend and confirm or contest the findings of this research. A number of different, more labour intensive research methods may now be justified in the light of these preliminary findings in the area.

Studies should make greater use of real life situations that care staff of older adults face and collect their actual attributions and behavioural responses to these situations. For example a study could utilise a debriefing interview after incidents of challenging behaviour. Such a study would add to the evidence of this study that attributions are important factors in care staff emotional reactions to their work and the clients, and in their decisions about management of challenging behaviour and future care tasks.

Future research should also examine differences in attributions between different staff groups. For example staff working with older adults with physical health problems and older adults with mental health problems; or staff working with people with mental health problems of different age groups younger v older adults. These designs would explore the extent to which care staff who work with older adults with mental health problems have beliefs that are shared amongst other care staff of older adults or whether they have a distinct 'attributional style'.
The effect of training upon care staff attributions may be one further extension of this study. If the recommendations that attributional approaches should be considered in elder abuse prevention training and challenging behaviour training are taken up, measurement of attributions before and after such training should demonstrate the effect of the training programme. Comparison of the management of challenging behaviour by staff trained and untrained in attributional considerations would also be a further test of the results of this study. Research with staff groups assessing the degree to which those staff members reporting higher degrees of burnout and stress have dysfunctional attributions regarding challenging behaviour is yet another way in which the attributional dimension of caring for older people can be examined.

Expansion of the number of attributional dimensions investigated may also be beneficial in improving the reliability of future research. Kinderman and Bentall (1996) have shown that people make a distinction between two kinds of external locus of causality: external personal and external situational. Inclusion of these dimensions in the research would enable a more detailed analysis of the beliefs of care staff regarding the cause of behaviour particularly the possibility that actions by the member of staff or by other clients may be responsible for triggering challenging behaviour.

Gender of the client and staff member may also prove to be a fruitful avenue for research into attributions of care staff facing challenging behaviour. Previous research has found that gender has an influence upon attributions and subsequent actions of judges (Elliot, 1988); in the levels of interactions of care staff (Lindesay & Skea, 1997) and in the perpetration of elder abuse (Homer & Gilseard, 1990). It is possible that following these studies that women who display challenging behaviour of an aggressive nature may perceived by care staff as more deviant than men. This in turn may have consequences for staff responses to such incidents.

4.6 Conclusions

The study indicates that care staff make attributions about the causes of challenging behaviour. The participants used information about the nature of the behaviour and the level of dependency to generate their attributional response. Stated intention to care for
the client was inversely related to levels of negative emotion. Negative emotion was best predicted by attributions of increased client control over the behaviour. Intention to intervene to change the behaviour was best predicted by level of optimism that in turn was inversely predicted by attributions of stability of the behaviour. Care staff reports of willingness to care for the client were related to reported increased likelihood of using appropriate management strategies. Abusive management responses of care staff were positively associated with negative affect but only tentatively found to be related to increased levels of client control over the behaviour. Perceived support from managers, colleagues and other professionals was positively associated with increased willingness to change the behaviour. Care staff who had more frequent contact with challenging behaviours reported being less likely to use abusive management strategies.

The research points to the need to consider attributions in training for care staff who work with older people. Specifically consideration of attributions may be beneficial in preventing elder abuse; in training in the management of challenging behaviours; and in staff retention. Staff selection procedures might also consider the attributions of applicants for posts involving care for older people with challenging behaviour. Psychologists have involvement at all levels of care for people with challenging behaviour and may influence attributions of care staff through staff selection, training, consultation and policy.

As such this study is an initial attempt to demonstrate the relevance of attributions in caring for older adults. Future research should aim to support or refute the findings of this study by using different methodology and research designs. In particular the attributions for real incidents of challenging behaviour and effects of attributional training should be examined as a further test of the conclusions drawn from this study.


Cottle, M., Kuiper, L., Murphy, G. & Oakes, P. (1995) Expressed emotion, attributions and coping in staff who have been victims of violent incidents. Mental Handicap Research, 8, 168-183.


Patel, V. & Hope, R (1992) A rating scale for aggressive behaviour in the elderly – the RAGE. *Psychological Medicine, 22,* 211-221.


PsychInfo (2000) Search retrieved May 29th 2000 from PsychInfo database, on the World Wide Web:


Definition of Abusive Behaviour

Abuse is behaviour by a professional that does not uphold the client’s rights to feel safe with the professional and to know that the professional will act professionally and objectively. Behaviour or lack of action that is against the professional’s code of ethics and is not in the best interests of the client or that harms the client in some way. The professional takes advantage of the client’s trust, does not act in their best interests and fails to keep appropriate boundaries or limits within the relationship.

(POPAN, 1998)

OR more specifically,

A single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person: e.g.

Physical for example hitting, slapping, burning, pushing, restraining, or giving too much medication or the wrong medication;
Psychological for example shouting, swearing, threatening, frightening, blaming, ignoring or humiliating a person;
Financial for example the illegal or unauthorised use of a person’s property, money, pension book or other valuables;
Sexual for example, forcing a person to take part in any sexual activity without their consent, this can occur within any relationship and;
Neglect for example where a person is deprived of food, heat, clothing, comfort, stimulation or social contact or essential medication and attention.

An older person may also experience abuse which is racist, religious or cultural in nature.

(Action on Elder Abuse, 1999)
Kitwood’s Malignant Social Psychology

Accusation The person is blamed for action, or failure to act, which results from their loss of skills or inability to understand the situation.

Banishment The person is either sent away or excluded – either physically, or psychologically, or both, thus depriving them of human contact.

Disempowerment The person is not allowed to utilise their remaining abilities. They do not receive assistance to complete actions that they have initiated.

Disparagement The person is given messages that they are incompetent, a failure and so on. This damages their self-esteem.

Disruption The person experiences a sudden disturbance to their frame of reference while in the middle of an action or reflection.

Ignoring Carrying on a conversation or actions as if the person was not present.

Imposition Overriding the desires of, or denying choice to, a person.

Infantilisation Treating a person very patronisingly, as if they were a young child.

Intimidation A person is made fearful by threats, physical power or by being placed in situations in which they are unable to make sense of their surroundings.

Invalidation The person’s subjectivity, especially their feelings, is either denied, not acknowledged or dismissed as insignificant.

Labelling The diagnostic category becomes the foundation for attempts to understand, and attempts to communicate with, a person.

Mockery A person’s disabilities are used as a source of humour.

Objectification A person’s status as a sentient human being is disregarded. They are treated as if they are not really present.

Outpacing A person is excluded by those around them acting and speaking at a pace which leaves them bewildered.

Stigmatisation The person is treated as an outcast.

Treachery Trickery and deception are used in order to manipulate a person into behaving in a way that is desired by others.

Withholding A person’s physical and psychological needs are disregarded.
The Abuse in the Workplace survey was conducted during March 1998 by Ruth Saffrey, a clinical audit officer based in the Quality Department of South Birmingham Mental Health Services for Older Adults. The survey was conducted in response to the concerns of staff about the abuse that they were receiving while at work. The survey required staff to fill in forms of all incidents of abuse towards them whether on or off duty, in the hospital or the community, perpetrated by patients or non-patients. This survey tapped many types of abusive incidents towards staff, for example, aggression to others, property damage witnessed by staff (vandalism), and sexually disinhibited behaviour. It would not however, have taken account of patient to patient abuse or self harm. Staff members were asked for their thoughts about what had contributed to the abuse and about what methods they had used to cope with the abuse.

A large number of incidents (367) were reported during the survey period. This is likely to be an under representation of the amount of abuse that occurs. Nurses and care staff reported the majority of incidents (88%). However, OT’s, CPN’s, Porters, Administrative staff, and Ambulance staff also reported incidents of abuse. The most common forms of abuse were physical abuse including punching, kicking, biting, pushing, slapping, spitting and scratching; and verbal abuse including swearing, and shouting.

Staff identified causal factors as: personal care, feeding, repetitive behaviour, offender’s lack of communication, diagnosis, poor staffing levels, offender’s fear, noise and location.

In 56% of the incidents the person completing the form felt that the offender had intended to harm them. In 36% of the incidents it was felt that no harm had been intended.

Some of the results indicated that staff members were sometimes unsure of the action that they should take in such situations. This was particularly true when non-patients were responsible for the abuse. This, in conjunction with other comments made on the reverse of the form indicated that staff need support in preventing abuse from occurring and to cope with the abuse in a more structured way.

Staff members identified coping methods including letting off steam to colleagues, discussion with the offender, supervision, debriefing and training. In 15% of incidents it was believed that there were no ways to cope with the incident. The survey showed that workplace abuse is an issue of great concern to staff working in Mental Health Services for Older Adults in South Birmingham Mental Health NHS Trust.
APPENDIX 3

Interviews with Staff Members for the Development of Vignettes and Management Strategies.

Semi-structured interviews with nurses working in the mental health trust with older people were held during their normal hours of work. Six members of staff were approached and five agreed to participate in this stage of the study. Two participants were male and three female. The interviewer was the researcher in all cases. A participant information letter and consent form was given to each participant at least 24 hours before the interview. The interviews lasted about 45 minutes each. The aim of the interviews was to gain background information about the setting the nurses worked in, the types of challenging incidents that typically occur, the potential causes of such incidents and the actions taken by the participants and their colleagues in response to such incidents. This information was used in combination with other sources of data to develop the vignettes and the management strategies for the research measures.

Areas covered specifically were:
1. Day to day experiences of working in inpatient and residential setting with older people.
2. A personal definition of challenging behaviour with particular reference to incidents where staff members experienced abuse.
3. More detailed information about their own experiences of challenging and abusive incidents involving older adult patients.
4. Examples of good and bad practice when dealing with challenging behaviour.
5. Training or other experiences that have helped them to deal with challenging behaviour.

Day to Day Experiences

The members of staff had worked in a variety of settings including residential homes, day centres and inpatient wards. Three participants had trained as psychiatric nurses and had experience of working with adults as well as older adults. The other members of staff held qualifications for their job and all participants had over 5 years of experience in this field. The participants held various positions in the trust, all were involved in the direct day to day care of older people with mental health problems. All of the staff had experience of caring for people who presented some level of challenging behaviour.

Definitions of Challenging Behaviour

The staff gave different definitions of challenging behaviour. It was felt that behaviours may be perceived as challenging by one individual but not by another and that each members of staff may have a specific tolerance level for particular behaviours.
'The most challenging behaviour for me personally, and that I need support to deal with is repetitiveness'.

Participants said that often they recognised behaviour as challenging by their own response to it. A behaviour that was challenging might test their patience or make them feel like responding in a way they felt would be inappropriate. Other examples of definitions included:

"Anything that compromises the individual’s safety, privacy and dignity, a whole range of things really. Also you have to think of yourself in this environment, and there are behaviours that make the work that we do difficult and are challenging to us”,

Other examples of challenging behaviour given included repetitive questioning, physical aggression, verbal aggression, self harm, sexually disinhibited behaviour, property destruction, wandering, absconding whilst under mental health act section, and self neglect.

‘ For example a few nights ago there was a patient charging around with the fire extinguisher - hitting other patients and staff on the head with it. He was extremely angry and out of control. Because of that he was very strong and very dangerous.’

All staff members felt that certain nursing tasks or patient behaviours were more likely to be the precursors to abuse. These included personal care tasks, particularly washing, undressing or toileting, communication difficulties, other people leaving the ward or centre, medication administration, the client’s disorientation, and conflict over leave from the hospital.

‘It’s often when we’re offering an intervention funnily enough. You quite often get people who don’t like the intimate care that they need. They find that very difficult, it’s probably why they’re here because they have become difficult to manage in their homes from where they came from for us to observe the behaviour’.

The participants also agreed that particular patients were more likely to become involved in incidents of challenging behaviour, these patients were described as aggressive or difficult patients, those lacking insight into their difficulties or not wanting to remain in the hospital.

Management of Challenging Behaviours – Good and Bad Practice.

It was known that the trust had a philosophy regarding managing behavioural challenges. This was said to be a person-centred approach to people’s difficulties. Participants understood that this required that different management strategies be found for different individuals and different behaviours taking account of the meaning and
function of the behaviour. However this was not always reflected in the participants' account of behaviour management in actual scenarios where a limited range of actions were discussed for a number of different behaviours. The participants acknowledged that the diagnosis of the patient had an impact upon the actions that they would take to manage the behaviour. For example one staff member said:

'Say if there is a risk factor involved, like self-harm or harm to others, or it is linked to their mental state. You would have a different reaction to if it was an enduring behaviour long term.'

The cause of the patient’s difficulties was also acknowledged to affect actions taken to manage the behaviour. For example four staff members said that they would take different actions when dealing with someone with dementia to those they would take if the patient had a functional mental illness.

All participants said that they would attempt to handle the situation with the minimum restriction on the patient possible, but all agreed that there were times when more intrusive procedures such as physical restraint and enforced medication were useful and appropriate actions to take. Examples of a first attempt to manage the behaviour were:

'Try to show that you understand what’s going on without colluding with the person.'
'Talk about what you are doing and why or talk about other things to distract them.'
'Give them a verbal put down (in the case of sexually disinhibited behaviour) – I’ve seen bigger and better'.
'Using humour in some situations can help some but not all patients'.

More persistent or abusive behaviours were more often likely to be met with more assertive and intrusive action. For example physical aggression when placing a patient in a hoist was responded to by two other members of staff restraining the patient until the procedure was completed.

'Sometimes just holding their hand as they go to hit you can work, just holding their hand and saying don’t hit me.'

'I think that when two or more people are involved the immediate action to be taken is to separate the people and to isolate them until calm has been restored. If they have a weapon I wouldn’t necessarily try to get it off them in case I got whacked on the head with it, but you’d have to try to ensure they put it down or whatever'.

'Because I haven’t had the training, I tend not to wade in really. I try to give people a lot of space, and call for help really from others.....If something’s really bad then we can call the alarm, and you get everyone from the other wards, some of them tend to
just grab… but we tend not to call them, when we do it’s because we really need it’.

Other actions were aimed at increasing the safety of the patient, for example the patient may become at risk if they are not constantly accompanied by a member of staff. The participants were aware of dangers in the environment such as the kitchen but also dangers inherent to a person’s difficulties for example walking out of sight could be seen to be a challenging behaviour if it was felt that the patient was at risk of falling. Participants mentioned the need to balance independence and safety in such situations.

Training and Other Experiences that Assist Managing Challenging Behaviour.

Training had helped some staff members to feel that they could legitimately take time out from their job to have a break or take a short time away from direct care for patients when they had dealt with challenging behaviour.

‘That’s why you need a supportive environment and team, people who will say to you “Why don’t you have a break and I’ll deal with this for a while”’,
‘You have to recognise the emotions it brings up in you, the danger comes when you don’t do that’.

One participant was aware of the use of control and restraint procedures in the management of aggressive behaviour but had not received such training herself. Caring for people in pairs was also felt to be helpful, where one member of staff can complete the task whilst the other talks to the patient reassuring or explaining what is going on. One reason this was felt to reduce the possibility of challenging behaviour was by confusing or outpacing the patient:

‘If two of you are working on them, then one can talk while the other whips off the pad and cleans up. They don’t really have time to register what’s going on then, really’.

Participants also mentioned calling the on-call doctor in the hospital. This was experienced as reassuring when requests were responded to promptly and the behaviour taken seriously. Some members of staff felt that the doctors did not respond soon enough to the requests of staff and had offered limited solutions to the nursing difficulties when they arrived. The use of the mental health act was cited as a consequence of challenging behaviour in some instances. It was felt that this would facilitate looking at the person’s history and background to try to understand the behaviour and prevent it in future.
12th November 2000.

Challenging behaviour of Older Adults Research
Inter-rater Reliability – Responses

Dear

Thank you for agreeing to help me with my research project. I am investigating the beliefs that nursing staff for older adults have about the causes of challenging behaviours (attributions). I am also investigating whether certain types of attribution affect the likelihood of responding in particular ways to challenging incidents. I would like to ensure that the following hypothetical responses to challenging behaviour are agreed to be abusive or not abusive by various professionals concerned with the care of older people or the prevention of abuse.

Please read the definitions of abusive behaviour and of malignant social psychology.

Then read the vignettes and begin to read the responses below.

- Using the definition of abusive behaviour please rate each response. If you think that the response in the context of the vignette is abusive tick the A box.

- If you do not think it is abusive please place a cross in the A box. Even if you feel a response would not be helpful or beneficial but it is not abusive using the definition, put a cross in the box.

- If you can’t decide whether the response is abusive or not please tick the Don’t Know (DK) box next to the A.

- Using the definition of Malignant Social Psychology (MSP) rate each response. Decide whether a response would be an example of MSP. If you feel that an item would represent an example of ‘malignant social psychology’ please put a tick in the MSP box.

- If you don’t feel the response represents MSP then put a cross in the MSP box.

- If you can’t decide whether a response is an example of MSP put a tick in the Don’t Know (DK) box next to the MSP box.
**Vignette 1**

You have been asked to help Client A. Client A has an advanced dementia with severe language difficulties and is unable to carry out any tasks independently. When you enter the living room, Client A is sitting in a chair but is obviously wet with urine. You go over to the chair and say “Shall I help you change those wet clothes?” Client A does not respond but allows you to lead them to the bedroom. Client A sits next to the wash hand basin and starts to pull at their clothes. You say, “Well done”, but Client A begins to struggle with the clothing and you reach out to help. As you are helping Client A to remove their underclothing Client A resists strongly and begins to hit your arms and chest with closed fists. You are hurt and stop for a moment but as you do so Client A kicks you in the stomach hard.

<table>
<thead>
<tr>
<th>Responses</th>
<th>Abuse?</th>
<th>Don’t Know</th>
<th>MSP?</th>
<th>Don’t know</th>
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</thead>
<tbody>
<tr>
<td>1. carry on as if nothing happened</td>
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<td>2. leave the room and come back 1 hour later</td>
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<td>3. give PRN medication</td>
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<td>4. in a loud voice say, “Stop hitting me that’s naughty”</td>
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<td>5. talk about something else</td>
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<td>6. increase the temperature of Client A’s room</td>
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<td>7. comfort Client A</td>
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<td>8. tell Client A they won’t get a cup of tea if they carry on</td>
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<td>9. ask Client A what the matter is</td>
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<td>10. use restraint equipment when changing A.</td>
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<td>11. have a talk with Client A about kicking staff</td>
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<td>12. ask Client A to brush their hair</td>
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<td>13. stop undressing Client A</td>
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<td>14. leave the room for two or three minutes</td>
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<tr>
<td>15. talk to Client A about their life/memories.</td>
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<td>16. kneel to be at eye level with Client A</td>
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### Vignette 2

Client R has early signs of dementia but is able to take an active part in activities and requires little personal care. Diaries have been kept for Client R's toileting and you are aware that normally this client is continent. Earlier in the day you found Client R and another person arguing over a particular chair in the day room. Eventually you decided that Client R should move to another chair. Client R was very upset and angry and walked about shouting for a few minutes afterwards. When you enter the room again Client R is obviously soiled and wet and has been smearing faeces around the walls and on furniture. Client R reluctantly goes to the bathroom with you to clean up, but smears faeces onto your hands and arms on the way there.

<table>
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<tr>
<th>Responses</th>
<th>Abuse? Or X</th>
<th>Don’t Know</th>
<th>MSP? Or X</th>
<th>Don’t know</th>
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</thead>
<tbody>
<tr>
<td>17. say “I don’t like you when you do this”</td>
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<td>18. joke with Client A and laugh it off</td>
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<td>19. call for help from other colleagues to restrain client A</td>
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<td>20. turn to be at Client A’s side and stroke their hand</td>
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<td>21. quietly ask Client A to take off their underclothes</td>
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<td>22. suggest to Client A that you help them get undressed</td>
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<td>23. remind Client A that you are a nurse and here to help</td>
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<td>24. say “It’s not my fault you need changing”</td>
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<td>25. shout at Client A “No, don’t”</td>
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<td>26. quietly say, “Don’t do that”</td>
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<tr>
<td>27. say “suit yourself, then” and leave Client A in the chair</td>
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<td>28. slap Client A’s arm</td>
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<tr>
<td>29. hold Client A’s wrists to stop hitting</td>
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<tr>
<td>Responses</td>
<td>Abuse?</td>
<td>Don’t know</td>
<td>MSP?</td>
<td>Don’t know</td>
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<tr>
<td>1. say something like “Ugh, that’s disgusting”</td>
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<tr>
<td>2. be understanding to Client R</td>
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<tr>
<td>3. ask Client R if something is troubling them</td>
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<tr>
<td>4. speak sharply to Client R</td>
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<tr>
<td>5. ask “What did you do that for?”</td>
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<td>6. say “I’ll help you”</td>
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<tr>
<td>7. leave the room</td>
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<tr>
<td>8. slap Client R</td>
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<td>9. leave Client R to toilet alone</td>
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<td>10. Say “You should be ashamed of yourself”</td>
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<td>11. ask colleagues to help you</td>
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<td>12. start a toileting programme for Client R</td>
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<td>13. ask another staff member to assist Client R</td>
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<tr>
<td>14. say “get off me”</td>
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<td>15. seriously discuss this behaviour with Client R</td>
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<td>16. avoid future arguments with Client R</td>
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<td>17. get Client R to help clean up</td>
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<tr>
<td>18. say “if you do that again, I won’t help you”</td>
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<tr>
<td>19. help Client R get used to sitting in different places</td>
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<td>20. give Client R the ‘cold shoulder’</td>
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<td>21. Put Client R in incontinence pads</td>
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<tr>
<td>22. give PRN medication</td>
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<tr>
<td>23. care for Client R as though nothing had happened</td>
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<td>24. support Client R in negotiating with other residents</td>
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<td>25. impose a sanction on Client R ie no trip outside</td>
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<tr>
<td>26. remind Client R where the toilet is from time to time</td>
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</table>
Vignette 3

You are writing the daily notes for the patients at the end of a busy day. It’s very difficult for you to concentrate because a client is screaming very loudly. This goes on for more or less ten hours each day. Client L has advanced dementia and is highly dependent upon the staff for all personal care needs. Client L does not scream a word but more of a high-pitched ‘eek’ sound. Whenever your colleagues talk to or pay attention to Client L the screaming stops. But as soon as they go away Client L begins to scream again. Your colleagues and other patients have been coming into the office and complaining to you about the noise. You can’t bear the noise anymore. Client L is sitting in the ‘quiet room’ alone. Whenever someone enters Client L does not acknowledge their presence in any way and carries on screaming very loudly.

<table>
<thead>
<tr>
<th>Responses</th>
<th>Abuse?</th>
<th>Don’t know</th>
<th>MSP?</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Check to find out if Client L is in pain</td>
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<td>2. Say “Shut up” to Client L</td>
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<td>3. Check the room heating</td>
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<td>4. Put Client L in a room further away</td>
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<td>5. Ask for Client L’s hearing to be investigated</td>
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<td>6. Shut the door to the room</td>
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<td>7. Fetch Client L a drink</td>
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<td>8. Leave Client L alone</td>
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<tr>
<td>9. Have a long chat with Client L about not screaming</td>
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<tr>
<td>10. Give PRN medication</td>
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<tr>
<td>11. Talk to Client L</td>
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<tr>
<td>Responses</td>
<td>Abuse? Or X</td>
<td>Don’t know</td>
<td>MSP? Or X</td>
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<tr>
<td>12. Try to ignore the noise</td>
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<td>13. Refuse Client L treats or privileges</td>
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<td>14. Turn the TV on</td>
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<td>15. Stroke Client L’s hand</td>
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<td>16. Tell Client L that they should stop shouting</td>
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<td>17. Move Client L into a busier room</td>
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<td>18. Give Client L a stuffed toy to hold</td>
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<tr>
<td>19. Tell all staff not to give Client L attention when screaming</td>
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<td>20. Give Client L a personal stereo of taped favourite music</td>
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<td>21. Go in and say “What do you want?”</td>
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<td>22. Ignoring Client L check that they are safe</td>
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<td>23. Turn the music up outside of the room</td>
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<tr>
<td>24. Take Client L to the toilet</td>
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<tr>
<td>25. Wrap Client L up warmly and sit them in the garden</td>
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</table>

**Vignette 4**

Client G has mild memory problems but is able to communicate personal needs effectively and requires only minimal help with personal care activities. It’s late evening and you are sitting in the day room with a few of the clients from the home. Suddenly you hear a loud banging noise and screams coming from the corridor. You get up and run to the noise. Client G is standing by the door pulling and banging it. Client G often likes to walk around the garden with members of staff. You call out to Client G “You can’t go out now”. Client G does not respond to you and starts to shout, “Let me out, I want to go out now”. When you approach, Client G starts shouting louder. Client G is shouting again “Come outside now”. This happens on a regular basis.
<table>
<thead>
<tr>
<th>Responses</th>
<th>Abuse?</th>
<th>Don't know</th>
<th>MSP?</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. shout &quot;Stop, get off me&quot;</td>
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<td>2. Say quietly, &quot;You're upset, what's wrong?&quot;</td>
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<td>3. Hold Client G's arms beside their side</td>
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<td>4. Give PRN medication</td>
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<td>5. Say &quot;You won't get a bedtime drink if you stay here&quot;</td>
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<td>6. Reassure Client G &quot;Everything's OK&quot;</td>
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<td>7. Quietly call Client G's name</td>
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<td>8. Have a long talk with G about not behaving like this</td>
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<td>9. Call for colleagues to restrain Client G</td>
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<tr>
<td>10. Talk about Client G's favourite parts of the garden</td>
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<td>11. Comfort Client G</td>
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<tr>
<td>12. Say &quot;You can't go out until a nurse can go with you&quot;</td>
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<td>13. Don't resist Client G's pushing or hold</td>
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<td>14. Tell Client G they can go out tomorrow</td>
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<tr>
<td>15. Joke &quot;It's bedtime now, don't be daft&quot;</td>
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<td>16. Suggest Client G helps you to get his coat from his bedroom and distract him</td>
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<td>17. Sit Client G in a restraining chair</td>
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<td>18. Push Client G out of the way</td>
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<td>19. Go for a walk outside with Client G</td>
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<td>20. Say &quot;Stop this or I'll tell the doctor&quot;</td>
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<tr>
<td>21. Say &quot;Your favourite TV programme is on&quot; (even through it's not)</td>
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<td>22. Lock the door and leave Client G</td>
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<td>23. Let Client G into the fenced garden area alone</td>
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<td>24. Impose a sanction on Client G</td>
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<tr>
<td>25. Using your weight guide Client G away from the door.</td>
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<tr>
<td>Responses</td>
<td>Abuse?</td>
<td>Don't know</td>
<td>MSP?</td>
<td>Don't know</td>
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<tr>
<td>26. Say “Don’t you remember we went out an hour ago?”</td>
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<td>27. With a colleague assist client G to bed</td>
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<td>28. Say “Do you need the toilet before going out?”</td>
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<td>29. Say “It’s so cold, I’m glad I’m inside”</td>
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<td>30. Say “I don’t know where the keys are”</td>
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<td>31. Say “shall we look at some garden magazines together?”</td>
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<td>32. Gently break free and walk away ignoring Client G</td>
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<td>33. Talk to Client G about their favourite hobby</td>
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<td>34. Say I’m going back to have a cup of tea and walk down the corridor</td>
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**Vignette 5**

Client F has mild dementia but is independent in most personal care tasks. Client F often spends time moving objects around the unit. Client F will take other resident’s property and clothing and objects from communal areas. Many times during the day you find that you have to take furniture and other items and put them back in their rightful place. Other clients often confront Client F over their missing possessions. Client F usually refuses to recognise that the items belong to other people or in a different place. You enter the group room just after all the clients have been given a cup of tea or coffee. Client F is taking the cups off the other clients before they have finished their drink and putting them back on the tea trolley. One of the clients is resisting giving their cup to Client F who is tugging at the cup. Any moment the hot drink could spill.

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<tr>
<th>Responses</th>
<th>Abuse?</th>
<th>Don't know</th>
<th>MSP?</th>
<th>Don't know</th>
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</thead>
<tbody>
<tr>
<td>1. Shout “Give that cup back now” to Client F</td>
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<td>2. Hold Client F’s wrists to stop the drink spilling</td>
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<td>3. Take the cup from the clients</td>
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<td>4. Tell the other client “F’s a bit funny I’ll get you another”</td>
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<td>5. Ask Client F “Can I help you?”</td>
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<tr>
<td>Responses</td>
<td>Abuse?</td>
<td>Don’t know</td>
<td>MSP?</td>
<td>Don’t know</td>
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<td>6. Say &quot;Thanks for your help, I think she'd like a drink could you get one for her?&quot;</td>
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<td>7. Tell Client F not to take other people’s cups</td>
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<td>8. Get the other client another drink</td>
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<td>9. Get the cup and make Client F sit down for their drink</td>
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<td>10. Use restraint equipment for Client F when drinks are served</td>
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<td>11. Ask Client F to tidy up another area</td>
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<td>12. Ask the other client to let Client F have the drink</td>
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<tr>
<td>13. Say &quot;Look, they haven’t finished yet&quot; to Client F</td>
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<td>14. Leave the room for a short while</td>
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<td>15. Encourage Client F to “put your feet up and have a drink”</td>
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<td>16. Give Client F their drink in a room on their own</td>
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<td>17. Ask your colleagues to help Client F</td>
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<td>18. Tell Client F to say sorry to the client</td>
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<td>19. Ask Client F if they could help by handing out the drinks</td>
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<td>20. Have a talk to Client F about taking things that don’t belong to them</td>
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<td>21. Say “Don’t do that” loudly</td>
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<td>22. Give medication</td>
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<td>23. Keep a close eye on Client F at all times</td>
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<td>24. Talk about the way Client F likes to tidy up</td>
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**Vignette 6**

Client M has memory problems and has great difficulty expressing personal needs and requires assistance in all activities. Client M often hides money in drawers and cupboards and other resident’s bedrooms all over the home. Small and large amounts of money have been found when cleaning. Client M seldom remembers where their
money has been hidden and becomes very upset when they can’t find the money. Client M is often preoccupied with the missing money and goes up to other patients and staff to say “My money has been stolen”. Client M only ever thinks that you have stolen the money. Over time things have got worse and one day Client M is very agitated and distressed with the idea that others are protecting you. Client M is crying and comes up to you shouting, “Why are you stealing from me?”

<table>
<thead>
<tr>
<th>Responses</th>
<th>Abuse? Or X</th>
<th>Don’t know</th>
<th>MSP? Or X</th>
<th>Don’t know</th>
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</thead>
<tbody>
<tr>
<td>1. Ask a colleague to explain to M that you’re not stealing</td>
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<td>2. Pull out your pockets and say “Look, nothing there”</td>
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<td>3. Decide not to go near Client M again</td>
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<td>4. Say “Shall we look for the money together?”</td>
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<td>5. Go to the managers office</td>
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<td>6. Deny privileges to Client M</td>
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<td>7. Say “Don’t accuse me of stealing”</td>
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<td>8. Joke about Client M beliefs and laugh it off</td>
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<td>9. Tell Client M to “Stop going on about that money”</td>
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<tr>
<td>10. Explain to Client M yourself that you haven’t got the money</td>
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<tr>
<td>11. Try to get to know Client M better and make friends</td>
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<td>12. Ignore Client M</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Try to comfort Client M</td>
<td></td>
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<tr>
<td>14. Find out if other things are bothering Client M</td>
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<tr>
<td>15. Ask Client M why they always pick on you</td>
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<tr>
<td>16. Change the subject to one that interests Client M</td>
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<tr>
<td>17. Remind Client M that you are a nurse and in charge</td>
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<tr>
<td>18. Impose a sanction on Client M</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>19. Say “I won’t talk to you while you’re like this</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. give PRN medication</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>21. care for Client R as though nothing had happened</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responses</td>
<td>Abuse?</td>
<td>Don’t know</td>
<td>MSP?</td>
<td>Don’t know</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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<td>------------</td>
<td>------</td>
<td>------------</td>
</tr>
<tr>
<td>22. Work with others to help Client M to find safe places for</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>their money</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Avoid Client M as much as possible</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>24. Tell Client M that they have spent all their money</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>25. Take all Client M’s money to be kept by the manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Grab Client M’s hands tight and say I haven’t got your money</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Say &quot;It can be very frightening to lose your money&quot;</td>
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<tr>
<td>28. Try to calm Client M down by listening to her</td>
<td></td>
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</tr>
</tbody>
</table>

Now you have finished rating the management strategies I would like to know what you thought of the descriptions of challenging behaviour by older people.

Did you think that the vignettes were realistic descriptions of events that happen in residential centres for older people with dementia? (circle answer)

<table>
<thead>
<tr>
<th>Vignette 1</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vignette 3</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Vignette 5</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Vignette 2</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Vignette 4</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Vignette 6</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Were there any details that you were not sure of or think that I should change in some way? (Please give details)

Thank you very much for helping with the study. If you would like to know more about my research please contact me at the address on the front sheet or on telephone number 0121 440 2497.

Yours sincerely,

Susan Thomas
Trainee Clinical Psychologist, University of Leicester
Patient Information Letter


Dear member of staff,

Staff beliefs and management of the challenging behaviour of older people.

Staff working in old people's homes and on long stay hospital wards for older people are facing increasing levels of disruptive or aggressive behaviour from residents. Knowing how to deal with the difficult behaviour of patients or residents concerns many staff members.

I would like to invite you to take part in a research project that is investigating how nursing staff feel about the challenging behaviours of residents and how they deal with such incidents. You will be asked if you would like to complete a questionnaire with myself about these issues.

You may be assured of complete confidentiality. You should not put your name on the questionnaire. No one else will be able to look at any of the questionnaires. The research forms part of my training in clinical psychology and is funded by the health service. The results will be analysed by myself and will be presented in a way that does not identify any individuals. I will feed back the results of my study to your service at a meeting where you can discuss the results with me if you wish. If you would like me to send the feedback directly to you, please let me know and I will do so following completion of the project. The results may help you, your managers, and other professionals to work with older people.

I would be grateful if you would agree to complete the questionnaire with me. It will take about 45 minutes. You might want to discuss the questionnaire or any issues it generates with friends or colleagues, alternatively, if you have any queries about the questionnaire or about the research please do not hesitate to call me on the number above or 0121 440 2497. You may like to keep this information sheet for future reference.

Thank you, in advance for agreeing to take part in this study and for the completion of the questionnaire.

Yours sincerely,

Susan Thomas
Trainee Clinical Psychologist.
Consent Form

CONSENT FORM

Project Title:
Staff beliefs and management of the challenging behaviour of older people.

Researcher:
Susan Thomas

I have read and I understand the information sheet dated 1st July 2000 for the above study and I have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.

I agree to take part in the above study.

NAME ....................................................................................................

SIGNATURE .......................................................................................

DATE ..................................

RESEARCHERS SIGNATURE .............................................................

NAME ...............................................................................................

DATE ..................................
APPENDIX 6

Interview Measure

A copy of the interview is presented which breaks down as follows:

Demographic information

Vignette
Attribution Questions
Willingness to Help  x 6
Optimism
Evaluation of Person and Behaviour
Management Strategies

Marlowe-Crowne Social Desirable Responding Scale (Short Version)

Support at Work
Challenging Behaviour Research

Thank you for agreeing to participate in this study about staff’s views on challenging behaviour by elderly residents. The questionnaire should take about 25 minutes. It is completely confidential, and you are not required to put your name on it. It will be analysed by people outside the service and a summary, but not individual responses, will be given to participants and managers.

I would like to ask you some questions about yourself. Please tick the appropriate box

Age: _______ Gender: [ ] Female [ ] Male

Current employer/placement: [ ] SBMHT

How long have you been working as a carer for older people? _______ years

Do you have any formal qualifications for your job? (NVQ, Nursing, other)

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>NVQ 1 or 2</th>
<th>NVQ 3</th>
<th>Student Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Other.................................

Have you had training in challenging behaviour? If so how long ago did you receive this training?

How often do the people you care for present challenging behaviour? .

<table>
<thead>
<tr>
<th></th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Regularly</th>
<th>Continually</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
The survey consists of six descriptions of incidents involving older people who are in institutional situations such as hospital or a residential home. The case studies are all descriptions of real incidents that have happened to people working with older people although care has been taken to make sure that you are not able to identify any individuals. Each case study is followed by questions concerning how you feel about the incidents described. Whilst reading each case you should try to vividly imagine that you are the carer involved.

Case 1
You have been asked to help Client A. Client A has severe memory problems and severe communication difficulties and is unable to carry out any tasks independently. When you enter the living room, Client A is sitting in a chair but is obviously wet with urine. You go over to the chair and say, “Shall I help you change those wet clothes?” Client A does not respond but allows you to lead them to the bedroom. Client A sits next to the wash hand basin and starts to pull at their clothes. You say, “Well done”, but Client A begins to struggle with the clothing and you reach out to help. As you are helping Client A to remove their underclothing Client A resists strongly and begins to hit your arms and chest with closed fists. You are hurt and stop for a moment but as you do so Client A kicks you in the stomach hard.
Based on what you know from this story and other information you have about people like Client A, please answer the following questions.

**How dependent is Client A?**

☐ Not very dependent    ☐ Highly dependent

Think about what might have caused Client A’s behaviour.

Please write down what you think was the **most likely cause** of Client A’s behaviour.

---------------------------------------------------------------------------------

1. **Is the cause of Client A’s behaviour due to something about them, or to something about other people or circumstances?**

   Totally due to Client A [7 6 5 4 3 2 1]    Totally due to other people or circumstances

2. **Is the cause due to something that just affects this situation or does it also influence other areas of Client A’s care?**

   Just influences this situation [7 6 5 4 3 2 1]    Influences all situations in Client A’s care.

3. **In the future, will this cause affect situations again?**

   Will always be present [7 6 5 4 3 2 1]    Will never be present again.

4. **Was this event intended by Client A?**

   Totally intentional [7 6 5 4 3 2 1]    Totally unintentional

5. **Was this event controllable in any way (e.g preventable or encouraged)?**

   Totally out of Client A’s control [7 6 5 4 3 2 1]    Totally within Client A’s control

6. **How willing do you think you are now to put extra effort into caring for Client A?**

   Extremely willing to put in extra effort [7 6 5 4 3 2 1]    Not at all willing to put in extra effort

7. **How willing do you think you are now to put extra effort into changing Client A’s behaviour?**

   Extremely willing to put in extra effort [7 6 5 4 3 2 1]    Not at all willing to put in extra effort
8. **How optimistic do you feel about changing Client A’s behaviour?**

   Extremely optimistic [7 6 5 4 3 2 1] Not at all optimistic

9. **How optimistic do you feel that you can provide good care for Client A?**

   Extremely optimistic [7 6 5 4 3 2 1] Not at all optimistic

10. **How do you evaluate this kind of behaviour?**

    Extremely Bad [7 6 5 4 3 2 1] Completely Neutral

11. **How do you evaluate Client A?**

    Extremely Bad [7 6 5 4 3 2 1] Completely Neutral

After being involved in this situation, please rate how you feel.

12. **Extremely angry** [7 6 5 4 3 2 1] Not at all angry

13. **Extremely sympathetic** [7 6 5 4 3 2 1] Not at all sympathetic

How do you think you might handle the situation with Client A?

**How likely are you to use the following actions to deal with the situation?**

<table>
<thead>
<tr>
<th>Action</th>
<th>Very Likely</th>
<th>Very Unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>carry on as if nothing has happened</td>
<td>[7-6-5-4-3-2-1]</td>
<td></td>
</tr>
<tr>
<td>give PRN medication</td>
<td>[7-6-5-4-3-2-1]</td>
<td></td>
</tr>
<tr>
<td>talk about something else</td>
<td>[7-6-5-4-3-2-1]</td>
<td></td>
</tr>
<tr>
<td>comfort Client A</td>
<td>[7-6-5-4-3-2-1]</td>
<td></td>
</tr>
<tr>
<td>tell Client A they won’t get a cup of tea if they carry on</td>
<td>[7-6-5-4-3-2-1]</td>
<td></td>
</tr>
<tr>
<td>ask Client A what the matter is</td>
<td>[7-6-5-4-3-2-1]</td>
<td></td>
</tr>
<tr>
<td>have a talk with Client A about kicking staff</td>
<td>[7-6-5-4-3-2-1]</td>
<td></td>
</tr>
<tr>
<td>stop undressing Client A</td>
<td>[7-6-5-4-3-2-1]</td>
<td></td>
</tr>
<tr>
<td>kneel to be at eye level with Client A</td>
<td>[7-6-5-4-3-2-1]</td>
<td></td>
</tr>
<tr>
<td>say “I don’t like you when you do this”</td>
<td>[7-6-5-4-3-2-1]</td>
<td></td>
</tr>
<tr>
<td>call for help from other colleagues to restrain Client A</td>
<td>[7-6-5-4-3-2-1]</td>
<td></td>
</tr>
<tr>
<td>suggest to Client A that you help them get undressed</td>
<td>[7-6-5-4-3-2-1]</td>
<td></td>
</tr>
<tr>
<td>remind Client A that you are a nurse and here to help</td>
<td>[7-6-5-4-3-2-1]</td>
<td></td>
</tr>
<tr>
<td>shout at Client A “No, don’t”</td>
<td>[7-6-5-4-3-2-1]</td>
<td></td>
</tr>
<tr>
<td>say “suit yourself, then” and leave Client A in the chair</td>
<td>[7-6-5-4-3-2-1]</td>
<td></td>
</tr>
</tbody>
</table>
Whilst reading this case you should try to vividly imagine that you are the carer involved.

**Case 2**

Client R has early signs of language and memory problems but is able to take an active part in activities and requires little personal care. Diaries have been kept for Client R’s toiletting and you are aware that normally this client is continent. Earlier in the day you found Client R and another person arguing over a chair in the day room. Eventually you decided that Client R should move to another chair. Client R was very upset and angry and walked about shouting for a few minutes afterwards. When you enter the room again Client R is obviously soiled and wet and has been smearing faeces around the walls and on furniture. Client R reluctantly goes to the bathroom with you to clean up, but smears faeces onto your hands and arms on the way there.
How dependent is Client R?

☐ Not very dependent
☐ Highly dependent

Think about what might have caused Client R's behaviour.

Please write down what you think was the most likely cause of Client R's behaviour.

29. Is the cause of Client R’s behaviour due to something about them, or to something about other people or circumstances?

Totally due to Client R [7 6 5 4 3 2 1] Totally due to other people or circumstances

30. Is the cause due to something that just affects this situation or does it also influence other areas of Client R’s care?

Just influences this situation [7 6 5 4 3 2 1] Influences all situations in Client R’s care.

31. In the future, will this cause affect situations again?

Will always be present [7 6 5 4 3 2 1] Will never be present again.

32. Was this event intended by Client R?

Totally intentional [7 6 5 4 3 2 1] Totally unintentional

33. Was this event controllable in any way (e.g. preventable or encouraged)?

Totally out of Client R’s control [7 6 5 4 3 2 1] Totally within Client R’s control

34. How willing do you think you are now to put extra effort into caring for Client R?

Extremely willing to put in extra effort [7 6 5 4 3 2 1] Not at all willing to put in extra effort

35. How willing do you think you are now to put extra effort into changing Client R’s behaviour?

Extremely willing to put in extra effort [7 6 5 4 3 2 1] Not at all willing to put in extra effort
36. **How optimistic do you feel about changing Client R's behaviour?**

   Extremely optimistic [7 6 5 4 3 2 1] Not at all optimistic

37. **How optimistic do you feel that you can provide good care for Client R?**

   Extremely optimistic [7 6 5 4 3 2 1] Not at all optimistic

38. **How do you evaluate this kind of behaviour?**

   Extremely Bad [7 6 5 4 3 2 1] Completely Neutral

39. **How do you evaluate Client R?**

   Extremely Bad [7 6 5 4 3 2 1] Completely Neutral

After being involved in this situation, please rate how you feel.

40. **Extremely angry** [7 6 5 4 3 2 1] Not at all angry

41. **Extremely sympathetic** [7 6 5 4 3 2 1] Not at all sympathetic

How do you think you might handle the situation with Client R?

**How likely are you to use the following actions to deal with the situation?**

42. Be understanding to Client R very likely [7-6-5-4-3-2-1] very unlikely

43. Ask Client R if something is troubling them very likely [7-6-5-4-3-2-1] very unlikely

44. Slap Client R very likely [7-6-5-4-3-2-1] very unlikely

45. Leave Client R to toilet alone very likely [7-6-5-4-3-2-1] very unlikely

46. Ask colleagues to help you very likely [7-6-5-4-3-2-1] very unlikely

47. Start a toileting programme for Client R very likely [7-6-5-4-3-2-1] very unlikely

48. Say “Get off me” very likely [7-6-5-4-3-2-1] very unlikely

49. Avoid future arguments with Client R very likely [7-6-5-4-3-2-1] very unlikely

50. Help Client R to get used to sitting in different places very likely [7-6-5-4-3-2-1] very unlikely

51. Give Client R the cold shoulder very likely [7-6-5-4-3-2-1] very unlikely

52. Give PRN medication very likely [7-6-5-4-3-2-1] very unlikely

53. Care for Client R as though nothing had happened very likely [7-6-5-4-3-2-1] very unlikely

54. Support Client R in negotiating with other residents very likely [7-6-5-4-3-2-1] very unlikely

55. Remind Client R where the toilet is from time to time very likely [7-6-5-4-3-2-1] very unlikely

56. Tell other Clients to keep away from Client R very likely [7-6-5-4-3-2-1] very unlikely
Whilst reading this case you should try to vividly imagine that you are the carer involved.

**Case 3**

You are writing the daily notes for the patients at the end of a busy day. It’s very difficult for you to concentrate because a client is screaming very loudly. This goes on for more or less ten hours each day. Client L has advanced memory and communication difficulties and is highly dependent upon the staff for all personal care needs. Client L does not scream a word but more of a high-pitched ‘eek’ sound. Whenever your colleagues talk to or pay attention to Client L the screaming stops. But as soon as they go away Client L begins to scream again. Your colleagues and other patients have been coming into the office and complaining to you about the noise. You can’t bear the noise anymore. Client L is sitting in the ‘quiet room’ alone. Whenever someone enters Client L does not acknowledge their presence in any way and carries on screaming very loudly.
How dependent is Client L?

☐ Not very dependent  ☐ Highly dependent

Think about what might have caused Client L’s behaviour.  
Please write down what you think was the most likely cause of Client L’s behaviour.

57. Is the cause of Client L’s behaviour due to something about them, or to something about other people or circumstances?

Totally due to Client L [7 6 5 4 3 2 1]  Totally due to other people or circumstances

58. Is the cause due to something that just affects this situation or does it also influence other areas of Client L’s care?

Just influences this situation [7 6 5 4 3 2 1]  Influences all situations in Client L’s care.

59. In the future, will this cause affect situations again?

Will always be present [7 6 5 4 3 2 1]  Will never be present again.

60. Was this event intended by Client L?

Totally intentional [7 6 5 4 3 2 1]  Totally unintentional

61. Was this event controllable in any way (e.g. preventable or encouraged)?

Totally out of Client L’s control [7 6 5 4 3 2 1]  Totally within Client L’s control

62. How willing do you think you are now to put extra effort into caring for Client L?

Extremely willing to put in extra effort [7 6 5 4 3 2 1]  Not at all willing to put in extra effort

63. How willing do you think you are now to put extra effort into changing Client L’s behaviour?

Extremely willing to put in extra effort [7 6 5 4 3 2 1]  Not at all willing to put in extra effort
64. How optimistic do you feel about changing Client L’s behaviour?

   Extremely optimistic [7 6 5 4 3 2 1] Not at all optimistic

65. How optimistic do you feel that you can provide good care for Client L?

   Extremely optimistic [7 6 5 4 3 2 1] Not at all optimistic

66. How do you evaluate this kind of behaviour?

   Extremely Bad [7 6 5 4 3 2 1] Completely Neutral

67. How do you evaluate Client L?

   Extremely Bad [7 6 5 4 3 2 1] Completely Neutral

After being involved in this situation, please rate how you feel.

68. Extremely angry [7 6 5 4 3 2 1] Not at all angry

69. Extremely sympathetic [7 6 5 4 3 2 1] Not at all sympathetic

How do you think you might handle the situation with Client L?

**How likely are you to use the following actions to deal with the situation?**

<table>
<thead>
<tr>
<th>Action</th>
<th>Very Likely</th>
<th>Very Unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>70. Check to find out if Client L is in pain</td>
<td>[7-6-5-4-3-2-1]</td>
<td>[7-6-5-4-3-2-1]</td>
</tr>
<tr>
<td>71. Say “Shut up” to Client L</td>
<td>[7-6-5-4-3-2-1]</td>
<td>[7-6-5-4-3-2-1]</td>
</tr>
<tr>
<td>72. Check the room temperature</td>
<td>[7-6-5-4-3-2-1]</td>
<td>[7-6-5-4-3-2-1]</td>
</tr>
<tr>
<td>73. Leave Client L alone</td>
<td>[7-6-5-4-3-2-1]</td>
<td>[7-6-5-4-3-2-1]</td>
</tr>
<tr>
<td>74. Have a long chat with Client L about not screaming</td>
<td>[7-6-5-4-3-2-1]</td>
<td>[7-6-5-4-3-2-1]</td>
</tr>
<tr>
<td>75. Give PRN medication</td>
<td>[7-6-5-4-3-2-1]</td>
<td>[7-6-5-4-3-2-1]</td>
</tr>
<tr>
<td>76. Talk to Client L</td>
<td>[7-6-5-4-3-2-1]</td>
<td>[7-6-5-4-3-2-1]</td>
</tr>
<tr>
<td>77. Try to ignore the noise</td>
<td>[7-6-5-4-3-2-1]</td>
<td>[7-6-5-4-3-2-1]</td>
</tr>
<tr>
<td>78. Refuse Client L treats or privileges</td>
<td>[7-6-5-4-3-2-1]</td>
<td>[7-6-5-4-3-2-1]</td>
</tr>
<tr>
<td>79. Turn the TV on</td>
<td>[7-6-5-4-3-2-1]</td>
<td>[7-6-5-4-3-2-1]</td>
</tr>
<tr>
<td>80. Stroke Client L’s hand</td>
<td>[7-6-5-4-3-2-1]</td>
<td>[7-6-5-4-3-2-1]</td>
</tr>
<tr>
<td>81. Tell Client L that they should stop shouting</td>
<td>[7-6-5-4-3-2-1]</td>
<td>[7-6-5-4-3-2-1]</td>
</tr>
<tr>
<td>82. Move Client L into a busier room</td>
<td>[7-6-5-4-3-2-1]</td>
<td>[7-6-5-4-3-2-1]</td>
</tr>
<tr>
<td>83. Tell all staff not to give Client L attention when screaming</td>
<td>[7-6-5-4-3-2-1]</td>
<td>[7-6-5-4-3-2-1]</td>
</tr>
<tr>
<td>84. Go in and say “What do you want?”</td>
<td>[7-6-5-4-3-2-1]</td>
<td>[7-6-5-4-3-2-1]</td>
</tr>
</tbody>
</table>
Whilst reading this case you should try to vividly imagine that you are the carer involved.

Case 4

Client G has mild memory problems and has some difficulty communicating personal needs effectively but requires only minimal help with personal care activities. It’s late evening and you are sitting in the day room with a few of the clients from the home. Suddenly you hear a loud banging noise and screams coming from the corridor. You get up and run to the noise. Client G is standing by the door, screaming and pulling the door. Client G often likes to walk around the garden with members of staff. You call out to Client G “You can’t go out now”. Client G does not respond to you and starts to shout, “Let me out, I want to go out now”. When you approach, Client G starts to shout louder. Client G is shouting and screaming again “Come outside now”. This happens on a regular basis.
How dependent is Client G?

- [ ] Not very dependent
- [ ] Highly dependent

Think about what might have caused Client G’s behaviour.
Please write down what you think was the **most likely cause** of Client G’s behaviour.

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>85. Is the cause of Client G’s behaviour due to something about them, or</td>
<td>Totally due to Client G [7 6 5 4 3 2 1] Totally due to other people or circumstances</td>
</tr>
<tr>
<td>86. Is the cause due to something that just affects this situation or does</td>
<td>Just influences this situation [7 6 5 4 3 2 1] Influences all situations in Client G’s care.</td>
</tr>
<tr>
<td>87. In the future, will this cause affect situations again?</td>
<td>Will always be present [7 6 5 4 3 2 1] Will never be present again.</td>
</tr>
<tr>
<td>88. Was this event intended by Client G?</td>
<td>Totally intentional [7 6 5 4 3 2 1] Totally unintentional</td>
</tr>
<tr>
<td>89. Was this event controllable in any way (e.g. preventable or</td>
<td>Totally out of Client G’s control [7 6 5 4 3 2 1] Totally within Client G’s control</td>
</tr>
<tr>
<td>90. How willing do you think you are now to put extra effort into caring</td>
<td>Extremely willing to put in extra effort [7 6 5 4 3 2 1] Not at all willing to put in extra effort</td>
</tr>
<tr>
<td>91. How willing do you think you are now to put extra effort into changing</td>
<td></td>
</tr>
</tbody>
</table>
| 148
92. How optimistic do you feel about changing Client G’s behaviour?
   Extremely optimistic [7 6 5 4 3 2 1] Not at all optimistic

93. How optimistic do you feel that you can provide good care for Client G?
   Extremely optimistic [7 6 5 4 3 2 1] Not at all optimistic

94. How do you evaluate this kind of behaviour?
   Extremely Bad [7 6 5 4 3 2 1] Completely Neutral

95. How do you evaluate Client G?
   Extremely Bad [7 6 5 4 3 2 1] Completely Neutral

After being involved in this situation, please rate how you feel.

96. Extremely angry [7 6 5 4 3 2 1] Not at all angry

97. Extremely sympathetic [7 6 5 4 3 2 1] Not at all sympathetic

How do you think you might handle the situation with Client G?

How likely are you to use the following actions to deal with the situation?

98. Say quietly, “You’re upset, what’s wrong?”
   very likely [7-6-5-4-3-2-1] very unlikely

99. Give PRN medication
   very likely [7-6-5-4-3-2-1] very unlikely

100. Say “You won’t get a bedtime drink if you stay here”.
   very likely [7-6-5-4-3-2-1] very unlikely

101. Reassure Client G “Everything’s OK”.
   very likely [7-6-5-4-3-2-1] very unlikely

102. Quietly call Client G’s name
   very likely [7-6-5-4-3-2-1] very unlikely

103. Call for colleagues to restrain Client G
   very likely [7-6-5-4-3-2-1] very unlikely

104. Talk about Client G’s favourite parts of the garden
   very likely [7-6-5-4-3-2-1] very unlikely

105. Say “You can’t go out until a nurse can go with you”.
   very likely [7-6-5-4-3-2-1] very unlikely

106. Suggest Client G helps you to get their coat from their bedroom and distract them
   very likely [7-6-5-4-3-2-1] very unlikely

107. Go for a walk outside with Client G
   very likely [7-6-5-4-3-2-1] very unlikely

108. Say “Stop this or I’ll tell the doctor”.
   very likely [7-6-5-4-3-2-1] very unlikely

109. Lock the door and leave Client G
   very likely [7-6-5-4-3-2-1] very unlikely

110. Say “Don’t you remember we went out an hour ago?”
   very likely [7-6-5-4-3-2-1] very unlikely

111. Say “It’s so cold I’m glad I’m inside”
   very likely [7-6-5-4-3-2-1] very unlikely

112. Say “Shall we look at some magazines together?”
   very likely [7-6-5-4-3-2-1] very unlikely
Whilst reading this case you should try to vividly imagine that you are the carer involved.

Case 5

Client F has mild memory problems and some difficulties with speech but is independent in most personal care tasks. Client F often spends time moving objects around the unit. Client F will take other resident’s property and clothing and objects from communal areas. Many times during the day you find that you have to take furniture and other items and put them back in their rightful place. Other clients often confront Client F over their missing possessions. Client F usually refuses to recognise that the items belong to other people or in a different place. You enter the group room just after all the clients have been given a cup of tea or coffee. Client F is taking the cups off the other clients before they have finished their drink and putting them back on the tea trolley. One of the clients is resisting giving their cup to Client F who is tugging at the cup. Any moment the hot drink could spill.
How dependent is Client F?  

☐ Not very dependent  ☐ Highly dependent

Think about what might have caused Client F's behaviour.  
Please write down what you think was the most likely cause of Client F's behaviour.

113. Is the cause of Client F's behaviour due to something about them, or to something about other people or circumstances?

Totally due to Client F [7 6 5 4 3 2 1]  Totally due to other people or circumstances

114. Is the cause due to something that just affects this situation or does it also influence other areas of Client F's care?

Just influences this situation [7 6 5 4 3 2 1]  Influences all situations in Client F's care.

115. In the future, will this cause affect situations again?

Will always be present [7 6 5 4 3 2 1]  Will never be present again.

116. Was this event intended by Client F?

Totally intentional [7 6 5 4 3 2 1]  Totally unintentional

117. Was this event controllable in any way (e.g preventable or encouraged)?

Totally out of Client F's control [7 6 5 4 3 2 1]  Totally within Client F's control

118. How willing do you think you are now to put extra effort into caring for Client F?

Extremely willing to put in extra effort [7 6 5 4 3 2 1]  Not at all willing to put in extra effort

119. How willing do you think you are now to put extra effort into changing Client F's behaviour?

Extremely willing to put in extra effort [7 6 5 4 3 2 1]  Not at all willing to put in extra effort
120. How optimistic do you feel about changing Client F’s behaviour?
Extremely optimistic [7 6 5 4 3 2 1] Not at all optimistic

121. How optimistic do you feel that you can provide good care for Client F?
Extremely optimistic [7 6 5 4 3 2 1] Not at all optimistic

122. How do you evaluate this kind of behaviour?
Extremely Bad [7 6 5 4 3 2 1] Completely Neutral

123. How do you evaluate Client F?
Extremely Bad [7 6 5 4 3 2 1] Completely Neutral

After being involved in this situation, please rate how you feel.

124. Extremely angry [7 6 5 4 3 2 1] Not at all angry
125. Extremely sympathetic [7 6 5 4 3 2 1] Not at all sympathetic

How do you think you might handle the situation with Client F?

How likely are you to use the following actions to deal with the situation?

126. Hold Client F’s wrists to stop the drink spilling very likely [7-6-5-4-3-2-1] very unlikely
127. Take the cup from the clients. very likely [7-6-5-4-3-2-1] very unlikely
128. Tell the other client “F’s feeling a bit funny I’ll get you another drink”.
129. Ask Client F “Can I help you?”
130. Tell Client F not to take other people’s cups very likely [7-6-5-4-3-2-1] very unlikely
131. Say to Client F “Thanks for your help, I think she’d like a drink, could you get one for her?” very likely [7-6-5-4-3-2-1] very unlikely
132. Use restraint equipment for F when drinks are served very likely [7-6-5-4-3-2-1] very unlikely
133. Get the other client another drink very likely [7-6-5-4-3-2-1] very unlikely
134. Leave the room for a short while very likely [7-6-5-4-3-2-1] very unlikely
135. Get the cup and make Client F sit down for their drink very likely [7-6-5-4-3-2-1] very unlikely
136. Ask Client F to tidy up another area. very likely [7-6-5-4-3-2-1] very unlikely
137. Tell Client F to say sorry to the other client very likely [7-6-5-4-3-2-1] very unlikely
138. Ask Client F “Can you help me hand out all the drinks?” very likely [7-6-5-4-3-2-1] very unlikely
139. Say “Don’t do that” loudly very likely [7-6-5-4-3-2-1] very unlikely
140. Keep a close eye on Client F at all times. very likely [7-6-5-4-3-2-1] very unlikely
Whilst reading this case you should try to vividly imagine that you are the carer involved.

Case 6

Client M has memory problems and has great difficulty expressing personal needs and understanding others, they require assistance in all activities. Client M often hides money in drawers and cupboards and other resident’s bedrooms all over the home. Small and large amounts of money have been found when cleaning. Client M seldom remembers where their money has been hidden and becomes very upset when they can’t find the money. Client M is almost always preoccupied with money and goes up to other patients and staff to say “My money has been stolen”. Client M only ever thinks that you have stolen the money. Over time things have got worse and one day Client M is very agitated and distressed with the idea that others are protecting you. Client M is crying and comes up to you shouting, “Why are you stealing from me?”
How dependent is Client M?

☐ Not very dependent  ☐ Highly dependent

Think about what might have caused Client M’s behaviour.

Please write down what you think was the most likely cause of Client M’s behaviour.

141. Is the cause of Client M’s behaviour due to something about them, or to something about other people or circumstances?

Totally due to Client M [7 6 5 4 3 2 1]  Totally due to other people or circumstances

142. Is the cause due to something that just affects this situation or does it also influence other areas of Client M’s care?

Just influences this situation [7 6 5 4 3 2 1]  Influences all situations in Client M’s care.

143. In the future, will this cause affect situations again?

Will always be present [7 6 5 4 3 2 1]  Will never be present again.

144. Was this event intended by Client M?

Totally intentional [7 6 5 4 3 2 1]  Totally unintentional

145. Was this event controllable in any way (e.g. preventable or encouraged)?

Totally out of Client M’s control [7 6 5 4 3 2 1]  Totally within Client M’s control

146. How willing do you think you are now to put extra effort into caring for Client M?

Extremely willing to put in extra effort [7 6 5 4 3 2 1]  Not at all willing to put in extra effort

147. How willing do you think you are now to put extra effort into changing Client M’s behaviour?

Extremely willing to put in extra effort [7 6 5 4 3 2 1]  Not at all willing to put in extra effort
148. How optimistic do you feel about changing Client M’s behaviour?
Extremely optimistic [7 6 5 4 3 2 1] Not at all optimistic

149. How optimistic do you feel that you can provide good care for Client M?
Extremely optimistic [7 6 5 4 3 2 1] Not at all optimistic

150. How do you evaluate this kind of behaviour?
Extremely Bad [7 6 5 4 3 2 1] Completely Neutral

151. How do you evaluate Client M?
Extremely Bad [7 6 5 4 3 2 1] Completely Neutral

After being involved in this situation, please rate how you feel.

152. Extremely angry [7 6 5 4 3 2 1] Not at all angry

153. Extremely sympathetic [7 6 5 4 3 2 1] Not at all sympathetic

How do you think you might handle the situation with Client M?
How likely are you to use the following actions to deal with the situation?

154. Say “Shall we look for the money together?” very likely [7-6-5-4-3-2-1] very unlikely
155. Deny privileges to Client M very likely [7-6-5-4-3-2-1] very unlikely
156. Say “Don’t accuse me of stealing” very likely [7-6-5-4-3-2-1] very unlikely
157. Joke about Client M’s beliefs and laugh it off very likely [7-6-5-4-3-2-1] very unlikely
158. Explain to Client M that you haven’t got the money very likely [7-6-5-4-3-2-1] very unlikely
159. Try to get to know Client M better and make friends very likely [7-6-5-4-3-2-1] very unlikely
160. Find out if other things are bothering Client M very likely [7-6-5-4-3-2-1] very unlikely
161. Ask Client M why they always pick on you very likely [7-6-5-4-3-2-1] very unlikely
162. Change the subject to one that interests Client M very likely [7-6-5-4-3-2-1] very unlikely
163. Remind Client M that you are a nurse and in charge very likely [7-6-5-4-3-2-1] very unlikely
164. Say “I won’t talk to you while you’re like this” very likely [7-6-5-4-3-2-1] very unlikely
165. Care for Client M as though nothing had happened very likely [7-6-5-4-3-2-1] very unlikely
166. Work with others to help Client M to find safe places for their money very likely [7-6-5-4-3-2-1] very unlikely
167. Take all Client M’s money to be kept by the manager very likely [7-6-5-4-3-2-1] very unlikely
168. Grab Client M’s hands tight and say “I haven’t got your money” very likely [7-6-5-4-3-2-1] very unlikely
Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is true or false as it pertains to you personally.

It is sometimes hard for me to go on with my work if I am not encouraged

I sometimes feel resentful if I don’t get my own way

On a few occasions, I have given up doing something because I thought too little of my ability

There have been times when I have felt like rebelling against people in authority even though I knew they were right.

No matter who I’m talking to, I’m always a good listener.

There have been occasions when I have taken advantage of someone.

I’m always willing to admit it when I make a mistake.

I sometimes try to get even rather than forgive and forget.

I am always courteous, even to people who are disagreeable.

I have never been irked when people expressed ideas very different from my own.

There have been times when I was quite jealous of the good fortune of others

I am sometimes irritated by people who ask favours of me.

I have never deliberately said something that hurt someone’s feelings.

How supported do you feel in your work?

1. Do you feel supported by colleagues to deal with incidents such as this in the case study?
   Very supported [7-6-5-4-3-2-1] Not at all

2. Do you feel supported by managers to deal with incidents such as this in the case study?
   Very supported [7-6-5-4-3-2-1] Not at all

3. Do you feel supported by outside agencies to deal with incidents such as this in the case study?
   Very supported [7-6-5-4-3-2-1] Not at all

4. Do you feel personal problems can affect your ability to deal with incidents such as this in the case study?
   Affects me very much [7-6-5-4-3-2-1] Not at all
APPENDIX 7

Comparison of Correlated Correlation Coefficients for Non-Independent Groups

\[ |R| = (1 - (r_{21})^2 - (r_{31})^2 - (r_{23})^2) + (2 \times r_{21} \times r_{31} \times r_{23}) \]

\[ r = \frac{r_{21} + r_{31}}{2} \]

\[ t_{(n-3)} = \frac{(r_{21} \times r_{31}) \times \frac{(n-1) \times 1 + r_{23}}{n-1}}{2 \times n-3 \times |R| + \frac{r^2}{2} \times (1 - r_{23})^3} \]