A Qualitative Analysis of factors influencing Staff Beliefs about the Challenging Behaviour exhibited by Adults with a Learning Disability

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Submitted in fulfilment of the Doctorate of Clinical Psychology at the University of Leicester

Year of Submission: 2008
I would like to thank both Angela Holland and Steve Allen for their effective supervision, as their guidance and support were pivotal and containing.

I would also like to thank my partner whose encouragement and support were invaluable throughout the course of me completing my research.
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1. ABSTRACT

Purpose: To review the literature on staff attributions of challenging behaviour (CB) exhibited by adults with a learning disability (LD). In particular, those studies which utilise Weiner’s (1986) attribution model.

Method: The review examined studies which contribute to understanding how staff understand and respond to CB exhibited by adults with LD. Studies were seen to do so in one of two ways. Firstly, by examining factors that influence staff attributions of CB. Secondly, by examining the effect of training programmes on staff attributions of CB.

Results: Studies using Weiner’s (1986) attribution model to examine staffs causal beliefs about CB exhibited by adults with LD highlighted the influence of particular cognitive and emotional factors. Variables specific to both the member of staff and the clients that can be seen to influence staff attributions of CB were also highlighted. Studies examining the impact of training on staff attributions of CB exhibited by adults with LD have yielded inconsistent results. Therefore, conclusions cannot be drawn regarding the efficiency of staff training on CB. The evidence provided by these studies suggests the utility of the attribution model is disputable. Problems with the validity and reliability of the methods such studies use are highlighted, and alternative approaches are noted.

Conclusions: The review highlighted the need for future research in the field to adopt alternative models to understand staff beliefs about CB, as the utility of Weiner’s (1986) model is questionable. It also draws attention to the need to consider alternative methods of enquiry as the validity of single-scale measures in assessing staff attributions is questionable.
2. INTRODUCTION

Challenging behaviours (CB) are associated with a range of personal and social consequences, and may significantly impair the health and quality of life of the person exhibiting the behaviour and those who care for them. Such consequences can go far beyond the immediate physical impact of CB, as the responses of the community and service agencies to such behaviour may prove to be significantly detrimental to a person’s quality of life. (Emerson, 2001). Research has previously shown that CB can be a significant barrier to obtaining services for people with learning disabilities (LD) (Allen, 1989). Therefore, there has been a large body of research on CB, particularly in relation to people with LD, which has been geared towards enhancing our understanding of the functions of this behaviour in order to construct appropriate and effective interventions.

The need for such knowledge has become increasingly important as services for people with LD are transferred from institutions into the community (Valuing people, 2001) and authorities strive to provide services that are informed and evidence based to ensure high quality care. This need has been highlighted in recent government documents, along with concerns that such aims are not being met. The Best Practice Guidance from the Department of Health (2007) noted growing concerns that some areas of the country are struggling to commission services that reflect current policy and best practice. It stated this has led to:
‘inappropriately funded services, outdated models, the poor development of a community infrastructure and an over-reliance on bed based services … and a lack of appropriately funded and skilled specialist learning disability health services’ (p. 6).

It noted that as a result people with LD are getting ‘stuck’ in often inappropriate systems that can fail to meet their needs. This may put them at risk of neglect and, at worse, abuse. It also highlighted that carers, formal and informal, receive inadequate support and training by specialist health care staff, which results in an increased demand for health interventions at a later date.

In relation to this, Mansell (2007) stated that the transfer of LD services from institutions into the community has not actually decreased the incidence of CB. He affirms that services provided for this population should be individualised and reflect available research evidence about best practice. This will require attention to factors other than just client behaviour. Mansell highlights the fact that psychological treatments for CB offer the most empirical support. Although psychological theories inform current interventions for CB (Emerson, 2001), in most environments the day to day implementation of such interventions are carried out by direct care staff. Therefore, changes in services expectations and provisions will impose additional strain on direct care staff, who will need emotional and practical support.

Current difficulties in services for this population highlight the significance of environmental and social factors, and emphasises the need for more comprehensive research into CB. Traditionally, behavioural and neurobiological / psychiatric traditions dominated applied research within the field of LD, and the principles of
applied behaviour analysis were used to understand and modify CB (Emerson, 2001). More recently, research has begun to examine cognitive and emotional factors that recognise its social context (e.g., McGill, 1993). For that reason the actions of significant others, such as formal care staff, are highlighted as important and considered to constitute towards such behaviour. Therefore, a strand of the research in this field examines the role that staff play in the development and maintenance of CB (Hastings & Remington, 1994a), in particular, how staff understand and interact with clients who exhibit CB. Initially the focus was on staff’s overt response to client behaviour, but more recently cognitive and emotional factors have been explored using attribution theory.

Attribution theory is concerned with describing the process whereby people search for the explanations and causes of an event that has provoked particular emotions. The conclusions people come to in this situation are termed ‘attributions’, and they may influence a person’s expectations, behaviour and emotional response in a situation. Errors can occur in this process when someone’s behaviour is attributed to internal and enduring states, such as personality, rather than external factors such as the environment (Heider, 1958). There are various theoretical perspectives within the general body of attribution theory, ranging from Heider’s (1958) theory of ‘naïve psychology’ to Weiner’s (1980, 1985, 1986) theory of motivation and emotion, which has been applied to our understanding of helping behaviour. Weiner’s model (1986) is an interpersonal theory of motivation and highlights the causal properties of help giving. According to the model, attributions regarding the locus of the behaviour (internal verses external to the person), the controllability ascribed to it and its stability (permanency) will influence help giving. The model predicts that the more
internal, controllable and stable the attributions the less sympathy and help are elicited. This model has been extended (Weiner, 1995) to consider aggressive behaviour, and placed an emphasis on how judgements of responsibility for such behaviour affect the causal attributions people make. It proposed that if harmful behaviour is perceived as intentional then the person exhibiting the behaviour is seen to be held responsible for the behaviour and its consequences. This will elicit anger and a tendency to engage in a hostile reaction. If the behaviour is not believed to be intentional then the person will not be seen as being responsible, which lessens anger and may even elicit sympathy.

Given the potential utility of Weiner’s work for our understanding of helping behaviour, researchers have attempted to use this theory to aid our understanding of staff behaviour, emotions and reactions to various types of CB exhibited by people with LD. Clearly such research has important implications for both staff and clients. For example, studies have noted that working with CB can provoke various negative emotions (e.g., Bromley & Emerson, 1995) and have an impact on levels of stress and burn out in staff (e.g., Mitchell & Hastings, 1998). Such factors will impact upon staff understanding of such behaviour and their interactions with clients. Indeed some studies (e.g., Dunne, 1994) have even suggested that attributions may lead to inconsistent care or even maintain CB.

This review aims to identify and critically consider the available research regarding staff causal explanations of the CB exhibited by adults with a LD, in particular those which utilise the attribution model. The quality of the literature will be assessed and findings will be synthesised in order to discover how the research contributes to the
following questions. How do staff make sense of CB exhibited by people with LD? What factors contribute to staff attributions? How do staff attributions impact on the service they provide? Can staff attributions be modified? The implications for clinical practice will also be discussed as well as limitations of current research, and possibilities for future research.

3. DEFINITIONS

Much of the research in the field of CB has examined the CB exhibited by people with LD. This may be because managing CB is a major issue for service provision within LD populations. A definition of LD is given below. The definition of CB used in the present review is specific to the CB exhibited by people with LD.

3.1 Definition of Learning Disability

Emerson (2001) notes that the UK term of learning disability is synonymous with the term intellectual disability and the North American term mental retardation. The British Psychological Society (BPS) document Learning Disability: Definitions and Context (BPS, 2001) asserts that both intellectual and adaptive/social functioning should be measured when assessing a person for LD. It outlines the three key features constituting the definition of ‘intellectual disability’ as being;

- Significant impairment of intellectual functioning (IQ < 69),
- Significant impairment of adaptive and social functioning (i.e. requires significant assistance to provide for their own survival and social/community adaptation); and
- An onset before the age of eighteen years.

This is consistent with the Diagnostic and Statistical Manual of Mental Disorders – Text Revised (DSM-TR, APA, 2000), and the Classification of Mental and Behavioural Disorders – Clinical Description and Diagnostic guidelines (ICD 10 – CDDG, WHO, 1992). In addition, the ICD-10 recommends using the Vineland Adapted Behaviours Scales (VABS; Sparrow et al., 1984) to assess adaptive/social functioning.

Services for LD in the UK adopt this definition but there can be variance in how literally it is adopted. This depends on available resources and the level of need that individuals present with. For example, some services adopt a cut off point lower than IQ of 69 due to service constraints, whereas some individuals with higher IQ may be accepted into a LD service because they have a great need for intervention.

### 3.2 Definitions of Challenging Behaviour

A recent department of health report noted the utility of Emerson et al.’s (1995) definition of CB. Emerson defined it as:

> “culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit or delay access to and use of ordinary community facilities.” (Emerson, 1995, as cited in Mansell, 2007, p. 6).
Emerson (1995) highlighted three important aspects of CB: First, that it is defined by its effect. Secondly, it has personal and social consequences for the individual, the people they live with and the people who care for them. Finally, it is socially defined (because whether or not it is considered challenging depends on the observers perceptions of the behaviour). More recently, Emerson (2001) noted that CB is not synonymous with psychiatric disturbance, as not all psychiatric disorders place the safety of the person or others in jeopardy, or lead to the person being denied access to community settings. Emerson goes on to add that many CBs appear to be functional adaptive responses to particular environments, rather than a manifestation of underlying psychiatric impairment.

The most recent definition of CB by the British Psychological Society states that behaviour is defined as challenging when;

“… it is of such an intensity, frequency or duration as to threaten quality of life and/or the physical safety of the individual or others and leads to responses from individuals or services that are restrictive, aversive, or result in exclusion.”

(BPS/RCPsych, 2006, as cited in Campbell, 2007, p. 407)

However, problems with such definitions have been noted, and highlights potential difficulties for researchers in this area. For example, Fenwick (1995) stated that because CB is by definition a social construction (and experiences of what is challenging will vary), it is not possible to have an objective definition of which types of behaviours are likely to be considered challenging. Therefore, Emerson et al.’s (1995) definition can only describe the severity of CB and not the form it may take.
Also, Mansell (2007) stated the phrase “challenging behaviour” should be used to refer to people whose behaviour presents a significant challenge to services whatever the presumed cause of the problem, including behaviour that is attributable to mental health problems. He noted that when the term ‘challenging behaviour’ was introduced, it was intended to emphasise that problems were often caused as much by the way in which a person was supported by services as they were by service user characteristics. However, in the ensuing years this has drifted towards using the term as a label for people.

3.3 Prevalence and topography

Debates about the prevalence and topographies of CB within LD populations has been a regular feature in the literature (Emerson et al., 2001; Harris, 1993; Keirnan et al., 1997; Kushlick & Cox, 1973; Oliver et al., 1987; Quresi & Alborz, 1992). Concerns over the reliability of prevalence rates have been raised as differences in the definitions adopted can lead to wide variation in the assessment of prevalence (Tustin et al., 1991). For the sake of brevity prevalence rates will not be debated in this review. The most recent findings will be cited and relevant clinical implications highlighted.

Lowe et al. (2007) examined current prevalence rates of CB amongst children, young people, and adults with LD. The prevalence rates reported in this study were considered comparable to those reported in the earlier studies, thus confirming previous findings. Results indicated that in total 4.5 (2.5–7.5) people per 10 000 population were rated as seriously challenging, representing 10% (5.5–16.8%) of the LD population. The most prevalent form of CB was difficult/disruptive behaviour,
with non-compliance being the most prevalent topography. The majority showed multiple behaviours and multiple topographies within each general behaviour category. It was also identified that there were substantial numbers of additional people reported as presenting CBs at lower degrees of severity, which the authors claim emphasises the need for enhanced understanding and skills among care staff. Emphasising this point further, Mansell (2007) noted that estimates include people with mild as well as severe LD and, whilst a few of these people will present a consistent challenge, many people will move into and out of this group and this can depend on how well services meet their needs over time.

Determining rates and types of CB is particularly important in light of moving LD services into the community. Studies have noted that aggressive behaviours represent major obstacles to the integration of people with LD into the community and pose significant management issues for carers (Crocker et al., 2006), increase the risk of placement breakdown and re-institutionalisation (Allen, 1999), has implications for services on meeting the needs of individuals (Mansell, 2007), and because those displaying CB are more at risk of abuse and neglect (Emerson et al., 1994).

3.4 Terminology

Throughout the present review, the term ‘learning disabilities’ (LD) will be used to refer to the population of interest. ‘Learning disability’ (LD) is synonymous with ‘intellectual disability’, the American term ‘mental retardation’ and with the definition of ‘mental impairment’ under the 1983 Mental Health Act (Department of Health). The term ‘Staff’ will be used to indicate paid professional carers.
4. METHODOLOGY

4.1 Search Strategy and search terms

References were initially obtained from a systematic literature search. A summary of the search terms used, the databases and the years covered can be found in Table B.1.

Additional citations were obtained by hand searching reference lists of selected journal articles and by looking in particularly relevant journals (Journal of Applied Research in Intellectual Disabilities, Journal of Intellectual Disability Research, and Journal of Learning Disabilities).

4.2 Inclusion/exclusion criteria

Studies were included if they added to the literature on staff attributions of the CB exhibited by adults with a LD either by exploring factors contributing to such attributions (such as personal and emotional variables) or exploring ways of modifying attributions (such as staff training). Previous literature reviews were also included.

Studies were excluded if they were not published in a UK journal due to difficulties with comparability in terms of definitions, differences in service provision for this population, and potential differences in research methods.

The review focussed only on adults with LD for a number of reasons. Research to date has tended to distinguish between children and adults with LD, and the differences in the way services are provided for adults and children has an impact on the comparability of research studies.
The current review focussed only on the attributions of formal care staff, and hence excluded studies that only examined families and informal carers. The literature on attributions of family and informal carers carries different implications as the variables affecting relatives who have a 24 hour care responsibility will be different from those influencing contracted carers (Kushlick, 1975). The current review also excluded studies examining teachers and special educators, as their roles and training will be different to formal carers working within Health and Social Care services, and the literature concerning the role of teachers is generally less well developed (Allen, 1999).

Conducting the literature search highlighted other exclusion factors, due to the specific nature of the studies reducing comparability. These included studies which examined CB in light of other diagnoses as well as LD (e.g., Downs Syndrome, Epilepsy, Psychosis), examined a specific type of CB only (e.g., inappropriate sexual behaviour, anger, risk management), or focussed on medical difficulties associated with CB (e.g., chronic pain, sensory impairment).
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5. RESULTS

5.1 Overview

In total, fifty-six studies were identified that met the review criteria. Five previous literature reviews were identified (Allen, 1999; Hastings & Remington, 1994a, 1994b; Hassiotis & Hall, 2004; Rose, 1995; Willner & Smith, 2008) that overlap with aspects of the current review in some way, though none had the same aims or broad scope as the current review. These literature reviews will be discussed in relevant sections of the present review.

Hastings (1997) highlighted two key reasons why researchers should focus on staff attributions of CB exhibited by people with LD. Indeed most of the studies identified in this review do in fact explore one of these two areas. Firstly, there is the assumption that staff beliefs about the causes of CB may interact with other variables and influence how they respond to the behaviour. Secondly, there is a need to evaluate the effectiveness of staff training regarding CB, as staff perceptions about the causes of CB may change as a result of theoretical and practical training. These two key reasons provide the structure for the current review.

5.2 Staff attributions of the causes of challenging behaviour

The way in which staff attributions of CB impact on their response to it has obvious clinical implications for patient care. For example, some studies have suggested that certain negative attributions held by staff may lead to inconsistent care (e.g., Dunne, 1994), can maintain CB or even cause it to develop (e.g. Hastings & Remington, 1994a; Hall et al., 2001), and decrease the probability of staff effectively implementing intervention programmes (e.g., Watts et al., 1997). Also, staff’s
experience of using physical intervention has been shown to be affected by their appraisal of CB (Hawkins et al., 2005). Therefore, it is important to understand the process by which staff perceive and respond to CB, and what factors are involved.

5.2.1 Previous literature reviews

One of the early literature reviews identified in this area (Hastings & Remington, 1994b) aimed to analyse staff responses to CB, but focused more on staff behavioural responses to CB than their beliefs. This highlighted that much of the research utilised a behavioural perspective up until this point. The review will therefore only be discussed in brief. Although the authors mainly discussed the results of observational and self-report studies on staff behaviour, it did note that staff may be affected by certain contingencies relating to CB as reports had shown it could contribute to high levels of stress (e.g. Bersnai & Heifetz, 1985), and was associated with various forms of negative affect (Hastings & Remington, 1993b). It was noted that such contingencies may contribute towards an explanation as to why staff do not follow behavioural programmes, but they also suggest the ecology of the setting for such interventions should be considered, which includes the staff within the setting.

The review also discussed the potential significance of rule-governed behaviours (Skinner, 1953, 1957, 1969) in understanding staff behaviour, as they may provide conflicting sources of control for staff and result in inappropriate responses to CB. The main recommendations for future research were for further exploration in understanding staff behaviour, to identify rules used by staff working with CB, and to develop a better understanding of the nature and influence of staff culture on staff behaviour. In another literature review conducted by the same authors (1994a) the
need to develop and extend our understanding of influences on staff behaviour through different theoretical orientations was highlighted as a priority.

Following this a more cognitive perspective was employed to study carers responses to CB, which emphasised that the way in which staff view CB effects their emotional response to it. Therefore, research began to pay more attention to carers’ cognitions and emotions than just their overt behaviour. For example, Hastings (1995) conducted exploratory interviews to investigate factors influencing staff responses to CB and found CB caused them to experience negative emotional states. Kushkick et al., (1997) suggested cognitive components needed to be incorporated into models of understanding staff performance to develop a more comprehensive account. In particular, the causal explanations that staff make about CB are seen to have a key role in determining their emotional and behavioural responses (Dunne, 1994) and have been a particular focus. Therefore, Weiner’s attributional model has been used to conceptualise staff behaviour within a cognitive behavioural framework in this field.

Consequently, there have many studies attempting to measure staff attributions and their contribution to staff behaviour, along with other associated factors such as emotional response. This review aims to summarise and critique recent findings in this field in order to highlight clinical implications and suggestions for future research.
5.2.2 Recent studies utilising the attribution model to examine staff causal explanations for challenging behaviour

The current review identified several recent studies that examined cognitive and emotional factors associated with CB as well as attributions. Frequently measured aspects include staffs’ emotional response to CB (Bailey \textit{et al.}, 2006; Dagnan & Cairns, 2005; Hill & Dagnan, 2002; Jones & Hastings, 2003; Rose & Rose, 2005; Wanless & Jahoda, 2002) and their intention to help (Bailey \textit{et al.}, 2006; Dagnan & Cairns, 2005; Hill & Dagnan, 2002; Jones & Hastings, 2003; Rose & Rose, 2005; Wanless & Jahoda, 2002). Other factors measured include participants’ level of optimism (Bailey \textit{et al.}, 2006; Noone \textit{et al.}, 2003; Rose & Rose, 2005; Wanless & Jahoda, 2002), ways of coping (Hill & Dagnan, 2002), burnout (Rose & Rose, 2005), and how responsible the participant feels the client is for developing and changing CB (Dagnan & Cairns, 2005).

Several of these recent studies have utilised attribution theory to understand carer’s propensity to offer help in relation to challenging behaviour (Bailey \textit{et al.}, 2006; Dagnan \textit{et al.}, 1998; Dagnan & Cairns, 2005; Hill & Dagnan, 2002; Jones & Hastings, 2003; McGuinness & Dagnan, 2001; Rose & Rose, 2005; Sharrock \textit{et al.}, 1990; Stanley & Standen, 2000; Wanless & Jahoda, 2002). A current review of the literature (Willner & Smith, 2008) on the application of attribution theory to staff helping behaviour towards people with LD who exhibit CB offers a comprehensive summary and critique of these studies. The authors found the results of these studies to be inconsistent. They state that current evidence at best provides only partial support for the theory as none of the studies provide unequivocal support for the model. Indeed, whilst some provide partial support (Sharrock \textit{et al.}, 1990; Dagnan \textit{et al.}, 1998; Dagnan & Cairns, 2005; Hill & Dagnan, 2002; Jones & Hastings, 2003; McGuinness & Dagnan, 2001; Rose & Rose, 2005; Sharrock \textit{et al.}, 1990; Stanley & Standen, 2000; Wanless & Jahoda, 2002). A current review of the literature (Willner & Smith, 2008) on the application of attribution theory to staff helping behaviour towards people with LD who exhibit CB offers a comprehensive summary and critique of these studies. The authors found the results of these studies to be inconsistent. They state that current evidence at best provides only partial support for the theory as none of the studies provide unequivocal support for the model. Indeed, whilst some provide partial support (Sharrock \textit{et al.}, 1990; Dagnan et al., 2006; Dagnan \textit{et al.}, 1998; Dagnan & Cairns, 2005; Hill & Dagnan, 2002; Jones & Hastings, 2003; McGuinness & Dagnan, 2001; Rose & Rose, 2005; Sharrock \textit{et al.}, 1990; Stanley & Standen, 2000; Wanless & Jahoda, 2002).
al., 1998; Stanley & Standon, 2000; McGuinness & Dagnan, 2001; Hill & Dagnan, 2002) they are inconsistent in the predictions they support, and other studies do not support any aspect of the model (Wanless & Jahoda, 2002; Jones & Hastings, 2003; Rose & Rose, 2005; Bailey et al., 2006). Willner and Smith (2008) state that the literature on attribution theory applied to CB appears to be different from its use in other contexts, such as education, where the predictions of the theory are supported. A main criticism of most of these studies is the use of vignettes as measuring attributions in relation to a written example may be arbitrary and meaningless, and it has been demonstrated that emotional responses to real incidents are more intense (Wanless & Jahoda, 2002). Another methodological problem highlighted is that the term ‘helping behaviour’ is not well defined so may be open to interpretation by the participants to some extent, which will affect the reliability of the results. Also, only one of the studies measured the relationship between expressed willingness to help and actual helping behaviour (Bailey et al., 2006), hence most of the measures of helping behaviour are only supposition. Indeed, most of the studies use single-item scales to measure cognitive and emotional factors and the authors question their reliability.

5.2.3 Studies examining other variables influencing staff response to challenging behaviour

Willner and Smith (2008) highlight other variables which have been found to influence staff attributions of CB, such as the topography of the behaviour (Hastings, 1995) and its perceived functions (Hastings et al., 2003; Noone et al., 2006), the severity of the client’s LD (Tynan & Allen, 2002), and the impact of emotional responses (Weigel et al., 2006), but do not review them. The current review also
found studies examining how staff attributions are influenced by the type of information participants are given on CB (McClausland et al., 2004; Noone et al., 2003), and the impact of staff burnout on attributions.

Examining how types of information influence attributions links to determining the way in which informal staff culture impacts on individual’s perceptions of CB, and the need for research in this area has been highlighted in previous reviews (Allen, 1999; Hastings & Remington, 1994b). However, there have been few studies which have done so and most of them have been descriptive (Noone et al., 2003). This review identified two studies in this vein, one which measured the effects of manipulating attributional information of CB using an experimental analogue (Noone et al., 2003). This study found that manipulating attributional information did affect subsequent perceptions of cause and level of optimism. The other study (McClausland et al., 2004) evaluated the impact of the type of information about CB on ratings of acceptability, but not on attributions, for two different treatment plans. It found the type of information the participants were given about an incident of CB (functional vs. non-functional) influenced how acceptable participants rated treatment plans to be.

These studies highlight the potential significance of language use in LD services, particularly when conveying causal information. Language used may affect perceptions of incidents, and also highlights other biases that can occur such as in assessment of behaviour, as care staff are frequently used as sources of information for functional assessment of CB. However, these studies are in a minority and limited by methodological difficulties, in particular external validity. Both studies used ‘naïve’ participants who had had no experience of working with LD, and suggest this equates to naïve care workers. However, such generalisations cannot easily be made,
particularly as they are done out of the context of a working environment. The studies suggest research with a non-naive population may help to address this issue.

The role of factors such as staff stress and burnout may be important. Research suggests that staff who work with LD and CB can experience poor morale, high stress and burnout which can impact on the users of the service (Murray et al., 1999). Studies in this field have examined the impact of stress on attributions (Rose & Rose, 2005), whether attributional and coping style can predict helping behaviour in staff (Hill & Dagnan, 2002), and the role of emotional reactions in staff burnout (Rose et al., 2004). Rose & Rose’s (2005) study tested the applicability of Weiner’s (1986) model of helping for the impact of perceived stress on the quality of care provided by staff. The results were generally not consistent with the predictions of Weiner’s (1986) model. In particular, the correlation between staff beliefs about CB and their emotional reactions was not significant. Also, stress was not shown to have a primary role in determining outcomes for clients as, although staff reported high stress levels and moderate burnout, this did not relate reported thoughts and feelings regarding CB. Although the study demonstrated limited support for the predicted relationships between variables in Weiner’s (1986) model, the authors noted this may derive from measurement issues.

5.2.4 Summary
Factors influencing staff attributions of CB are clearly an important area to research given their potential clinical implications. However, the current review has indicated various methodological difficulties that limit the reliability and validity of the
findings. In addition, the research on staff perceptions is largely correlational in design and so conclusions on cause and effect are limited.

The majority of research utilises vignettes to represent CB and assesses constructs with questionnaires. The validity of vignettes is frequently questioned as emotional reactions to real incidents of CB have been shown to be stronger, and vignettes ‘represent an abstract event that may not have a great deal of personal significance to staff’ (Wanless & Jahoda, 2002, p. 508). Rose and Rose (2005) note scaled measures offer limited support for the predicted relationships between variables of the attribution model. They suggest the use of experimental observations of actual incidents of CB as a solution to the limitations of vignettes and scales measures. The review identified two studies utilising the Leeds Attributional Coding System (LACS) to extract spontaneous staff attributions of CB (Noone et al., 2006; Snow et al., 2007). Snow et al., (2007) claimed this has high face validity and may have higher content validity than questionnaires, and its use may lead to more robust findings. Further research on these tools may be beneficial.

The utility of the attributional model in understanding staff responses to CB is questionable. Willner and Smith (2008) suggested alternative theoretical approaches that may be more appropriate for understanding staff responses to frequently occurring challenging behaviour. These include the theory of planned behaviour (Ajzen, 1991) and a model proposed by Hastings (2002) that focuses on the cumulative impact of CB. Also, Campbell (2007) recently discussed the potential value of applying a cognitive representation framework, a model frequently used in health to investigate the mechanisms underlying illness representation and
perceptions, in order to explain how staff may view challenging behaviour in a similar way. Such alternatives would require further investigation to clarify their utility.

5.3 **Studies examining the impact of training on staff attributions of challenging behaviour**

The need to examine staff knowledge and training for those working with LD and CB has been noted by many studies. Ager and O’May (2001) state a barrier to quality services is the level of knowledge and skills of frontline staff, upon whom successful implementation of interventions largely depend. Indeed previous studies had found that staff can behave in counter-habilitative ways towards clients (Hastings & Remington, 1994b) or may be unwilling or unable to implement interventions (Hastings & Remington, 1993). They argued that staff training which targets a reappraisal of assumptions may have a subsequent beneficial effect on their behaviour with respect to service users and implementing interventions and support. The fact that CB is aversive to staff and may motivate them to avoid it also highlights the need to reduce negative emotional responses and increase knowledge (McGill *et al.*, 2007). These factors have highlighted the need to modify staff beliefs about CB through training to encourage more appropriate responses to CB. Therefore, a considerable amount of research evaluates the effectiveness of such training programmes.

5.3.1 **Previous literature reviews**

Hastings and Remington (1994a) reviewed the literature to consider empirical evidence for the notion that staff behaviour has an influence on CB. The impact of staff attributions was not reviewed as studies mainly adopted a behavioural perspective at the time. However, the authors did stress the need for a more
comprehensive analysis of factors contributing to staff behaviour, particularly for other theoretical perspectives, as this work would have profound implications for the content and process of staff training and management.

Allen (1999) reviewed research on setting conditions impacting upon carer’s abilities to implement behavioural interventions, part of which covered interventions for formal and paid carers. The review did not describe or critique the research on staff training in detail. However, it did raise clinical implications of current research and the need for further research to verify these. In particular, the need to recognise how negative emotional responses to CB may impact on carers’ attributions was highlighted, and Allen suggested this should be dealt with more directly through, for example, stress reduction techniques. Allen also stressed the importance of the context of staff training, highlighting that supportive management (McGill & Bliss, 1993; Mansell et al., 1994) and workplace cultures (Hastings & Remington, 1994; Hastings, 1995) have an impact on the training provided and how it is retained and utilised. Therefore, more wide scale ecological interventions are required (Mansell et al., 1994; Hastings et al., 1995; Harris et al., 1996). Whilst this review raises important considerations and recommendations, it is limited in its critique of the reliability of the research and methods it used.

Gentry et al. (2001) reviewed several studies examining the effect of staff training their attributions of CB. They noted that whilst participants in Berryman et al.’s (1994) commonly cited study showed increased sophistication in how they understood possible causes of CB and generated behaviour management based on skill development and environmental change, the study was limited because it did not
examine changes in staff behaviour. Other studies were criticised for utilising a small sample size (Schepis & Reid, 1994), recruiting participants from various parts of a large service rather than adopting a team based approach (Parsons et al., 1993; Schepis & Reid, 1994), or because the training was not interactive (Allen et al., 1997; Schepis & Reid, 1994), and because the training had limited impact on participants competence and practice (Stalker & Campbell, 1998). An editorial by Grey (2007) which considered some of the ‘representative’ studies in this field (e.g. Berryman et al., 1994; Grey et al., 2002) also noted that no measures of observed staff or client behaviour was a major problem in many studies, as it is not possible to ascertain whether there had been changes as a result of training mediated through attribution change.

5.3.2 Recent studies examining the impact of training on staff attributions of CB

The present review found a recent focus on examining the effectiveness of staff training on changing causal attributions of CB in the literature, which may have been encouraged by recent special editions in relevant journals (the Journal of Applied Research in Intellectual Disabilities) and the documented need for further research in this field. Whilst some studies measured the effect training has on staffs’ causal attributions of CB alone (Dowey et al., 2007; Grey et al., 2002), others show a shift towards more comprehensive exploration. For example, by measuring the impact of training on additional factors such as knowledge (Gentry et al., 2001; McKenzie et al., 2002; Lowe et al., 2007), skills (Gentry et al., 2001), emotional response (Lowe et al., 2007; McGill et al., 2007; Tierney et al., 2007), confidence (Lowe et al., 2007), and self-efficacy (Tierney et al., 2007). One study identified highlighted that CB can serve a communicative purpose, so analysed changes in communicative interactions
as well as attributions and behaviour (Smidt et al., 2007). However, the success of such programmes is disappointing as, overall, the impact of training on staff’s attributions of challenging behaviour was shown to be mixed. Some studies found no significant differences in staff’s causal attributions following training (Grey et al., 2002; McKenzie et al., 2002; Tierney et al., 2007), some reported small changes (Smidt et al., 2007), or changes that were short lived (Lowe et al., 2007), and others had mixed findings (McGill et al., 2007). One study (Gentry et al., 2001) found significant increases, but looked at attitude change rather than attributions. Issues with the reliability and validity of methods used also make the results questionable.

There are numerous problems which made measuring the true effectiveness of such programmes problematic. A major issue is that many studies did not include a follow up (Dowey et al., 2007; Grey et al., 2002; McGill et al., 2002), hence it is not possible to determine whether any changes in attributions are maintained. Those that did conduct follow ups were variable in the time scope adopted, for example, from 8 – 12 weeks (McKenzie et al., 2002; Tierney et al., 2007) to 12 months (Smidt et al., 2007), and generally changes in attributions were not maintained. Also, most studies identified did not utilise control groups, although the implications of withholding resources to improve patient care are given as significant grounds for this. Even so, the current review identified one control group study (Grey & McClean, 2007) conducted two years after the original study examining the efficacy of Person focused training (McClean et al., 2005) using existing longitudinal data. Groups were matched and results showed that 6 months after the training programme the target client group had significant reductions in the frequency, management difficulty and severity of challenging behaviour, when compared with the control group. Whilst this is valuable
in potentially demonstrating the efficacy of staff training, the study only measured client behaviour and did not re-assess staff. Therefore, changes in client behaviour cannot be accredited to staff attributions of CB that have changed as a result of training.

Verifying the effectiveness of staff training programmes requires observing changes in staff practices that result from training (Grey, 2007). However, a major criticism of studies in this area has been that only a small number have noted whether the training has had an effect on staff behaviour (McKenzie et al., 2002; Smidt et al., 2007) or client behaviour (McClellan et al., 2005; Smidt et al., 2007). Most of the studies used vignettes and single scale measures to assess attributions and related factors. The problems noted with these methods in previous sections are applicable here. In addition, such measures can only give an impression of whether a programme as a whole has had an impact. They cannot isolate which components were potentially more beneficial than others, and so could be targeted in further developing training. Therefore, questions as to what aspects of causal attributions staff training programmes are addressing cannot be answered.

Many of the studies used the Challenging Behaviour Attributions Scale (Hastings, 1997) to assess staff attributions. The reliability and validity of this scale is questionable. For example, some subscales of the measure were reported to have low internal consistency (Tierney et al., 2007), poor reliability (McGill et al., 2007), and lack content validity (Grey et al., 2002). It has also been suggested that some of the subscales imply intentionality of behaviour (Grey et al., 2002, McGill et al., 2007),
and fail to allow for reactive strategies that may be appropriately used to reduce harm in the context of behavioural support programme (Grey et al., 2002).

An overarching problem with the studies identified is comparisons between them is not possible due to large differences in sample sizes used and the types of training delivered. For example, length of training varies from one day sessions (Dowey et al., 2007; McKenzie et al., 2002) to a Diploma which is a series of 2-4 days over 2 years (McGill et al., 2007). The intensity of training conducted was also variable, from basic training in understanding challenging behaviour and behavioural support or strategies (McKenzie et al., 2002; Tierney et al., 2007) to an intensive programme advanced qualification in positive behavioural support (Lowe et al., 2007) and Diploma certificate (McGill et al., 2007).

5.3.3 Summary

Grey (2007) states that although there seems to be sound theoretical reasons for working with staff knowledge and beliefs, there is little empirical support for a relationship between staff attributions of, and their responses to, CB. The current view appears to support this, although there may be questions regarding the extent to which the methods the studies employ hinder or facilitate the discovery of such a relationship. The difficulty of tapping into attributions in a consistent and valid way has been highlighted in the literature (Munton et al., 1999), and it has been suggested that more psychometrically robust measures may be more effective in detecting changes in attributions (Tierney et al., 2007). However, the methodological problems already noted mean it is difficult to determine whether the problem is that current measures are inadequate in accessing attributions, or whether the training programmes are not effectively modifying attributions.
6. DISCUSSION

Research in the field of staff attributions of CB in clients with LD is clearly relevant and has significant clinical implications, yet the results of current studies are inconclusive and cannot be generalised. The tendency in the reviewed literature to focus on quantitative methods and rely on one model to understand staff causal beliefs has hindered more thorough exploration. Therefore, at present it is not possible to answer the questions raised at the beginning of this review. There seems to be a consensus that factors such as emotional reaction and knowledge, as well as beliefs, will influence how staff understand and respond to CB. However, the process by which this occurs is not clear and requires further investigation. It could be argued that the evidence presented does not suggest staff training can modify attributions, but again this is not conclusive as the measures used this far may not be as valid or reliable as one may hope. It may also be argued that staff training which is done in situ and is supported afterwards would yield more relevant results.

A key observation of this review is that the two strands of research discussed are seemingly independent, and this may be a hindrance to developing a more comprehensive understanding of staff beliefs about CB. Research focussing on identifying factors contributing to staff beliefs of CB appears separate from the research examining the effectiveness of staff training on modifying attributions. Questions about the utility of the attribution model highlights that focussing on modifying and assessing staff attributions may not be the most effective way of training staff to improve their interactions with clients. Yet there still seems to be a reliance on this assumption. There is a move towards exploring the impact of other
significant factors such as emotional response and knowledge, but further research is needed to substantiate their utility.

7. CLINICAL IMPLICATIONS

Given the uncertainty regarding the utility of the attribution model, and the difficulties highlighted in modifying and measuring attributions, it may be beneficial for staff training programmes to target other relevant factors which are observable and measurable, or can be of more practical benefit. For example, Hastings & Remington (1994a) suggested that as CB has been shown to be aversive to staff (e.g. Hall & Oliver, 1992) it may be valuable to teach staff coping skills, self-instruction, problem solving, and relaxation. They also suggested that the notion that CB is aversive should help program designers develop interventions that are more likely to be followed. For example, it has been noted that interventions which lead to quick reductions in CB are more likely to be followed (e.g. McConnachie & Carr, 1993). More recently, studies have also emphasised the need to target factors other than attributions, for example McKenzie et al. (2002) suggested training targeting staff knowledge may be more beneficial, and the need to provide in situ training has also been highlighted (Lowe et al., 2007). Another important issue is the need to consider staff causal beliefs within their context. Allen (1999) emphasised the need to examine the impact of staff cultures on causal attributions. Gentry et al. (2001) noted there can be organisational barriers in staff implementing new knowledge, and suggest staff need a motivational system in order to implement them. Such factors require adequate consideration when
assessing and modifying staff beliefs to ensure conclusions and interventions are comprehensive and long term.

Another suggestion is that staff training may need to be individualised to be effective (Grey, 2007), as different people will have different experience and perceptions of CB, and may require different strategies to deal with it.

8. RECOMMENDATIONS FOR FUTURE RESEARCH

Clearly there is a need to consider using alternative models when researching staff causal attributions, as current evidence does not entirely support Weiner’s (1986) attributional model. Using other models would allow for comparisons of utility and appropriateness, and may highlight alternative intervention needs. In relation to this, the use of alternative means of assessment, such as the LACS system, may provide further insight into the utility of the attributional model.

McGill et al. (2007) state that existing measures need to be updated to reflect both scientific and philosophical developments in positive behaviour support. This certainly seems to be supported by discussed inadequacies of commonly used measures in this review. It is also suggested that the social and predictive validity of the measures should be examined through investigations in the natural environment rather than contrived settings. Grey (2007) also notes the need to measure more observable outcomes, and indeed this review highlights that measuring changes in staff and client behaviour, rather than just staff attributions, is important in assessing
the effectiveness of training programmes and determining the utility of models used to understand CB.

The use of vignettes as a means to access staff beliefs has questionable validity. Therefore, the value of using real life examples to research staff beliefs of CB requires more attention.

Grey (2007) suggested a functional analysis of staff behaviour would be beneficial for two reasons: for determining variables and processes influencing staff behaviour; and so that training programmes can be based on functional hypotheses and follow evidence based practice.

Conclusion

Whilst research in the field of staff attributions of CB exhibited by adults with LD has highlighted the influence of certain factors on staffs causal beliefs and the potential utility of training programs in modifying these beliefs, difficulties with the methods used limit the conclusions that can be drawn from the data. Much of the research in this field has been conducted within behavioural and cognitive models, and although analysis has recently incorporated emotional factors through adopting Weiner’s (1986) attributional model, the utility of this model has been questioned. This indicates a need to explore the benefits of adopting alternative models, as well as using different methods of enquiry to explore relevant influential factors in more detail. It should be noted that studies have also tended to focuses on assessing and training staff as individuals, despite previous reviews (Allen, 1999) highlighting the need to examine and consider staff practices in context.
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1. **ABSTRACT**

**Objectives:** The main aim of the current study was to explore factors influencing staff beliefs about the challenging behaviour (CB) exhibited by adults with a learning disability (LD), and the role of contextual factors in this process. A subsidiary aim was to compare the themes elicited by the analysis of the data with the constructs used in a questionnaire used to assess staff causal attributions of CB.

**Design:** A qualitative study using Template Analysis. A Latin Square design was also utilised to see whether administering a questionnaire prior to the interview could be seen to have an effect on the themes elicited during the interview.

**Method:** Fourteen members of staff from the Learning Disabilities Directorate of the host trust participated in the study. The sample was split into two groups. The first group conducted the Challenging Behaviour Attributions Scale (CHABA) (Hastings, 1997) before doing the semi-structured interview. The second group conducted the semi-structured interview before doing the CHABA. Transcripts were analysed according to the thematic analysis techniques drawn from Template analysis (TA).

**Results:** The analysis yielded five main themes of knowledge of CB, emotional response, confidence, coping, and optimism, which have previously been cited in the literature. The impact of systemic factors was also highlighted. Whilst the causal factors assessed in the CHABA were found in the transcripts, they were not as prominent as the themes already mentioned.

**Conclusions:** The analysis suggests that various factors contribute towards staff beliefs of the CB exhibited by adults with a LD. But whilst some factors related to the client or the member of staff as an individual, many of them are influenced significantly by their context; the work culture and the service. Clinical implications of the results are discussed.
2. INTRODUCTION

Staff have a significant role in managing challenging behaviour (CB) exhibited by adults with a learning disability (LD) (Bromley & Emerson, 1995). It has been hypothesised that staff beliefs about the causes of CB may interact with other variables and influence how they respond to clients (Hastings & Remington, 1994a; 1995), and can impact on the levels of care offered (Dunne, 1994). Therefore, staff beliefs have been highlighted as an appropriate focus for intervention that could have an indirect impact on the CB itself (Hastings, 1997). In this vein, studies have examined what factors influence staff beliefs of CB, how these beliefs impact upon staffs responses to CB, and the ways in which staff beliefs of CB can be modified (see Allen 1999; Hastings & Remington, 1994a, 1994b; Rose, 1995; and Willner & Smith, 2008 for reviews).

In determining what factors influence and interact with staff beliefs of CB, studies have examined numerous variables that can be seen to relate to both staff and clients. Factors related to staff that have been considered relevant include their emotional responses to CB (Bailey et al., 2006; Dagnan & Cairns, 2005; Hastings & Brown, 2002; Hastings & Remington; 1995; Hill & Dagnan, 2002; Jones & Hastings, 2003; Rose & Rose, 2005; Wanless & Jahoda, 2002; Weigel et al., 2006), their perceived functions of the CB (Hastings et al., 2003; Noone et al., 2006), the level of experience they have (Hastings et al., 1995), their level of optimism (Bailey et al., 2006; Noone et al., 2003; Rose & Rose, 2005; Wanless & Jahoda, 2002), aspects of their personality (Rose & Rose, 2003), and the impact of stress and ways in which staff cope (Hill & Dagnan, 2002; Rose & Rose, 2005). Factors relating to the client that
have been shown to influence staff beliefs include the topography of the CB (Hastings, 1995) and the severity of the client’s LD (Tynan & Allen, 2002).

In relation to determining the significance of staffs’ experience and knowledge, many studies have examined the impact of training on staffs causal beliefs of CB (e.g. Berryman et al., 1994; Dowey et al., 2007; Gentry et al., 2001; Grey et al., 2002; Lowe et al., 2007; McClean et al., 2005; McGill et al., 2007; McKenzie et al., 2002; Smidt et al., 2007; Tierney et al., 2007).

As the above list of variables demonstrates, research in this field has moved from adopting a mainly behavioural model to currently focussing on cognitive and emotional factors. To facilitate this, many studies have used attribution theory to help understand staffs’ causal beliefs and their propensity to offer help in relation to CB. Weiner’s (1986) model predicts that staffs’ attributions of CB can be reliably associated with their emotional responses, which will in turn either increase or decrease willingness to help the client. In particular, if staff feel the client is in control of their behaviour, they are more likely to feel angry and less likely to help. If staff perceive that control is external then they are more likely to feel sympathy and assist the client.

Willner and Smith (2008) reviewed several recent studies that use Weiner’s model (Bailey et al., 2006; Dagnan et al., 1998; Dagnan & Cairns, 2005; Hill & Dagnan; 2002; Jones & Hastings, 2003; McGuinness & Dagnan, 2001; Rose & Rose, 2005; Sharrock et al., 1990; Stanley & Standen, 2000; Wanless & Jahoda, 2002). They found that none of the studies provided unequivocal support for the model and
concluded that the utility of the attributional model in understanding staff responses to CB is questionable. In particular, Willner and Smith (2008) suggested that Weiner’s model may not be appropriate for understanding staff responses to CB, as it was designed for understanding less severe and infrequent behaviour. Therefore, alternative theoretical approaches may be more suitable. For example, the theory of planned behaviour (Ajzen, 1991).

Adopting a mainly cognitive-emotive approach has meant that research has focussed on examining staff in isolation from their context, and hence may not represent a comprehensive understanding of what factors influence their beliefs of CB. In his review Allen (1999) emphasised that workplace cultures exert a powerful influence on staff behaviour, and noted the value of wide scale ecological interventions (Mansell et al., 1994; Hastings et al., 1995; Harris et al., 1996) which focus on a wider array of organisational variables rather than just staff. He recommended that for interventions to be more effective they need to take a more systemic perspective on functional analysis, and stated the capacity of care systems should be assessed as well as staff practice. In relation, some studies have stressed the importance of conducting staff training in situ. They also highlight that supportive management (McGill & Bliss, 1993; Mansell et al., 1994) and workplace cultures (Hastings & Remington, 1994; Hastings, 1995) have an impact on the training provided and how it is retained and utilised.

However, despite such recommendations most recent studies do not assess staff beliefs or conduct training in context. Only two studies attempt to examine the impact of staff culture through looking at how language can influence staff beliefs about CB
(McCausland et al., 2004; Noone et al., 2003). The focus on examining staff individually and the reliance on a cognitive-emotional model has meant that the influence of contextual factors on staff beliefs about CB have not been explored thoroughly in this field. In analysing the influence of work context and culture on care staff research in other fields has adopted psychodynamic and systemic models (e.g., Goodwin & Gore, 2000; Hinshelwood, 2000; Menzies, 1960, 1985; Obholzer & Roberts, 1994). Such studies have been conducted within the fields of general nursing, enduring mental illness, and the impact of institutions on children. Research examining staff who work with adults with LD exhibiting CB has not utilised these models.

As well as difficulties with examining staff beliefs about CB through adopting the attribution model, methodological constraints also limit the reliability and validity of the noted studies. The majority of studies use standardised questionnaires to elicit and assess staff beliefs about CB. For example, the Attributional Style Questionnaire (ASQ) (Peterson et al., 1982), the Challenging Behaviour Attributions Scale (CHABA) (Hastings, 1997) and the Self Injury Questionnaire (SIBUQ) (Oliver et al., 1996) are commonly used measures. Whilst using such measures quantifies responses and allows for statistical testing, they may not be entirely reliable or valid.

Interpretations of questions may differ as they essentially measure an abstract concept, and the use of multiple choice answers limits participants’ choice and could possibly shape their responses. With specific reference to the utility of assessments used to assess staff attributions of CB, Rose & Rose (2005) stated that scaled measures offer limited support for the predicted relationships between variables of the attribution model. Indeed, the utility of the CHABA has been questioned by numerous
studies. Hastings (1997) reported moderate reliability for the tool and stated validity could be assessed through using the CHABA to monitor attributions of staff through training. However, studies using the CHABA for this purpose have found the reliability and validity of the tool to be questionable. For example, some subscales of the measure were reported to have low internal consistency (Tierney et al., 2007), poor reliability (McGill et al., 2007), and lack content validity (Grey et al., 2002). It has also been suggested that some of the subscales imply intentionality of behaviour (Grey et al., 2002, McGill et al., 2007).

Exploring what factors influence staff attributions of CB is clearly an important area of research given the potential clinical utility in understanding how staff comprehend CB, and how training may improve practice. However, difficulties with the methodology and models adopted in this field to date limit the conclusions that can be drawn. Reliance on the attribution model may be unsubstantiated (Grey, 2007) and studies often fail to account for contextual factors. Also, the utility of quantitative methods in eliciting and assessing attributions is questionable, yet a limited number of studies in this field use qualitative methodology to explore factors influencing staff beliefs about CB (Noone et al., 2006; Snow et al., 2007; Whittington & Burns, 2005).

The main aim of the present study is to explore factors influencing staff beliefs about the CB exhibited by adults with LD by adopting a qualitative approach in order to provide a more detailed analysis of influential factors. It is felt that an exploratory approach will allow the influence of work context and culture to be examined to determine the role of contextual factors in this process. As the applicability of attribution theory in this field has been questioned, the current study will not attempt
to elicit or assess ‘causal attributions’, but will instead explore factors influencing staff beliefs about CB.

As difficulties have been noted with single-scale measures, a subsidiary aim of this study is to compare the themes elicited with qualitative analysis with the constructs used in a standardised questionnaire designed to elicit and assess causal attributions. This will be done firstly to highlight whether such assessments can be seen to influence participants responses in an interview, and secondly to determine how the themes elicited using a semi-structured interview compare with the constructs used in a standardised questionnaire. To facilitate comparisons, Template Analysis (TA) (King, 1998) will be used to analyse the data as it is a flexible method which allows the use of a priori codes, which will facilitate comparison. The template can be organised in a way which represents the relationship between themes. The results could reinforce previous research if similar themes are detected in the analysis, and may also highlight areas requiring further research if original themes are found. It is also hoped that the research will highlight relevant clinical implications for the service within which it is being conducted.

3. METHOD OF ENQUIRY

3.1 Design

A qualitative approach was adopted to facilitate the exploratory aims of the study. Semi-structured interviews were used to collect data, and each interview was recorded using a voice recorder. As a starting point, participants’ beliefs about the vignette (see Appendix 1) were explored. The interview then aimed to elicit factors that influence
participants’ beliefs about CB in general, such as level of experience and means of coping. The CHABA (Hastings, 1997) (see Appendix 2) was also administered in order to compare the themes elicited from interviews with the constructs of a standardised measure.

A ‘Latin square’ or ‘reverse’ design (Myers, 1972) was adopted, so half of the participants were administered the CHABA before commencing the interview, and the other half completed it after doing the interview. This was done in order to determine whether a standardised measure could be seen to impact on the way participants responded in the interview.

3.2 Participants

3.2.1 Selecting participants

The Locality manager for the Learning Disabilities Directorate of the host Trust distributed an email to members of staff working within all relevant services to volunteer for the research project. The email included the information sheet (see Appendix 3) and consent form (see Appendix 4). Staff who were interested in taking part, or required more information, were requested to contact the researcher. To attempt to gain a sample representative of all professions that potentially work with clients, both directly and indirectly, this email was sent to staff in the following professions and no level of qualification was requested: Nursing (including nursing assistants, staff nurses in residential settings, and community nurses), Speech and Language Therapy, Psychiatry, Clinical Psychology, and Occupational Therapy.
3.2.2 Sample

A researcher with experience of using Template Analysis was consulted to determine the appropriate sample number for the study. They stated between fourteen and twenty interviews would provide a sufficient amount of data to analyse, provided they were more than forty-five minutes long. As the current study utilised a Latin Square design even numbers were required. Volunteers were accepted until fourteen interviews had been conducted. At this point it was felt sufficient data had been collected as participants were frequently discussing similar topics in interviews. Full details of the participants in the sample are included in Appendix 5. Participants were allocated to group one or group two when they volunteered. This was dependant on participants already in the groups as attempts were made to match the groups in terms of profession, but this was only achievable to a point as some professional groups had only one representative. The sample is not entirely representative of the wider staff group from which it was recruited for a number of reasons. Firstly, Psychiatry and Occupational Therapy are not represented. Secondly, only one participant worked directly with clients, the majority of participants worked in a role which implicates indirect client contact. Also, the majority of the participants in the sample had done further training, which comparatively is not as frequent in the wider service.

3.3 Research instruments

A vignette (see Appendix 1) was used as a starting point for the interviews. The vignette used was adapted from the CHABA vignette to fit the client group the participants worked with more appropriately.
As the study was exploratory, the interview used a flexible topic guide (see Appendix 6) rather than prescribed questions. This was to encourage participants to share in the direction of the interview (Smith, 1995) so the researcher could gather richer data through following their trains of associations and perspectives (Burman, 1994). Current research regarding staff beliefs about CB informed the topic guide, as is recommended when using Template Analysis (King, 2008). Therefore, it included probes regarding emotional response, optimism, and knowledge and experience. Three practice interviews were conducted to pilot the topic guide and help the researcher become comfortable with the flexible interview approach.

The measure used in this study was the CHABA (Appendix 2) as it has frequently been used in research in this field (e.g. Bailey et al., 2006; Grey et al., 2002; Lowe et al., 2007; McGill et al., 2007; Smidt et al., 2007; Tierney et al., 2007). The CHABA is a standardised measure that was specifically developed to assess staff attributions as to why clients may exhibit CB. It is a self-report instrument with thirty-three statements relating to six causal models of CB dominant in the behavioural research literature: learned behaviour (positive and negative), emotional, physical environment, and self-stimulation. Respondents rate the applicability of each statement on a five point rating scale ranging from ‘very unlikely’ to ‘very likely’.

3.4 Procedure

Interviews were conducted in a meeting room on the service site that was private and easily accessible for participants. Before commencing each interview the researcher reiterated its purpose, the limits of confidentiality, and the participants’ right to withdraw from the study at any point. Participants were asked to sign the consent
form (see Appendix 4) to confirm they consented to participating in the study and being audiotaped in the interview. Participants were also asked to fill in a brief form to give relevant details of their working history and the training courses they have attended (see Appendix 7). This was done as research has cited levels of work experience and knowledge as influential on causal beliefs of CB.

Participants in group one were asked to complete the CHABA at the start of the interview. They were given the vignette on a separate sheet and informed it was the same as the vignette in the questionnaire. The example was as a starting point for the interview and participants were encouraged not to feel limited to discussing the vignette.

Participants in group two were given the vignette at the start of the interview. They were also told the vignette was just a starting point, and were encouraged to discuss things they felt were relevant to their experiences and opinions about CB. They were asked to complete the CHABA after finishing the interview.

The interviews lasted between forty-five and ninety minutes, with the average length being sixty minutes. Participants were informed the researcher would conduct follow up interviews to feedback the information and allow them to comment or expand on their discussion and the researcher’s analysis where necessary. Three participants were available to be re-interviewed, and these discussions lasted approximately 30 minutes.
3.4.1 Ethical Considerations

Informed consent

Participants were given an information sheet that detailed the purpose of the study (See Appendix 3). At the time of the interviews, participants were asked if they were clear about the purpose of the study. The researcher reiterated they were interested in discussing participants’ experiences and opinions of CB, and wanted to examine the utility of a questionnaire.

Confidentiality

Participants were informed that no information attained within the interviews would be passed on to other professionals unless it indicated harm towards others. They were also told that the study would only use non-identifiable information. They were aware interviews would be audio recorded, and the consent form detailed how the recordings would be stored and protected.

Participant Distress

As discussing CB can potentially be distressing, measures were in place to deal with any issues arising from the interviews. The researcher allowed for extra time at the end of interviews to hopefully resolve any distress, and the Locality manager agreed to be put forward for professional supervision if required. The Trusts counselling and psychological support services consented to be recommended if required, and provided a leaflet to hand out to participants (See Appendix 8).
4. ANALYSIS OF THE DATA

4.1 Analytic procedure

4.1.1 Method of analysis

Template analysis (TA) is an approach that was originally described by Crabtree and Miller (1999) and has been developed specifically by King (1998). TA can be used from a range of epistemological positions. It is a set of techniques rather than a distinct methodology which aims to organise qualitative data into meaningful and constructive themes using a coding template. The template is organised in a way which represents the relationship between themes. The template usually involves a hierarchical structure, where broad codes encompass more narrowly focussed codes. There can be as many levels of coding as the researcher finds useful, though most templates have within the three to five levels. Codes are not just specified for themes found in most or all transcripts, but also for those found only in a minority of the transcripts, as coding is about significance not quantity. The technique is flexible, and allows the researcher to tailor the analysis to match their own requirements. For example, parallel coding is permitted; meaning the same section of text can be coded under multiple themes.

Unlike other forms of phenomenological analysis such as IPA or grounded theory, TA uses a priori codes. This allows the researcher to define a number of themes that reflect ideas that are significant to the aims of the research project before beginning the process of constructing a coding template. Even so, these themes are provisional and open to modification or even deletion as the coding template is developed from its initial form to the final version. Therefore, the coding template used may include both
codes that have been highlighted as relevant *a priori*, and codes that have been identified through careful reading of the transcripts

TA was selected for this study for numerous reasons. Firstly, the use of *a priori* codes would facilitate the aims of the study in that it allow for comparison of the themes elicited in the current data with both the constructs used in the CHABA, and the factors identified in the literature as influencing staff beliefs. Secondly, it was felt that TA complemented the social constructionist stance of the study. This is because TA is useful where the researcher seeks to discover how participants describe and make sense of particular elements of their lives, rather than to quantify the experience or uncover ‘real’ beliefs and attitudes (King, 2008). Although Grounded Theory (GT) can also work within this epistemological stance (e.g. Charmaz, 1995) it was felt the approach was not suitable as it aims to create a ‘model’ as a result of analysis, which seemed incompatible with the exploratory nature of the study. Using TA as opposed to a straightforward content analysis also facilitated a more in-depth analysis. Rather than simply examining the frequency of codes, TA encourages further development in analysis and exploration of additional codes. This was more constructive as it allowed for consideration of the process issues of the interviews and multiple interpretations of the final template.

4.1.2 *A priori* codes

King (1994) noted both the interview guide and initial template should use three sources for deciding what topics to be included in the interview: the research literature, the researcher’s own personal knowledge and experience in the area, and informal preliminary work such as structured discussions with people who have
researched in the area. Therefore, the current study included several themes that have often been identified in the literature as being significant in staffs’ explanations of CB which are listed in Table 1. Discussions with people in the service highlighted that it was in a stage of transition and uncertainty, therefore ‘the wider service’ was included provisionally. ‘Training’ was also important to consider as the service runs a training program for staff designed to encourage them to consider the functionality of CB, and the impact of training on causal beliefs of CB has also been a focus for research in the field. It was anticipated that the *a priori* codes may be higher level codes, and the codes emerging from the transcripts would be lower level codes within the *a priori* codes.

The five causal explanations for CB given in the CHABA (shown in Table 1) were used as a separate set of *a priori* codes in order to compare the two methods used for exploring staff beliefs of CB, and to determine whether a standardised assessment can be seen to impact on the way staff respond in interview. Therefore, as these codes are being used comparatively they will not be included in the final template, but will instead be discussed separately.
### Table 1  A priori codes

<table>
<thead>
<tr>
<th>A Priori Code</th>
<th>Source</th>
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<tbody>
<tr>
<td>Emotional reactions</td>
<td>Highlighted in the literature (e.g. Bailey et al., 2006; Dagnan &amp; Cairns, 2005; Hill &amp; Dagnan, 2002; Jones &amp; Hastings, 2003; Lowe et al., 2007; McGill et al., 2007; Rose &amp; Rose, 2005; Tierney et al., 2007; Wanless &amp; Jahoda, 2002)</td>
</tr>
<tr>
<td>Coping / Stress</td>
<td>Highlighted in the literature (e.g. Hill &amp; Dagnan, 2002; Rose &amp; Rose, 2005)</td>
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<tr>
<td>Experience / Knowledge</td>
<td>Highlighted in the literature (e.g. Gentry et al., 2001; McKenzie et al., 2002; Lowe et al., 2007)</td>
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<tr>
<td>Optimism</td>
<td>Highlighted in the literature (e.g. Bailey et al., 2006; Noone et al., 2003; Rose &amp; Rose, 2005; Wanless &amp; Jahoda, 2002)</td>
</tr>
<tr>
<td>Client factors</td>
<td>Highlighted in the literature (e.g. Tynan &amp; Allen, 2002)</td>
</tr>
<tr>
<td>Confidence</td>
<td>Highlighted in the literature (e.g. Lowe et al., 2007)</td>
</tr>
<tr>
<td>Work culture</td>
<td>Highlighted in Allen’s (1999) literature review; study aimed to explore the impact of the wider service.</td>
</tr>
<tr>
<td>Training</td>
<td>Many studies have examined the impact of training on staff beliefs; the service runs a training program on CB.</td>
</tr>
<tr>
<td>The wider service</td>
<td>Highlighted in Allen’s (1999) literature review; considered important due to difficulties in service; study aimed to explore the impact of the wider service.</td>
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<tr>
<td>Learned behaviour</td>
<td>Construct used in the CHABA.</td>
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<tr>
<td>Biomedical</td>
<td>Construct used in the CHABA.</td>
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<tr>
<td>Emotional</td>
<td>Construct used in the CHABA.</td>
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<tr>
<td>Physical environment</td>
<td>Construct used in the CHABA.</td>
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<td>Stimulation</td>
<td>Construct used in the CHABA.</td>
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#### 4.1.3 Creating the template

All transcripts were read before the initial stage of coding. This was reinforced through listening to the audio recordings of the interviews, as intonations of speech can highlight different meanings and emphasis that may be missed through reading alone.

The method followed for the current analysis was described by Miles and Huberman (1994) and developed by King (1998). In TA an initial template is constructed then
applied to the transcripts and revised in order to create a final template. The current study was exploratory so it was important to avoid presuppositions. Therefore, the initial template was not created until all of the fourteen transcripts had been coded independently to minimise potential for missing or mislabelling themes, or collapsing them too soon. After each transcript was read and listened to, it was re-read and notes were made in the margin next to data where it either appeared relevant to the research question, or seemed to relate to the *a priori* codes (see Appendix 9 for an example of coding). This was done until the researcher believed a comprehensive description of the data had been attained. Themes from all fourteen interviews were then collated and organised hierarchically into more general ‘higher’ level codes with corresponding ‘lower’ level codes within them. This meant the initial template (see Appendix 10) was highly inclusive and detailed.

To create the final template, the initial template was developed to provide the best possible representation of the themes identified in the data. To do this, the initial template was applied to the transcripts to re-code all relevant segments where necessary modify them as relevant to the research question. This mainly involved changing the scope and order classification of the themes. It was felt that the initial template, whilst highlighting the significance of many indirect factors, was too descriptive and did not reflect the processes of or relationships between themes. Therefore, similar themes were collapsed to make the template more manageable, and codes were reordered and renamed to represent the process and interactions between the themes which the researcher had understood from the interviews. This helped to make the analysis more interpretive than just thematic, and ensured the results were consistent with the aims of the study.
4.1.4 Quality assurance issues

The researcher attempted to remain reflexive by examining their research experience and interpretations of the data in an open and truthful way to clarify the extent to which their own beliefs and assumptions influenced the results. A research log (see Appendix 11 for examples) was kept to facilitate this by keeping track of developments of the research, coding template and interpretations of the results.

Regular supervision to discuss the coding, templates and interpretations also encouraged clarity and consistency, and well as reflexivity. The researcher also attended a qualitative support group to reinforce this and asked members to code sections of the data independently.

Conducting follow up interviews with participants enhanced respondent validity and further enriched the data. Participants agreed with the analysis and were able to comment on factors which had been influential since the interviews, such as service developments.

4.2 Analysis

4.2.1 Stage 1: Discovering factors influencing staff beliefs about challenging behaviour exhibited by adults with a learning disability

The main aim of the study was to discover what factors may contribute to staff beliefs of challenging behaviour exhibited by adults with a learning disability. This was addressed through attempting to identify relevant themes in the data. As explained,
TA was adopted and coding was done in three stages in order to create the final template. Parallel coding was particularly beneficial as some of the codes were relevant in multiple themes, and coding them in parallel helps to illustrate the interaction between the themes.

To enhance clarity, the five main themes of the final template (knowledge of CB, emotional response, coping, confidence and optimism) will be presented and discussed separately, and supported by selected quotations from the interview transcripts. Presenting analysis under thematic headings is recommended to help to address the research questions (Burman, 1994), and is often adopted when using TA (e.g. King et al., 2002). Supporting quotes are included in Appendix 12.

4.2.1.2 Theme One: Knowledge of CB

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<td>Training</td>
<td>Academic</td>
<td>Motivation</td>
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<td>Provided by Service</td>
<td>Support from Service</td>
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<td></td>
<td>Experience</td>
<td>Varied Job Roles</td>
<td>Experience of CB</td>
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<td></td>
<td>Experience of other diagnoses</td>
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<td>Working in community as well as</td>
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<td>residential settings</td>
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<td></td>
<td>Supervision</td>
<td>Reflection</td>
<td>Other perspectives about the causes of CB</td>
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<td>Better outcomes for client</td>
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<td></td>
<td></td>
<td>Knowing clients well personally</td>
<td>Depersonalise experiences</td>
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<td>Learning from incidents</td>
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Many of the participants had held various roles within the service and done additional training. They felt this was helpful in developing a comprehensive understanding of CB and related difficulties. Being open to new knowledge and practices was highlighted as important, and participants suggested not doing so may contribute
towards unhelpful beliefs about CB. In particular, it was often noted that having experience of working in community as well as residential services was beneficial, although some participants felt ill equipped and unsupported in this transition.

“Moving into community as well, because a lot of the issues that people have are with regard to their mental health, so I just sort of, I didn’t really feel geared up to supporting people properly. So I’ve actually, you know, and I think you do have to stay motivated because you’re not always pushed in the right direction to do the right training. I think you have to show that you want to do it and almost, you have to kind of realise your own training needs I think along the way. I think the service is quite poor at that really” (Transcript 13, line 324)

Knowing clients well was also significant, but not just in terms of having a ‘working’ knowledge. The way participants referred to the clients they worked with suggested a genuine sense of appreciation for the clients as individuals, and in some cases a significant attachment to them.

“Oh it’s the personalities, it’s amazing how anybody it, they’ve all got their own personalities, and working alongside them like, you know, for seven years you get to know them like they were your brother or your sister and your and whatever, you do. And because you were there you know five days a week day in and you know I mean?” (Transcript 10, line 343)

Many of the participants spoke of the need to be analytical and reflective of their practices, and using supervision to facilitate this. Reflection was spoken of as a ‘skill’
not all staff were capable of, either because they did not have the ability or were
restricted by service pressures.

“Not everybody can reflect. Some people will need guided reflection; some people
have got the insight to know they need to reflect. And some people just aren’t
interested”  (Transcript 2, line 640)

4.2.1.3  Theme Two:  Emotional Response

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<th>LEVEL 1</th>
<th>LEVEL 2</th>
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<th>LEVEL 4</th>
<th>LEVEL 5</th>
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<td>Contact</td>
<td>Risk</td>
<td>Predictability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multiple diagnoses and type of CB</td>
<td>Perceived intentionality of behaviour</td>
<td>Controllability</td>
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<td></td>
<td>LD</td>
<td></td>
<td>Staffs’ understanding of difficulties</td>
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<td>Support</td>
<td>Other staff</td>
<td>Debriefing</td>
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<td>Views of CB</td>
<td>Response to client</td>
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<td></td>
<td>Knowledge and experience of CB</td>
<td>Understanding CB</td>
<td>Depersonalise</td>
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<td></td>
<td></td>
<td>Ability to predict and manage CB</td>
<td>Knowledge about client</td>
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<td></td>
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<td></td>
<td>Previous experiences of CB</td>
<td>Emotional attachment</td>
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</table>

Various factors seemed to contribute towards participants’ emotional responses to
CB. Interestingly, participants tended not to speak about experiencing negative
emotions in relation to experiences of CB unless prompted. Examples of feeling
scared or overwhelmed were usually given in past tense when referring to initial experiences of CB. Even so, participants spoke of seeing clients being poorly cared for evoking sadness in the present tense, and many acknowledged that frequency of direct contact with clients has an impact on emotional response. Having had experience and developing appropriate understandings of CB, in particular depersonalising the behaviour, were seen as helpful in dealing with emotional responses.

“Yeah, I remember crying at home, you know, being terrified of going back to work. But if that happened now, if I went out and I had to work with somebody and that happened … I think I’d be able to leave it work a lot easier because I’m much, I’m quite capable of saying, you know, looking at the situation, and thinking it’s no me personally that that person was lashing out at.” (Transcript 6, line 386)

Participants spoke of being more emotionally affected by clients who exhibited self-injurious behaviour, had personality disorder, or were considered ‘risky’. These difficulties made participants feel more anxious and less in control as it meant clients were less ‘predictable’ and ‘manageable’. This seemed to be significant in both emotional reactions and coping.

“You know, risk is a trigger word for anxiety and probably too, it goes up. It puts people at priority on the waiting list, all those sorts of things really. But then people might be more scared of them” (Transcript 8, line 358)
Whether support was available, both from team members and the wider service, was an important indirect factor on how staff may react emotionally. The extent to which such support was available was cited as insufficient by some participants.

“For me the important thing about afterwards is just being able to talk through it, talk to colleagues, talk to other people about it and then, sort of, bounce ideas and feelings, you know you’ve got to be able to talk about something, you’ve got to get those feelings out, yeah. I mean there’s no point, if it becomes, say you work in a service where you experience those sort of things day after day and it’s just expected of you, it would become to mean less and you’d become desensitised to some degree to what was happening. You know, I think that’s sort of, you’d be in danger of sort of burning out very quickly. You’d certainly be in danger of ending, or doing things without really understanding what you’re doing, or responding in the way that you were.” (Transcript 1, line 436)

4.2.1.4 Theme Three: Coping

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<tbody>
<tr>
<td><strong>Knowledge of CB</strong></td>
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<tr>
<td>Job Role</td>
<td>Ability to effect change for client</td>
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<td></td>
<td>Knowing limitations</td>
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<td></td>
<td>Varied Caseload</td>
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<td></td>
<td>Experiencing Successes</td>
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<tr>
<td><strong>COPING</strong></td>
<td>Team</td>
<td>Supervision and debriefing</td>
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<td></td>
<td></td>
<td>MDT working</td>
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<td>Support</td>
<td>Service</td>
<td>Providing adequate training</td>
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<td></td>
<td></td>
<td>Attitudes, i.e. ‘blame culture’</td>
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<td></td>
<td></td>
<td>Valuing staff</td>
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<tr>
<td>Distance</td>
<td>Emotional</td>
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<td></td>
<td>Physical</td>
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<tr>
<td>Confidence</td>
<td>Ability to predict and manage CB</td>
<td>Control</td>
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Most participants cited the way they understand CB and being able to separate themselves from work as necessary in coping. Individually, factors such as being aware of the limitations of your role, being able to distance yourself from work, and varying the type of cases you take were put forward as strategies for coping with CB.

“It’s knowing when it’s appropriate to go back and work on something and try and change things and knowing when you’ve just got to step back almost for change to happen. It’s knowing where to draw a line really” (Transcript 7, line 670)

“Being able to detach from it, yeah, I’m quite detached, I think that’s quite a good descriptive word.” (Transcript 6, line 393)

Experiencing successes was seen as important in coping with CB, as was having good supervision. The input of other professionals in the MDT was spoken of as being helpful in enhancing understandings of CB. The role the ‘wider’ service has to play in supporting staff, and how this can affect confidence when it is not available, was highlighted. Some participants described a ‘blame culture’, and felt many staff did not feel safe or valued in their role, and this would impact on their work.

“The best, the most helpful thing is when things are really bad, is having a good supervisor. And I had a phase where I had nobody and I was really miserable, but I’ve had a good supervisor this last, say 7 years now, and that keeps you sane”. (Transcript 4, line 471)
“If there’s a serious adverse incident that gets investigated, if there’s an organisation, the person, the kind of, the aim is to focus on whose fault it is rather than as a learning opportunity. To recognise that somebody might be at fault and if they’re seriously at fault they would need to be dealt with.” (Transcript 8, line 315)

4.2.1.5 Theme Four: Confidence

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<tbody>
<tr>
<td></td>
<td>Knowledge and Experience</td>
<td>Learning from incidents</td>
<td>Control over outcomes</td>
</tr>
<tr>
<td>CONFIDENCE</td>
<td>Developing practices</td>
<td>Job role</td>
<td>Experiencing successes</td>
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<td></td>
<td>Training</td>
<td>Impact of the wider team</td>
<td>Coping</td>
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<td></td>
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<td></td>
<td>Expectations from other staff to ‘fix’ problem of CB</td>
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<td></td>
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<td></td>
<td>Support from managers of homes / wards</td>
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</table>

Knowledge and experience were important contributors for confidence, and experiencing successes seemed to reinforce feeling capable. The need to develop practices and be open to new ideas was discussed in terms of avoiding becoming ‘stuck’ in inappropriate working patterns or developing unhelpful beliefs. Further professional training was cited as beneficial for this. The need for such courses to be practical and useful was also emphasised. A key factor in confidence was the level of control participants had over interventions and outcomes. Some of this was related to role limitations, but was also about coordination with other services in MDT and support from the service.

“But, you know, residually, even if you’re not there you can hand it over then to somebody else that will then carry that work on, whereas in the community you just
sort of have to go in, do your bit and then just walk away and hope for the best really” (Transcript 13, line 128)

“What happens is you end up going in and doing your bit and waiting for the other person to come along and do their bit. So by then things have changed”
(Transcript 1, line 394)

Expectations of wards / homes to ‘fix’ CB was a recurrent theme and was significant in that participants felt it evaded responsibility from carers for facilitating change, which in turn meant they felt less confident in their role. Little support from home managers and the way in which managers can influence other staff attitudes and ‘work culture’ was also significant.

“I think there’s some people who erm actually I would say look to all the other professionals and think that somehow you’re gonna come up with the answer that’s going to change it and stop the challenging behaviour. They’ll never hit out or kick anybody else and they’ll never do self-injurious behaviour and that you know, as a professional I would say well the change for that to happen is perhaps within you know you, and your staff team. Isn’t it about how you approach things, how you give messages, how you communicate” (Transcript 11, line 335)

“The manager isn’t going to support you or support the staff, and the staff may really want to change and do something good. But the manager’s not going to put themselves behind it or encourage consistency, you know it’s going to be ineffective don’t you. It’s very frustrating” (Transcript 2, line 198)
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<th>LEVEL 5</th>
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<tbody>
<tr>
<td><strong>Client</strong></td>
<td>Type and severity of CB</td>
<td>Other diagnoses / risks</td>
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<tr>
<td><strong>Staff’s control over interventions and outcomes</strong></td>
<td>MDT</td>
<td>Coordinating services</td>
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<td>Reliant on other staff to carry out interventions</td>
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<td>Attitudes</td>
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<td>Behaviour</td>
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<td>Resistance to ‘change’</td>
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<td>Relationship with ‘outside’ services</td>
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<tr>
<td><strong>OPTIMISM</strong></td>
<td>Job role</td>
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<td></td>
<td>Knowledge and experience</td>
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<td></td>
<td>Inadequate services and resources</td>
<td>Staff feel un-empowered</td>
<td>Cannot effect change</td>
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<td></td>
<td></td>
<td>Staff feel unvalued</td>
<td>No motivation to change practices</td>
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<td></td>
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<td>Inadequate training resources</td>
<td>Attitudes</td>
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<td></td>
<td>Inadequate understanding of LD and CB</td>
<td>Depersonalises clients</td>
<td>Inappropriate services</td>
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</table>

Generally, when asked whether they would be hopeful for change when working with a client such as the vignette, participants believed some changes could be made. Certain factors personal to client were relevant, mainly related to the static nature of learning disabilities, or that more enduring and severe CB was seen as harder to change.

“Yeah, the person’s not going to stop having a learning disability. You hope always that, you know, there are various things that they are able to do or change or whatever, but their fundamental learning disability is still going to be there so you know kind of where you’re starting from, whereas with somebody with mental health
problems it can be, you know, they can be very lucid today and things are on the one level and then tomorrow things are very different”  (Transcript 5, line 143)

“If they’ve got people that are very challenging then often you do go back to pathological models I guess really and thinking, you know, people are doing, it’s all located within that person”  (Transcript 3, line 72)

What appeared more influential on optimism than client factors were systemic factors. The level of control staff had over interventions was again important here, and was dependent on their role and aspects of the wider service. For example, whether MDT working was coordinated, whether staff in homes / wards were able to carry out interventions, and whether home / ward managers were supportive of ‘outside’ services. Participants spoke of ‘other’ staff having unhelpful attitudes towards clients exhibiting CB, which in turn effects whether the client can change as these staff will be implementing guidelines. Participants also felt these attitudes had a negative impact on the relationship between wards / homes and outside services.

“Quite often it is the staff habits that cause the problems as well, rather than just the individuals, which I think people struggle to deal with and they struggle to admit that sometimes. But often I think staff feed behaviour and cause it.”  (Transcript 13, line 591)

“I mean the general consensus I got is that you know we wouldn’t understand the day-to-day realities of working somewhere like that and we wouldn’t understand the
patients because we haven’t worked with them intimately or anything like that and 
they were qualified as well as we were”    (Transcript 7, line 387)

Participants rationalised why other staff held unhelpful beliefs about CB. While 
individual personalities and attitudes were felt to be influential, the significant 
impact of staff culture and the wider service was also discussed.

“They’re probably the most untrained people that are left with the majority of the 
caring because everybody else up the line is doing this paperwork or that paperwork 
or whatever, you know, and we leave the least skilled who can’t get off to do training 
because of staffing levels etcetera to, you know, carry out all of the things we would 
hope should be happening to that individual”
(Transcript 3, line 577)

The influence of the wider service was also noted with respect to how it treats 
people with LD and CB. Participants felt this impacted on the care offered, and 
hence what staff can achieve within their role. Concerns about clients being 
treated as ‘commodity’ were noted numerous times, and how this may impact on 
aspects of the ‘work culture’.

“There’s less emphasis and status and money pumped into actually how you talk to 
that person and how you interact with them on a day-to-day basis than there is on 
how you assess them.”        (Transcript 14, line 690)
“The trouble is some of the people model this view in the community, some of the owners particularly. They show absolutely no respect for their clients whatsoever, they just see them as a moneymaking activity.” (Transcript 4, line 172)

4.2.1.7 Summary

There are three main points to consider from this analysis. Firstly, the main themes elicited correspond to factors noted to be relevant in the literature that may influence ‘causal attributions’. Secondly, the main themes seem to be interrelated and dependant on each other. This can be expressed in a diagram, as is shown in figure 1 below. It is interesting to note is that the role of ‘optimism’ is highlighted as a direct influence within Weiner’s (1986) model. Some lower order themes of the present study could also be seen as comparable to the attributional model. For example, controllability is included within the ‘emotional response’ theme. However, a direct comparison cannot be made as the study did not aim to elicit or explore the relationships between the themes in Weiner’s model. Also, the significant difference between the current study and Weiner’s (1986) model is that the themes and relationships between themes in the present study highlight contextual factors. This highlights the final main observation that impact of indirect factors, particularly the wider service and homes / wards, was also significant and something which was highlighted in all transcripts. This can also be illustrated through a diagram, as is shown below in figure 2.
Whilst the five main themes were interdependent to a degree, the diagram illustrates the hierarchy of themes as some seemed more influential, in particular ‘knowledge and experience’. ‘Coping’, ‘confidence’ and ‘emotional response’ all seemed pivotal for each other. However, optimism seemed to be influenced more by factors beyond the participant’s control to a degree, such as the behaviour of other staff. ‘Knowledge and experience’ and ‘confidence’ did seem to affect ‘optimism’, and this may in the sense that being more skilled and confident in your abilities increases hope for better outcomes.
The diagram demonstrates the influence the parts of the system have over each other. The interactional arrows indicate the direction and level of power and control exerted by the components of the service. The ‘wider service’ appears to have a direct impact on the ‘team / home’, member of ‘staff’ (intended to represent the participants), and ‘client’, and can impact on the ‘staff’ and ‘client’ through the ‘team / home’.

However, it is not influenced by the other aspects of the system. Also, the ‘team / home’ have more impact on the ‘staff’ and ‘client’ than they can reciprocate, particularly the ‘client’.

4.2.2 Stage 2: Comparison of CHABA constructs and interview themes

A subsidiary aim of the study was to compare the themes extracted from the interviews with the constructs utilised in the CHABA. Stage one of the analysis
highlighted that factors influencing staff beliefs about CB may relate to the staff as individuals, the clients they work with, or to the service they work in. Such factors seemed complex and interrelated. Measures developed to assess attributions of care staff are single-scale and tend to use simple constructs which may not adequately describe these influences, particularly as these factors may not be static. If this is true, assessments like the CHABA could potentially miss important factors influencing staff beliefs, particularly systemic factors, or misattribute them.

Indeed, the constructs used in the CHABA were not entirely represented in the analysis. Table 2 below illustrates which CHABA constructs were identified in the transcripts of the two groups. The communication category is not used in the CHABA. It was found to be an ‘ambiguous item’ and was eliminated from the assessment. Its scores were instead represented as a ‘learned behaviour’ score (Hastings, 1997). However, communication is included as a category in Table 3 to demonstrate the fact that all participants appropriately suggested CB may serve a communicative function in a way that was not comparable to the ‘learned behaviour’ constructs of the CHABA.
What is particularly noticeable is that the learned behaviour categories were not well represented in the transcripts. Indeed, many participants also commented on the fact that the CHABA suggested the client was responsible for their behaviour in a negative way.

“I found that very difficult in the questionnaire when it said something about attention seeking because, yes they are but it has such negative connotations. We don’t use those words anymore because it immediately has that negative sense of ‘attention seeking’ as opposed to seeking interaction”  (Transcript 5, line 560)

What is also noticeable from the above table is that participants who conducted the CHABA before commencing the interview were more likely to cite biomedical, learned behaviour, and stimulation as explanations for CB than those who did the

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### Table 2: CHABA constructs found in interview transcripts

<table>
<thead>
<tr>
<th>CHABA Construct</th>
<th>Participants who completed the CHABA before the interview</th>
<th>Participants who completed the CHABA after the interview</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Transcript 5</td>
<td>Transcript 4</td>
</tr>
<tr>
<td>Learned behaviour</td>
<td>√</td>
<td>√</td>
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<tr>
<td>Learned Positive</td>
<td></td>
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<tr>
<td>Learned Negative</td>
<td></td>
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</tr>
<tr>
<td>Biomedical</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Emotional</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Physical environment</td>
<td>√</td>
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</tr>
<tr>
<td>Stimulation</td>
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*Communication*
CHABA following the interview. Indeed, CHABA constructs were often detected within the first section of the transcripts for this group, which may suggest that the CHABA did in some way influence the way in which participants responded in the interview.

Participants tended to fill in the CHABA using only the middle point of a five point scale (‘equally unlikely / likely’), therefore valid comparisons of the results of the assessment and the themes of the interviews cannot be made. The main problem highlighted by participants when filling in the CHABA was that it was difficult to consider and answer the questions for the given example as they did not actually know the example as a person. Therefore, any of the offered causal explanations could potentially be valid. Participants felt they would answer the CHABA differently if they were completing it for a known client, and some felt it may be a useful tool as a ‘quick guide’ to understanding clients’ difficulties.

4.2.2.1 Summary
A true comparison of the CHABA constructs with the themes elicited in the interviews was difficult for two reasons. Firstly, the use of a vignette seemed to impact on how participants were able to respond to the CHABA. Most stated they could not give meaningful answers due to not actually knowing ‘person A’. Secondly, the explanations that participants offered for causes of CB in the interviews were more sophisticated and comprehensive than those which a single scale questionnaire could access. Even so, the results do seem to indicate that the use of a standard questionnaire could influence the way in which participants respond in an interview.
5. DISCUSSION

5.1 Summary of findings

The main aim of the current study was to explore the factors influencing staff beliefs about CB exhibited by adults with LD and the role of contextual factors in this process. The analysis highlighted both direct and indirect factors effected staff beliefs. The main themes detected in the analysis were knowledge, emotional response, coping, confidence and optimism. These factors are to an extent comparable with those highlighted in the current literature as influencing staff beliefs of CB. Even so, what is different in the current analysis is the emphasis on how indirect influences, such as the service and work culture, impact upon these factors. The significance of work culture and context will be discussed in more detail through interpreting the findings using systemic and psychodynamic models.

As a subsidiary aim, the study also intended to compare the themes elicited through qualitative analysis with the constructs used in a standardised measure. A true comparison was difficult due to methodological problems, and the fact that the explanations participants gave for CB in interviews were more complex than those offered by the CHABA. Even so, the analysis did highlight important considerations for the use of measures in eliciting and assessing staff attributions of CB. The complex and interrelated nature of factors influencing staff beliefs about CB highlighted by the qualitative analysis suggests that such beliefs may not be static. Therefore, it would be difficult to elicit or adequately assess with a single-scale measure. Also, most participants commented that the CHABA suggested the client was responsible for their behaviour in a negative way. This corresponds to previous criticisms that the learned behaviour subscales of the CHABA lack content validity.
and have poor reliability, and in particular implies intentionality of behaviour (Grey et al., 2002, McGill et al., 2007). There is also the fact that such measures cannot determine the reason behind the belief or the context within which it is made. Therefore measures such as the CHABA could, for example, fail to allow for appropriate reactive strategies, a difficulty which has also been noted previously in the research (Grey et al., 2002).

Despite these difficulties, the current research also demonstrated that the use of a vignette may have affected the participants’ ability to complete the CHABA. Most participants stated it was difficult to complete the questionnaire on an unknown person, and they would have completed it differently for a known client. Therefore, the noted problems with the CHABA may also relate to methodological difficulties rather than just inadequacies of the measure. It could be suggested that asking participants to complete the CHABA in response to a real incidence of CB would yield more substantive results.

5.2 Interpretation of the results

Whilst comparison of the methods highlights relevant considerations, the main aim of the study was to explore factors influencing staff beliefs about CB exhibited by adults with LD and the role of contextual factors in this process. Whilst the analysis did indeed highlight relevant factors that are comparable with current literature, the most significant factor in the interviews and analysis was the extent to which participants discussed factors not directly related to their views of the given example of challenging behaviour. For example, the beliefs and attitudes of ‘other’ staff and the impact of systemic factors on their beliefs and practices were frequently discussed.
The influence of the wider service on staff beliefs of CB could be understood using a systemic model, and a psychodynamic model may explain the relationship between the service and its staff. Therefore, the discussion will apply relevant aspects from each of these models to consider a more comprehensive understanding of the findings.

5.2.1 Systemic Interpretation

Systemic approaches emphasise that people are profoundly influenced by their context and the systems they are a part of. Particular aspects of the current data highlighted the need to use a systemic model to explore the influence of the service and work culture on staff. For example, the extent to which participants spoke about the service, managers, and ‘other staff’ without prompting from the researcher was interesting. Also significant was that the impact of service limitations on staff and clients was frequently discussed in negative terms by participants.

The ‘problem’ of CB serving a function

The focus of systemic approaches has changed since the model was established in the 1950’s, yet concepts from the different stages may all offer pertinent explanations when interpreting the results. A basis for early systemic thinking was the notion that problems in systems serve the function of stabilising them. In the case of the service this research was conducted in, the ‘problem’ of CB may be functional in the sense that it justifies staffs’ role by emphasising a need for them in a time when the unpredictable and changing service makes them feel insecure. One participant commented on this process as follows:
“They’ve created, I think, some of the problems and some of the labels for people. Because their belief is that they’re the only people who can manage them and hopefully they’ll always be there, and they’ll always be in a job because they’ll always be needed” (Transcript 3, line 442)

Unsuccessful solutions to problems

Dallos and Stedman (2007) note another useful concept is that problems can arise from applying unsuccessful solutions to difficulties (Watzlawick et al., 1974). This may happen because the system has not ‘deconstructed’ the problem, which involves defining what it is and how it relates to the difficulties the system has tried to overcome. This may apply to the current study in the sense that the solutions the service has applied to the ‘problem’ of CB have created more difficulties, or that the service and the staff within it have different perceptions of what the problem is. Therefore, the solutions applied are not helpful for all parts of the system. Participants spoke of how the service now puts more pressure on staff and has greater expectations of them, yet offers less support as it provides inadequate training, limited resources, little support, and insufficient guidance through role transition. Participants also felt that many care staff were not valued by the service, because they were not supported or paid a decent wage, and that this in turn impacts on their motivation for being effective in their role. It could be interpreted that, although the service has tried to address the ‘problem’ of CB by changing service provisions for clients, difficulties arose because it did not anticipate or provide for the changing needs of staff through the transition. Changes were made without consulting staff or providing support and resources, so staff felt uninvolved and unvalued. Consequently, changes in service provision meant the service is more outcome driven and expectant of staff, but staff
are demoralised and unable to deliver outcomes due to resource and skill limitations. Some staff also spoke of feeling isolated as a result of the transition. Follow-up interviews affirmed this idea, as receiving more information about service developments and being involved in making positive changes in service provisions resulted in staff feeling more hopeful and secure.

The impact of narratives

An enduring concept of systemic approaches is that problems are a product of the relationships in the system, and relate to difficulties in interaction and communication between parts of the system. Contemporary systemic approaches stress the importance of language and culture in these interactions and relationships (Dallos & Stedman, 2007). They propose that language helps people to actively make sense of and construct it their world, and the constructions people make are shaped by dominant ideas a given culture holds central. In turn, these constructions impact on and are reaffirmed and reproduced in everyday conversations. Therefore, dominant ideas shape expectations and actions.

The influence of language and culture was demonstrated in the current study as participants frequently discussed how staff on wards and in homes have negative narratives of clients with CB, and how these narratives can be passed on to newer staff through supervision, management, and everyday conversations about the clients.

‘Because they, new staff, coming in pick up bad attitudes from old staff don’t they so, unless you’ve got a strong personality that comes in and says ‘hang on a minute’”

(Transcript 12, line 960)
‘Yeah and I also think over time you’re subjected to that, whether you would just start thinking like that as well’ (Transcript 7, line 597)

These narratives in turn impact on practice, and clients come to be seen only as a ‘problem’ and become depersonalised. Participants also spoke about the messages which the service gives to staff about clients by ‘locking clients up’ and emphasising risk assessment rather than care, and how these may in turn effect staff beliefs and practice.

A systemic interpretation of the current data highlights the influence the service has on staff beliefs and behaviour, and the limitations of examining staff as individuals or removed from their context.

5.2.2 Psychodynamic Interpretation

The way in which unconscious processes impact upon stress in organisations has been explored within a psychodynamic framework, and this approach may be valuable when considering aspects of the current analysis. For example, how participants discussed emotional responses to CB mostly in the past tense and only when prompted raised interest. Although participants felt increased experience meant they were less affected by CB, there was the sense that this desensitisation may be functional, and avoiding addressing negative and distressing emotions could be defensive or even necessary to cope. The way participants presented initially in interviews, in terms of seeming to respond ‘in role’ and not voluntarily discussing emotional responses, also raised the question of whether they feared their competence...
was being judged in the interviews. The researcher wondered whether this mirrored the relationship between staff and the service.

**Parallel processes**

It seemed as though parallel processes were occurring between staff and clients, and staff and the service. In discussing this concept, Cardona (1994) notes the contradictions of staff feeling abused when service users are abused, and feeling challenged when service users are challenged. In the current analysis, participants spoke of difficulties in communicating with teams and other professionals, feeling hopeless and unempowered at times when they were unable to be effective in their role, and feeling unvalued by the service.

‘I mean I feel like when I can make a difference as well and I can handle, you know, when I can make changes into how I’m dealing with something. Whereas the situation at X I thought because I felt like no changes will be made you know I might now go and have all these opinions on what needs to happen, but changes wouldn’t be made … so that’s why I felt I had to go.’ (Transcript 7, line 574)

This seems to reflect how clients with LD must feel at times in the service.

**Splitting and blaming**

Obholzer (1994), notes how splitting can occur between staff on a ward / home and ‘outside’ professionals. The resident staff he observed constantly requested solutions to their problems, yet felt outside services had little value and would be ‘indignant’ that they would not consult with them or seek their opinion. Elements of this seem to
be mirrored in the current analysis. The way participants spoke of ‘other’ staff who were felt not to have appropriate beliefs about CB at times created an ‘us and them’ split. Another parallel process was observed when participants would at times internalise problems in the ‘other staff’ by attributing inappropriate practice to their personality or attitudes and hence blame them as individuals, just as these ‘other’ staff were said to do with client behaviour. There was a sense from participants that resident staff felt they knew clients best so would only refer in a crisis, but would then not take on board guidance and recommendations provided by ‘outside’ staff. Therefore, participants felt helpless and became frustrated with repeat referrals for problems they felt they had already dealt with.

Obholzer states the depressive position counterpart of this view would acknowledge the difficulties of working with an LD population, and accept that no individual profession knew the answers or had a simple solution. He felt that recognising this could lead to greater sharing of difficulties and uncertainties between staff, rather than competition and blame. Indeed it may be interpreted that the blame between resident and outside staff acts as a buffer. The fact that there may be no real solution to a problem or that the work you have done with a client has been ineffective may be too difficult to take on board. Therefore, it is easier to locate the blame elsewhere rather than accept there may not be a solution, in order to avoid dealing with the sadness of being unable to improve things for the client.

Linked to this, another possible explanation would be what Menzies (1960) describes as ‘reducing the impact of responsibility by delegating to supervisors’, although in the case of the current study tasks are forced onto professionals who work ‘outside’ the
home/ward, so all responsibility for performance of staff in the home/ward can be disclaimed.

**Ill-fitting solutions to problems**

Roberts (1994) offers another relevant explanation as to why services come to blame each other for difficulties and ill-fitting solutions. She observed that as services move into communities, clients become involved with numerous different professionals who each come and do their bit for the client, and refer new problems on to other professionals. Without coordination, gaps and overlaps are likely to occur in the services these professionals provide and as the client gets passed from one agency to another, each can blame the other for any difficulties. This seemed apparent in the current analysis in the way participants spoke of difficulty in coordinating MDT work, and how they were able to reflect on the frustration resident staff and carers felt with outside services doing disconnected work at different times.

“I’ve had cases where I’ve got involved where they’ve had previous input from health with regard to the behaviours and they’ve not been very happy with the outcome. So they haven’t sort of been all that willing to engage with myself because they’re like we’ve told them once this story, we’ve worked with them once to do this and it either didn’t make any difference or they left before the work was done and why should we do it all again with you” (Transcript 7, line 164)

Even so, there were also elements of blaming the staff who did not respond to referrals quickly enough, or care staff who did not implement guidelines, although the
real problem seemed to be that limited staff and resources meant the best service
could not be provided.

**Defence mechanisms**

Menzies (1960) describes various ways in which nurses use the ‘social structure’ of
their working environment as form of defence because, by the nature of their
profession, they are at considerable risk of being flooded by ‘intense and
unmanageable anxiety’, guilt, doubt, and uncertainly. Indeed, working with adults
with LD who exhibit CB may evoke similar emotions for all professionals. Menzies
emphasises that the culture, structure and mode of functioning of an organisation are
determined by the psychological needs of the members within it, and proposed that
the members come to use the organisation in their struggle against anxiety. This
results in socially constructed defence mechanisms which appear as elements in the
structure, culture, and mode of functioning of the organisation.

Similarly, Obholzer (1994) states defence mechanisms can be personal as well as
institutional, and gives the example of staff who will claim ‘I treat them as normal’.
He notes that not only do they represent themselves with this view, but they come to
represent everyone else in the institution that needs to regard clients as normal, and
the part of the institution which deals with abnormality by denial. Indeed many of the
participants described how they view the clients as ‘normal’ people who deserved to
be treated the same as everyone else. Whilst this view is in many ways appropriate, it
may highlight that the participants need to acknowledge this view comes from the
service, as many other staff in the service are not advocating this view. Indeed,
participants described the service as depersonalising clients and treating them as
‘problems’ rather than ‘people’. This is comparable to what Menzies (1960) describes as ‘depersonalisation, categorisation and denial of the significance of the individual’.

The way in which professionals split competencies could further support the notion of defence. For example, some staff were described to regard CB as something more pathological or medical than being related to outside contingencies.

‘Occasionally you do get somebody that’s just not got the right attitude … they do use words like manipulative or you know, or else they shift it round and say well it’s because they’re children you know … they’ve a mental age of whatever.’

(Transcript 8, line 243)

Another observation which could be interpreted as a defence mechanism would be the way in which participants seemed to evade discussing the emotional impact of work in the present tense. In her study Menzies (1960) noted how, despite seeming detached, senior members of staff would vividly recall the agonies of their training, something which many participants in the current study demonstrated. She proposes that ‘detachment and denial of feelings’ helps staff to control feelings and maintain professional independence, and this is done by minimising the mutual interaction of personalities which may lead to forming an attachment.

The impact of transition

Another factor which was particularly relevant at the time of conducting the interviews was the transition the service was going through, and how uncertainty about the future of the service impacted on staff. Cardona (1994) observed how uncertainty can elicit anxiety and stress in staff and initiate hopelessness in health
organisations. Staff can become insecure in and confused about their role and practice. Consequently, staff may use clients to ‘express a more profound sense of frustration with an organisational structure unable to give them adequate support or direction’ (p. 141). She also notes that incomplete transition and uncertainty can result in organisations becoming fragmented, in which layers of different cultures and contrasting models co-exist with no real interchange between them.

In considering the impact of transition on staff, Menzies (1960) describes how ‘avoidance of change’ can be used as a defence. She states that staff can struggle to embrace change as it entails committing to unpredictability and implies changes in the existing social relationships and structure. Any significant social change implies changes in the operation of the social system as a defence system. Therefore, change will enforce restructuring of social defences, so anxiety will be more open and intense in periods of transition. To avoid experiencing this anxiety, the service tries to avoid change wherever possible.

Anxiety resulting from uncertainty, frustration with the wider service, and fragmentation of the organisation seemed to be apparent in the current analysis. Participants clearly voiced being anxious about the uncertain nature of the services, as well as feeling insecure in their role. Service provision for clients with LD and CB has shifted to adopt a more person-centred approach and expectations of care are now higher. Participants described previous practices as more boundaried and less personal, but with more certainty about task expectations. They also described feeling unequipped to deal with current challenges and expectations, and there was a sense
that clients’ behaviour may be fuelled by the unreliability and uncertainty of the authority structure.

“You know you’ve got to juggle a lot more things now and there’s a lot more pressure to perform erm to, to individualised care, or to how others see what is individualised care without the resources to provide it” (Transcript 9, line 276)

The shift in the service model and stress of changing may have caused a split in the way staff perceive clients and their role in caring for them. Participants spoke of some ‘other’ staff being resistant to change, and these staff may continue to see clients as a diagnosis or potentially dangerous and in need of control, wanting them to be well behaved and containable because they remain unchanged by service developments. Some staff, such as the participants, have moved with the transition so see clients more as individuals who are basically good but in need of help and emotional support.

“I’ve always treated them as equal people, never been anything different. I think that’s why I am what I am.” Transcript 4, line 441

“I shifted along with some of the cultures … you see some things in your past then you thinks, yes, you know, I need to change that” Transcript 9, line 217

Indeed, participants spoke of moving with the times being essential for good practice and developing appropriate views of CB, but also being challenging. The fragmented nature of the service was, as already noted, highlighted in the way participants spoke of MDT working as not always being coordinated or correlated.
“It’s much better if you’re all looking at it together and saying, but to be honest in reality that’s still not happening very often because everybody’s so stretched and all of the resource issues”

Transcript 5, line 253

A psychodynamic perspective again highlights the significance of the wider context, but in terms of the processes that occur between the system, its staff and the clients it cares for. The approach also demonstrates the way in which individual defences may impact influence their practice.

5.3 Limitations of the Research

The external validity of the current study may be questioned as the results cannot be generalised beyond the service within which it was conducted. Certain biases and extraneous influences seem to have impacted on the sample, including the noted systemic and psychodynamic factors. The changes happening in the service at the time of the interviews may have affected the data collected in the sense that it had a negative impact on staffs’ motivation and views of the service. The sample was also biased in the sense that all participants held what could be considered appropriate and positive views about CB, and most had done further professional training. Therefore, their beliefs cannot be considered as representative of all staff within the service. There is also the fact that not all professional groups were represented in the sample, and only one of the participants is male. Other professional groups may have had different experiences and held more diverse opinions of CB.

Even so, the results did yield relevant clinical implications for the service it was conducted in, and highlighted relevant systemic factors. Studies of this nature often
cannot produce generalisable conclusions, but the results may also be considered a starting point for further research aiming to explore the impact of contextual factors on staff beliefs about CB.

Internal validity may be seen to have been achieved for the study to a degree. The results indicated that a standardised measure can be seen to impact upon participants’ responses in an interview, and this was achieved through utilising an experimental design (Latin Square).

There is a need to critically consider the validity of using a vignette. The current study used a vignette as it was not ethically possible for the researcher to use a ‘real’ example of challenging behaviour. It was also hoped a vignette would encourage staff to consider their own experiences of CB in the interview, as these are more meaningful. However, it is recognised that the using a vignette may have impacted upon the participants responses. For example, participants not discussing emotional reactions to the vignette unless prompted may be due to the fact that the example was not provocative.

5.4 Clinical Implications of the Research

The results of the study yield various clinical implications. Overall, the interpretations emphasise the need to consider staff beliefs about CB within their context. Previous research has highlighted the need to examine the impact of staff cultures on causal attributions (Allen, 1999) and the significance of organisational barriers in staff practice (Gentry et al., 2001), and the current analysis reinforces this.
The interviews highlight the fact that there are staff in the service who have positive attitudes and appropriate beliefs about CB, so are an important resource which may be better used.

The impact of negative of language on staff and teams is a problem which can be addressed if the service puts in appropriate measures and motivates staff to follow them.

There may be a need to ‘deconstruct’ the problem of CB in order to define it and deal with it more effectively. Different parts of the service may have different perceptions of what the problem is. Therefore, definition of the problem and agreement on how to deal with it would contribute towards not applying further ‘ill-fitting’ solutions. In relation, there is also a need to examine the expectations of the service for staff outcomes, as currently they are felt to be unrealistic at times. Participants spoke of feeling pressured to produce meaningful outcomes, yet perceptions of what this involves may vary. It was felt that the service may be expecting too much as CB cannot necessarily be ‘cured’ or completely changed, particularly when resources are insufficient. Accepting the ‘problem’ of CB may not be completely changeable could result in less pressure being put on staff.

The negative impact of the service transition was spoken of frequently in interviews. It seemed particularly pertinent for those who felt misinformed of uninvolved in the process, or had had to endure significant changes in their role that felt unmanageable. As noted, this notion was reinforced in some of the second interviews as a change in this yielded a more positive outlook. This highlights the importance of appropriately
informing or involving staff in transitions, and adequately preparing and providing for staff through periods of service development.

MDT working was spoken of as being difficult by most of the participants, and is not always achieved. Coordinating services is actually a skilled task, and is dependant on many factors other than the staff as individuals. The service could take on more of an active role in ensuring that coordination of services is possible. For example, by addressing resource limitations, by ensuring adequate staffing levels, and by providing adequate training and support to improve skills in this area.

The professional and personal impact of working with CB is emotive and challenging. If the interpretations offered are considered valid then the ‘blame culture’ and use of defence mechanisms could suggest the need to be more open about this. The service could facilitate more opportunities for staff to discuss and receive support for their thoughts and feelings in this area, and would need to ensure this time is protected. The messages the service seems to give to staff are also significant here. Giving permission to staff to feel upset and drained through acknowledging the reality of the difficulties and having realistic expectations could be helpful. On a practical level, efforts to make the service less fragmented and to improve coordination of services would also be beneficial.

Training provided by the service was also something considered problematic for various reasons, but could be addressed. Whilst participants felt that the training offered by the service on understanding and managing CB was necessary and valuable for delivering a good service to clients, it was questioned whether it is pitched at the
right level. For some staff it may be too simplistic, but for others too complicated. A more efficient way of running such training would be to tailor it to different groups. However, this would require the service investing time and resources to allow the trainers to do this. Many participants also noted that it can be difficult for staff to find time to do training due to staffing levels and work pressures such as paperwork, particularly in residential settings. Again, this would involve the service dedicating more resources and allowing protected personal development time for staff to be able to do training. It was also questioned whether theory practice links were made through training being followed up in homes and on wards. To ensure this happens the service could put measures in place to make it necessary, and also encourage and motivate staff to follow up training.

5.5 Recommendations for future Research

Replication of a qualitative analysis of staff beliefs may be beneficial if the sample was more representative and the methodology was improved. Including other professions with more varied experience and addressing the gender imbalance may produce more varied results. Where ethically possible, it may be beneficial to use a ‘real’ example of challenging behaviour when studying beliefs, as the validity of using written vignettes has frequently been questioned. This would also help to clarify the utility of the CHABA, which could make the mixed-methods design more significant.

The current study proposed to examine ‘beliefs’ due to the exploratory nature of the study, and difficulties noted with the attributional model. If attribution theory was accepted in further research, the Leeds Attributional Coding System (Stratton et al.,
1988) could be utilised to access causal attributions of CB in a more systematic way. This procedure can be used to look systematically at the content of attributions, and allows qualitative material to be quantified in a way that makes statistical analysis possible (Munton et al., 1999).

For a more conclusive idea of the impact of particular factors on beliefs, it may be useful to compare the beliefs of specific populations who differ in, for example, levels of knowledge about CB. A more structured approach may be beneficial in gathering and analysing data for this approach, or using mixed methodology.

The fact that the influence of systemic factors has been highlighted in the current research, suggest that it maybe beneficial to conduct research on the impact of work culture on causal beliefs. Much of the research to date has focussed on staff as individuals or groups and has not acknowledged the impact of their context. Ways in which research could attempt to access group beliefs could be through analysing staff focus groups, case conferences, or team meetings.

6. CRITICAL APPRAISAL

6.1 Development of the research project

6.1.2 Reasons for choosing the area of research

I chose to conduct a study within the field of LD as, having worked with this population prior to clinical training, it is an area which I am interested in and have experience of working in. Working as an assistant psychologist within LD services involved working collaboratively as part of a multi-disciplinary team (MDT). I found
the different views and understandings staff held about clients and their behaviour interesting. Different professionals seemed at times to have diverse perceptions of clients who were challenging, and at times struggled to reach an agreement of the causes of a client’s behaviour.

When considering areas of research for my thesis, I approached the psychology department of the LD service within which the study was conducted to discuss potential areas for research. The department had various ideas for studies that may be helpful, and the area of staff beliefs about CB was considered to one of potential utility.

A review of the literature in the field emphasised the clinical relevance of examining staff beliefs about CB exhibited by adults with LD, and indicated many studies had investigated factors influencing staff attributions and the impact of training on staff attributions of CB. It was apparent that most studies had utilised quantitative methodology and there were limitations to this approach. There also seemed to be a gap in the literature in the sense that, despite recommendations, studies had rarely examined the impact of contextual factors on staff beliefs about CB exhibited by adults with LD. Therefore, it seemed appropriate to conduct a more exploratory study through adopting qualitative methodology in order to attempt to address the restrictions of using quantitative methods, and to examine the impact of work context and culture in the analysis.
6.1.3 Epistemological stance

I chose to work within a social constructionist framework as I believe there can potentially be multiple interpretations of the same phenomenon, and an individual’s beliefs are shaped by their context. This fits with the notion of discovering the influence of work culture and context. Also, attempting to discover a static ‘truth’ seemed to be a problematic assumption with research in this field to date. I considered the use of qualitative methods such as Grounded Theory (GT) and Interpretive Phenomenological Analysis (IPA) but chose to use Template Analysis (TA). I felt that GT was not an appropriate method as it is builds a model or theory by using purposeful and theoretical sampling. Whilst I wanted to gain a sample representative of all professionals who may work in LD services, I was cautious of creating a ‘model’ as this seemed incongruous with the exploratory aims to the study. IPA may have been an appropriate method as it is a discursive and reflexive approach which has its roots in constructivism. However, the analysis process of IPA is interested in more in-depth exploration of individual cases and is not suitable for handling large amounts of data. The key issue was that neither approach would allow for comparative analysis.

Therefore, TA was considered appropriate for various reasons. Firstly, as a set of techniques rather than a distinct methodology, TA is a flexible approach which can be adapted to suit the aims of the study, and can be used from a range of epistemological positions. Secondly, the use of a priori themes allows the researcher to acknowledge their prior knowledge on the subject and suggest themes they believe they will find, hence allowing for comparison. Also, TA can incorporate large data sets into a
meaningful template, thus potentially allowing the researcher to examine a larger sample than GT or IPA would permit.

6.2 Conducting the research

6.2.1 Recruitment issues and sample

Recruiting people to the study was difficult and time consuming due to it being in part dependant on the action of others. An ethical requirement was that I could not approach staff members directly to inform them about the interview and attempt to recruit. Whilst this was appropriate in protecting staff, it meant I was reliant on the service manager imparting information about the study, and then had to wait for staff to volunteer. Initially, the manager distributed an email to relevant members of staff and I received no responses in the first three weeks. The manager then sent out further emails and the issue was also then raised in relevant meetings, where team leaders and managers were asked to encourage staff to take part and informed they were allowed time out of work to participate in the project. Gradually, staff started to volunteer to take part in the study. However the recruitment rate and busy schedules of the staff who volunteered meant it took five months to gain the complete sample and conduct interviews. This also made allocation of staff into one of the two study groups problematic as for the most part staff had to be allocated as they were recruited, which made adequate matching difficult.

6.2.2 Sample characteristics relevant to research question

Burman (1994) encourages the researcher to consider the impact of the route by which you contact participants, and how this structures the way they see you. As the study was advertised mostly through the service, I wondered whether staff may have
perceived it to be service led, or a project the service had initiated in order to assess whether staff were doing their job adequately.

I also felt the sample was in some ways biased. Firstly, most of the participants had gone on to do further training which, although is not uncommon, is not usual in such services. Therefore, the sample was not entirely representative of a typical staff group. Potter and Hepburn (2005) also encourage consideration of how the vested interest participants have in taking part in the interview may impact on the process. As already noted participation in the study was voluntary, so staff had to put themselves forward and take time out of work to be interviewed. What was apparent was that all participants were person-centred in their approach and had very appropriate beliefs about CB, and many had undertaken further professional training be more effective in their role. It may then be fair to assume their motivation for participating in the research related to a genuine interest in CB, and feeling comfortable with their beliefs. Consequently, the sample did not represent staff who may have less appropriate views of CB. Indeed, ‘inappropriate’ beliefs were only spoken of with reference to how ‘other’ staff understand CB, so caution must be adopted when inferring this as ‘fact’ as it is just the opinion of the participants.

6.3 Interviewing

6.3.1 Developing an interview style

Burman (1994) notes the value of doing a practice interview, and I conducted three pilot interviews in order to feel comfortable with a more flexible style of interviewing. I anticipated it would be challenging to remain impartial and not lead interviews, and also felt it was important to ensure my enquiries were clear and open. Conducting the
pilot interviews was very useful, and allowed me to consider my questions and presentation thoroughly before commencing the interviews.

I believed it was important for the interviews to be a collaborative process so participants felt they could be open in discussing their opinions and experiences of CB. Smith (1995) notes for participants to share more closely with the direction of the interview and be able to introduce new issues the researcher hasn’t thought of, the researcher needs to use a flexible topic guide. Therefore, I used a topic guide which suggested areas and prompts to cover rather than specific questions. It was also important to monitor the effect of the interview on participant to judge whether they felt comfortable, and if I was adopting an appropriate line of questioning.

I found conducting the interviews challenging at first, and was constantly aware of trying to remain neutral, asking open-ended questions, and responding to what participants brought to the interview. Keeping a balance between responding to what participants discussed and containing the interview within the framework of the study aims was difficult. However, after conducting four or five interviews I became more comfortable with the process, and realised that participants often discussed relevant issues without questions or prompting.

6.3.2 Influence of the interview of participants
A social constructionist perspective encourages critical examination of the interview process, highlighting the relevance of the way people present themselves in interviews and how the setup of the interview can affect participants. The biased nature of the sample and the way participants presented in interview indicated the need to consider
how the interview process could have affected participants. Potter and Hepburn (2005) offer some useful considerations that may be relevant when interpreting the current analysis. They highlight the influence of the complex and varying ‘footing positions’ of the interviewer and interviewee. They note that researchers tend to recruit participants as being representative of a particular category because of their research hypotheses. Participants may become aware of this, and respond as a ‘type’ in the interview rather than as an individual. They may also respond according to what they believe the interviewer expects or wants to hear. Such influences may be further reinforced by the interview set-up and how it is conducted.

I felt these processes may have occurred in the current study to a point. Many of the participants seemed to respond to the initial part of the interview in their professional ‘role’ as they described how they would assess and manage the person described in the vignette, although they were only asked their ‘initial thoughts’. The setup of the interview may have also encouraged this presentation. All participants were given a vignette to read at the beginning of the interview as a starting point, and many commented it seemed like a referral. Administering the CHABA to Group 1 prior to the interview may have encouraged participants to respond according to what they believed the interviewer wanted. Their responses seemed more aligned to their role, and analysis of their transcripts revealed more themes related to the CHABA constructs when compared to participants who conducted the CHABA following the interview. Even so, I do not feel that these processes affected the interviews to the point where validity could be questioned as participants did not seem to ‘stay in role’ for the length of the interview, and many made personal comments and admissions.
This suggests they became comfortable enough in the interviews to present as themselves.

6.4 Write up

6.4.1 Epistemological stance

Adopting a social constructionist stance requires acknowledging that the results of the study cannot be claimed to represent a ‘real’ and static truth. Instead, I feel that the results achieved denote the processes and interactions that occurred at the time of interview, which may represent the participants’ beliefs and opinions to a point. Whilst some may question the utility of this concept, I feel it is important to consider the fluidity of beliefs and the fact that factors influencing them may vary.

6.4.2 Process

I felt that adopting TA facilitated comprehensive analysis and informed the interpretations of the results, mainly through the process of creating an initial template and developing this to create the final template. In TA an initial template is applied in order to analyse the text through the process of coding, but is revised in the light of ongoing analysis. The stage at which the initial template is produced depends on the methodological position adopted by the researcher. This flexibility supported the exploratory nature of the current study and encouraged neutrality, as it permitted all fourteen transcripts to be coded before creating the initial template. I feel this helped minimise the potential for missing or mislabelling themes, or collapsing them too soon. This also meant that the initial template was highly inclusive and detailed. Whilst coding the transcripts I felt it was a constant challenge to remain open as, whilst I believed it was important to recognise the a priori themes, I did not want to
overemphasise them and miss possible new themes. Keeping an audit trail of the coding helped me to be aware of this.

I found the process of applying the initial template to the transcripts and recoding extremely useful. Having done the first stage of coding and constructed the initial template, I felt it was too descriptive and basic. I questioned whether it was a true reflection of the interviews, as it did not seem to represent some of the messages and processes I had taken away from the interviews. It also felt more like a content analysis than an interpretive analysis. Smith (1995) notes that meanings are not transparently available in analysing transcripts. He states they must be obtained through a sustained engagement with the text and a process of interpretation. Indeed, recoding and developing the final template helped to reconsider the analysis and construct a more meaningful template through considering process issues of the interviews and understanding systemic influences. Parallel coding was also useful in the analysis as there were subsidiary codes which seemed relevant for more than one of the first level codes, and using them in parallel helped to represent the interrelated nature of the themes.

6.5 Reflexivity and Quality

6.5.1 Reflexivity

Staying reflexive was particularly important as I had prior knowledge about LD services, and also because the service was going through a period of difficult transition which participants may have been responding to. It would have been easy for me to make assumptions about what was influencing staff and how. Therefore,
although it was more time consuming; coding all interviews before constructing the initial template was important to encourage reflexivity.

Supervision with a professional who worked in the service the research was conducted in was extremely helpful. They were able to comment on whether my results and analysis accurately reflected staff and service issues, and determine whether the interpretations I made were suitable and did not just adhere to what I was looking for. Impartial support from people who were not aligned to my study was also helpful, and throughout conducting the study I gained this from attending a qualitative research group. Members of the group independently coded exerts from transcripts, not with the aim of discovering whether I had elicited the ‘truth’, but to compare their coding to my own to see if it was similar. This encouraged me to question why I had selected and coded particular text. Discussing interpretations in this group was also helpful, and the fact that people could see why I had made the interpretations I did based on the given evidence was reassuring. I also kept a research log throughout the process so I could keep track my thoughts and interpretations, and again check why I came to particular conclusions.

6.5.2 Quality

Meyrick (2006) notes that achieving quality in qualitative research can be seen to be difficult. However, she presents a model which allows for a pluralistic approach to rigour or quality building on two key common principles; transparency and systematicity. The model is shown below in Figure 4. Meyrick describes ways in which these principles can be applied to qualitative research throughout the process of conducting and writing up research. By attempting to adhere to this model I feel I
have achieved quality in my research project to a degree. For example, by clearly stating my epistemological stance and acknowledging the impact this may have had on the study, ensuring that I collected data until I felt that no new relevant themes seemed to emerge, and by not relying only on cases that support my conclusions. With particular reference to the analysis process, creating an audit trail, using multiple and independent coding, gaining respondent validation and triangulating methods contributed to accounting for my results and interpretations.

**Figure 3**  
Quality framework for qualitative research

### 6.6 Development of research knowledge

Having completed the project, I am more able to reflect on the strengths and weaknesses of its design and what I feel I have learnt from conducting a substantial piece of research. Firstly, I feel that the study generated a lot of data, and could probably be split into two more focussed projects. Whilst I attempted to make the
study comprehensive by addressing multiple aims and using mixed-methods, it was a fairly complex project. This may impact on the overall clarity of the study. It may have been more appropriate to address one of the study aims in a more focussed way. When considering future projects I will probably aim to use simpler designs and have fewer study aims to facilitate clarity.

If ethically possible, I would have liked to have had more control over recruiting participants in order to attempt to gain a more representative sample. The biased nature of the study has been discussed, and I feel I may have attained more diverse views if I had recruited staff from other professions and with different levels of experience and qualification.

Using TA was difficult in the sense that it is a technique which is not as recognised as other qualitative methods such as GT or IPA, so I received little support regarding the technicalities of my analysis procedure. Even so, I feel this was encouraging in the sense that I therefore made concerted efforts to thoroughly understand and apply the method. I feel that using TA was appropriate for this study, as it allowed me to draw comparisons and adapt the method to suit my research aims. However, if the aim had been solely to explore factors influencing staff beliefs about CB exhibited by adults with LD, then IPA may be more appropriate to allow for more in-depth analysis and open exploration.

Time constraints did have an impact on the process in the sense that both the participants and I were limited as to when we could arrange interviews. This was particularly noticeable when trying to conduct follow up interviews. My intention was
to re-interview all participants to enhance respondent validity. However, this proved difficult and some participants have so far been unable to take more time out of their work schedules to be re-interviewed. They may also be less motivated to do so having already conducted the main interview, as the follow-up interviews may seem less important. I have managed to conduct three follow-up interviews to date. They were informative and highlighted new issues to consider. They also made the process feel more collaborative and valued the participants’ contributions. I intend to conduct more follow-up interviews before writing for publication.

It was a challenge to remain neutral and not side with participants at times, given that I have had experience of working in LD services and of some of the problems they discussed. When participants discussed particularly difficult or frustrating issues about the service or the other staff they work with, I sometimes felt they were looking to me for affirmation. I would therefore occasionally comment that I could see how such problems were frustrating. However, on reflection I was able to consider that this may in part be more about my interpretations of what the participant expected and prior knowledge of the area than the reality of the situation. Even so, there were times when it felt appropriate to agree with participants. For example, when they spoke of it being unjust that people with LD were stigmatised by society I agreed, as I felt this was more about a genuine personal opinion than being related to my research interests.

Overall, I have learnt to spend a lot more time on developing and designing a research project and have come to appreciate the need for rigour and reflexivity. I feel I would be more equipped to deal with the intricacies of designing and conducting a
qualitative study and would allow myself much more time to both conduct and reflect upon the process.

Please request permission from the researcher to see copies of the addendum.
REFERENCES


King, N. ‘Template Analysis’.

URL: [http://www.hud.ac.uk/hhs/research/template_analysis/](http://www.hud.ac.uk/hhs/research/template_analysis/)

Date of retrieval: 04/03/2008.


‘A’ is a person who has learning disabilities. They have social and psychological difficulties.

Sometimes ‘A’ is aggressive towards the people who care for them and live with them. They may shout at and push people, and will sometimes kick and punch people.

‘A’ has been observed to stand and rock from one foot to the other.

‘A’ has also been known to harm themselves.
Appendix 2  The Challenging Behaviour Attributions Scale (CHABA)  
(Hastings, 1997)

Please read the following brief description:

‘A’ is a person who has learning disabilities. They have social and psychological difficulties.

Sometimes ‘A’ is aggressive towards the people who care for them and live with them. They may shout at and push people, and will sometimes kick and punch people.

‘A’ has been observed to stand and rock from one foot to the other.  

‘A’ has also been known to harm themself.

Consider how likely it is that the following statements are reasons for ‘A’ behaving in the way described above. You have been given very little information compared to that you might have if you worked with ‘A’. Therefore, simply think about the most likely reasons for someone like ‘A’ behaving in this way. Please give your response to each of the possible reasons and use the scales below each reason to indicate your opinion. Please indicate your response by placing a circle around the answer you have chosen.

1. Because she/he is given things to do that are too difficult for her/him

Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

2. Because she/he is physically ill

Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

3. Because she/he does not like bright lights

Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

4. Because she/he is tired

Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

5. Because she/he cannot cope with high levels of stress

Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

6. Because her/his ward is too crowded with people

Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

7. Because she/he is bored

Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely
8. Because of the medication she/he is given
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

9. Because she/he is unhappy
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

10. Because she/he has not got something she/he wanted
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

11. Because she/he lives in unpleasant surroundings
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

12. Because she/he enjoys it
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

13. Because she/he is in a bad mood
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

14. Because high humidity makes her/him uncomfortable
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

15. Because she/he is worried about something
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

16. Because of some biological process in her/his body
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

17. Because her/his surroundings are too warm / cold
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

18. Because she/he wants something
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

19. Because she/he is angry
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

20. Because there is nothing else for her/him to do
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely
21. Because she/he lives in a noisy place
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

22. Because she/he feels let down by somebody
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

23. Because she/he is physically disabled
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

24. Because there is not much space in her/his ward to move around in
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

25. Because she/he gets left on her/his own
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

26. Because she/he is hungry or thirsty
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

27. Because she/he is frightened
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

28. Because somebody she/he dislikes is nearby
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

29. Because people do not talk to her/him very much
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

30. Because she/he wants to avoid uninteresting tasks
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

31. Because she/he does not go outdoors very much
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

32. Because she/he is rarely given activities to do
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely

33. Because she/he wants attention from other people
Very unlikely  Unlikely  Equally likely/unlikely  Likely  Very likely
Appendix 3  Participant Information Sheet

A study exploring staff views of Challenging Behaviour

PARTICIPANT INFORMATION SHEET

You are being invited to participate in a research project. Before you decide, it is important that you feel you have enough information to understand why the research is being done and what it will involve for you. Please take the time to read the following information carefully, and feel free to contact me if you would like further information.

Title of Project: A Qualitative Analysis of factors influencing Staff Beliefs about the Challenging Behaviour exhibited by Adults with a Learning Disability.

Researcher: Sarah Jane Andrews is a Trainee Clinical Psychologist currently studying at the University of Leicester and employed by Leicestershire Partnership NHS Trust.

What is the purpose of this study?
The purpose of this study is to explore the staff beliefs about the challenging behaviour exhibited by clients with a learning disability, and what factors influence and cause these beliefs.

Why have I been asked to take part in this study?
Various professionals who work within the Health and Social Care sector of Leicestershire Partnership NHS Trust are being invited to take part.

Do I have to be involved in the study?
It is up to you to choose whether you wish to take part in this study or not. If you do decide to take part you are still free to withdraw from the study at any time without giving a reason.

What will I be asked to do if I agree to take part?
You will be asked to provide some basic details relating to your professional training and qualifications.

You will be asked to do two interviews, both lasting for approximately 90 minutes. In the first interview, you will be asked about your thoughts and views about an incident and will also be asked to fill in a brief questionnaire. In the second interview, the researcher will feedback from your first interview and ask you to comment on the conversations and views you had.

Will my input be confidential?
No information attained within the interviews will be passed on to other professionals unless it indicates harm towards others. No personal identifying details will be used in
the write up of the research, though results in relation to aspects such as profession and differences in views of the incident may be explored.

The researcher will ensure that she is careful when writing up the study to only use information or quotes that are non-identifiable, and if this is not possible then information will not be used. Also, you will be given the opportunity to comment or expand upon your views in the second interview, and you may wish to ask for certain information not to be used.

Digital recordings of the interviews will be stored on a USB memory stick and kept in a locked container throughout the study, and only the researcher and their supervisor will have access to them. They will be held for five years but they will continue to be stored in a locked container. Transcripts of the interviews will be stored on a PC but will be encrypted to ensure they are protected.

What will happen to the results of the study?
The results of this study will be written up as part of a thesis in accordance with the requirements of the fulfilment of the Doctorate in Clinical Psychology. A briefer version of the findings may also be written up for possible publication in a relevant journal.

Research findings will also be made available to the staff who took part in the study in the form of a presentation. Should any findings highlight potential recommendations for the service these may also be presented.

Who has agreed for this study to be carried out?
This study is being organised and funded by the Leicestershire Partnership NHS Trust. It has been reviewed and approved by both the University of Leicester and the Leicestershire Local Research Ethics Committee (LREC). The LREC is a body appointed by the Strategic Health Authority to review proposed research and consider its ethical merits. This involves considering potential advantages of the proposed research and ensuring participants are not exposed to significant risks. Research projects are not undertaken without LREC approval.

Should you require further information, you can contact your researcher at:

user@le.ac.uk

Telephone: ***** ***** to leave a request for more information. Leave your name and number and I will call you back.
Appendix 4  Consent Form

Leicestershire Partnership NHS Trust

STAFF CONSENT TO PARTICIPATE IN THE STUDY

I (please print name) _______________________________ consent to take part in this study.

Please read the following points regarding you consenting to participate in this study and ensure you agree with all of them before signing this form.

1. I have been provided with details about what this study will involve and believe I have enough information about the study to make an informed decision to participate.

2. I am aware of the limits of confidentiality and how they apply to this study, which is as follows:
   - No information attained within the interviews will be passed on to other professionals unless it indicates harm or risk.
   - No personal or identifiable aspects of the interviews will be used in the write up of this study
   - Quotes or themes from the interview transcripts may be used in the write up of this study, but the researcher will only include them without identifiable details.

3. I am aware that the interviews will be recorded using a digital voice recorder to allow them to be analysed effectively by the researcher, and that the following measures will be in place:
   - All interview recordings will be stored on a USB memory stick that will be kept in a locked box in a secure environment for the duration of the study. They will be kept for 5 years after the study is completed then destroyed.
   - Only the researcher and her supervisor will have access to the recordings and be allowed to listen to them.
   - Transcripts of the interviews will be anonymised, encrypted and password protected and only the researcher and her supervisor will be able to see them.

4. I am aware that I am able to withdraw from the study at any time, and if I do so no information I have provided will be used in the study.

Signed: ____________________________________________

Please print name: _______________________________________

Date: ________________________________________
<table>
<thead>
<tr>
<th>Group One: Conducted CHABA before interview</th>
<th>Profession</th>
<th>Sex</th>
<th>Age</th>
<th>Time in current post</th>
<th>Other posts in Learning Disability Services</th>
<th>Transcript Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech and language Therapist</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
<td>None – previously worked in mental health services.</td>
<td>*</td>
</tr>
<tr>
<td>Team Leader / Ward Manager (Nurse)</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
<td>17 posts since qualification including Staff Nurse and Ward Sister.</td>
<td>*</td>
</tr>
<tr>
<td>Practice Development Nurse</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
<td>Team Leader; Staff Nurse</td>
<td>*</td>
</tr>
<tr>
<td>Community Nurse</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
<td>Home Leader/Ward sister for 20 years, Deputy Ward Sister, Staff Nurse, Nursing Assistant.</td>
<td>*</td>
</tr>
<tr>
<td>Community Nurse</td>
<td>*</td>
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<td>Ward sister, home manager</td>
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<td>Health Care Assistant</td>
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<td>Health Care Assistant</td>
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<td>Senior Practitioner (Social Work)</td>
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<td>Social worker</td>
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<th>Group two: Conducted CHABA after interview</th>
<th>Profession</th>
<th>Sex</th>
<th>Age</th>
<th>Time in current post</th>
<th>Other posts in Learning Disabilities for 15 years</th>
<th>Transcript Number</th>
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<tr>
<td>Speech and Language Therapist</td>
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<td>4 Previous SALT posts in other areas</td>
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<td>Team Leader (Nurse)</td>
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<td>Staff Nurse (ward); HCA</td>
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<td>Outreach Nurse and SKIP trainer</td>
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<td>Health Care Assistant (x2), Nursing Assistant, Staff Nurse</td>
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<tr>
<td>Community Nurse</td>
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<td>Registered Nurse for Learning Disabilities for 15 years</td>
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<td>Community Nurse</td>
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<td>Placements on Nurse Training</td>
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<tr>
<td>Community Nurse</td>
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<td></td>
<td>Staff Nurse: day care 10 years, residential 8 years</td>
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<tr>
<td>Consultant Clinical Psychologist</td>
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<td>Assistant Psychology Posts</td>
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* Information was collected but has been censored to protect confidentiality
Appendix 6  
Interview Topic guide

Interview prompts:

• Does the participant feel the vignette is a realistic example of challenging behaviour?

• What are the participant’s initial thoughts about the vignette?
• How would the participant feel if they saw someone behaving in this way?
• How would the participant feel towards the person who is being challenging?
• How do they think they may respond to a situation like this?
• What are the participants thoughts about what may have contributed to the incident?

• Would the participant feel optimistic for change with this person?
• Would other diagnoses influence the participant’s thoughts?
• Would an implied level of cognitive functioning impact on the participant’s thoughts?
• Would a high level of implied risk alter the participant’s thoughts?

• Ask about the participants experiences of challenging behaviour
• Ask about the participants understanding of challenging behaviour
• Has the participants views of challenging behaviour changed over time?
• Has the participant received training on understanding challenging behaviour? If so, ask them to discuss this.

• How does the participant feel other professionals / staff would view the example?

• Encourage the participant to discuss experiences in different contexts and reflect on the impact of the context.

• Has the participants view about CB changed over time?

• Is there anything the participant feels contributes to their understanding of challenging behaviour which they have not had the opportunity to discuss in the interview?
Appendix 7    Participant details Questionnaire

1. Job title: ____________________________________________________________

2. In what type of setting do you usually work on? (i.e. inpatient, community, etc)
   ___________________________________________________________________

3. How long have you been in your current post: ____________________________
   ___________________________________________________________________

4. Did you receive any formal training / qualification prior to taking up your post? Yes / No
   If yes, please specify: ________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

5. Have you held other posts in learning disability services? Yes / No
   If yes, please specify: ________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

6. Have you held other posts in mental health services? Yes / No
   If yes, please specify: ________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________

7. Have you received any training about the causes of challenging behaviour? Yes / No
   If yes, could you please briefly describe the training you received: __________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   How useful did you find this training?
   Not very useful 1 2 3 4 5 Extremely Useful

8. Have you received any training on how to respond to challenging behaviour? Yes / No
   If yes, could you please briefly describe the training you received: __________
   ___________________________________________________________________
   ___________________________________________________________________
   ___________________________________________________________________
   How useful did you find this training?
   Not very useful 1 2 3 4 5 Extremely Useful

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE
Appendix 8  Counselling Service Leaflet

From time to time all of us may need help in dealing with the stresses and strains on our personal lives - whether they be work-related or in the NHS, staff are working under tremendous pressure - with increasing demand on our services from the public and in a climate of stringent financial control.

The trust is well aware that the pressures on staff do not end when they go home and that often there are added problems at home to cope with. Sometimes, the stresses and strains on our staff become too much. It is for this reason that the Antica Telephone Counselling Service is being provided.

The service is provided by Antica Counselling & Psychological Support Services, an NHS-based service.
Appendix 9  
Example of Coding

I mean I suppose when I reflect back on it, I've always been fairly laid back, so it's not something that I, other people you see would tend to sort of take it quite personally, I was able to distance myself 99.9% of the time. There was obviously the odd occasion when someone, sort of, you might be hit or thumped and something happens that's sort of totally unexpected and they catch you unawares, and, you know, the difficulty is you sort of, you have that kind of immediate response, but it's then sort of reiniging it in and being aware of where you are and trying to sort it out in a positive way. So, you know, I can think back and think well I remember so and so, you know, when I had my shirt ripped off by that person or walked out of a room, things like that, you know, but it's all sort of, you know at the time I never saw it as a big deal, I thought, you know, this has upset things, but today's a day, tomorrow's another day and we'll move on. You know, and again, because of the place I worked, I didn't move from place to place, I mean there were certain people you worked with, and there were people I worked with for 8 or 9 years, and you got to know them really well, and it was sort of almost like, yes you're caring for them but you know them fairly well, it's almost like a friend, you know, they might see you as the nearest thing they have to family, because they've been in institutions and there's been a turnover of staff or whatever, you know, and sometimes that's borne out of, because I might bump into someone in the community that I used to, you know, and they'd remember you, and that's sort of, interesting, because I thought I'm sure they'll forget me, but they don't.

Well obviously it means, like you said, if you're there for that huge length of time and they haven't got anyone else, then, and if you are caring for them and you are doing a good job of caring for them obviously you're going to be very important in their lives and they will remember you.

Yeah. And there were people like that and then, because of where we were, it was sort of like a large building in a community setting, but in sort of like, if you're going back that many years, I mean we were quite forward thinking in the fact that we were right in the middle of the community, we used community facilities, we used shops round the corner, we used the local GP, dentist, everything, you know, it was sort of how it should have been. So I mean, the other thing that was quite good was that, we
went through a period where we actually had a change of people, some of the people that were more able moved on and out and some of the other institutions in the area were closing, some of the people that were more difficult to care for came to us, so that mixed things up a little bit. So, I mean, the environment when I first went there after qualifying, it was based, it was, basically there was about 4 or 5 people that were really quite able, and everybody else, and we’re talking of 1 think probably about another 12, 14, 16 people, you know there was quite a few people there, in fact at one stage there were 28 people, but it was a big building, and most people had their little bedroom to themselves, which again was not usually because a lot of people had moved there from like big, sort of like dormitory style accommodation, but most of them were men because they’d come from a big establishment that was just men, but then when things changed we sort of had a lot less able people and women and it made it quite different to how it had been.
Appendix 10  Initial Template

FACTORS RELATING TO THE CLIENT

1. Learning disability
   1. Level of functioning
      1. Communication
      2. View of intentionality of behaviour
      3. View of responsibility for behaviour
   2. Static nature of difficulties
      1. Narratives of not being able to change
      2. Effects staff optimism for and motivation to create change
   3. Status and difference
      1. Not empowered
      2. Not respected
      3. Perceived as diagnosis not person
         1. Effects staff optimism for and motivation to create change
         2. Effects staff emotional attachment to client

2. Challenging Behaviour
   1. Severity / Type
      1. Risk
      2. Willingness of staff to engage
         1. Staffs emotional reactions
      3. View of intentionality of behaviour
      4. Predictability
         1. Staff confidence
         2. Staff fear
         3. Effects staff emotional attachment to client

3. Multiple Diagnoses
   1. Treatability
      Optimism for change
   2. Understanding of nature of difficulties
      1. Effects staff emotional attachment to client

FACTORS RELATING TO THE MEMBER OF STAFF

1. Role
   1. Ability to create change for client
      1. Expectations of other staff to ‘fix’ problem
      2. Support from home / ward managers
      3. Control over outcomes
         1. MDT working
         2. Residential / community setting
         3. Service provisions
   2. View of duty of care
      1. To client
         1. Manage behaviour
2. Manage environment
2. To other staff
   1. Modelling attitudes and practice
   2. Support
   3. Empower
   4. Teaching / informing

3. Working with MDT
   1. Communication
   2. Coordination

2. Knowledge and experience
   1. Of clients
      1. Effects staff emotional attachment
      2. Staff confidence
   2. Training
      1. Academic / Professional
         1. Motivation
         2. New practices
      2. Practical ‘in house’
   3. Varied job roles
      1. Varied experience of CB
      2. Knowledge of multiple diagnoses

3. Coping
   1. Job role
      1. Clarity
      2. Knowing limitations
         1. Burnout
      3. Varied cases
         1. Burnout
      4. Control
         1. Predicting and managing CB
      5. Success
      6. Motivation
         1. Job as ‘identity’
   2. Support
      1. Clinical Supervision
      2. Team
      3. Wider Service
         1. Training
         2. Expectations
         3. Valued
   3. Distance
      1. Emotional
         1. ‘Cutting off’ from work
         2. Understanding CB
            1. Reflective
            2. Analytical
      2. Physical
         1. Time spent with client
4. Attitude
   1. Optimistic
   2. Confidence in abilities
      1. Control
         1. Predicting and managing CB
   3. Experience and knowledge
      1. Learning from incidents
      2. Developing practices
   4. Praise
      1. Clinical supervision
      2. Team
      3 Wider service

FACTORS RELATING TO THE WIDER SERVICE

1. Homes and wards
   1. Manager
      1. Role
         1. Duty of care to staff and clients
         2. Being part of the team
         3. Modelling good practice
            1. Leading culture
      2. Skills
         1. Experience of CB
         2. MDT working
      3. Personality
      4. Relationship with wider service
         1. Not empowered by higher managers
         2. Not supportive of ‘outside services’
            1. Effects work culture

3. ‘Other staff’
   1. Personal factors
      1. Motivation
         1. Relationship with clients
         1. Ability to reflect
      2. Knowledge / perception of CB
         1. Opinion vs. fact
            1. Negative narratives
         2. Training
      3. Blaming client
         1. Negative narratives
         2. Effects practices
      3. Relationship with wider service
         1. Not supported
            1. Inadequate training
            2. Inadequate supervision
            3. Service changes
         2. Not valued
            1. Poor pay
2. Treated as commodity

**2. Relationship with clients**

1. **Depersonalised**
   1. Treated as commodity
   2. Emphasis on assessment and risk
   3. Outcome driven
   4. Inadequate understanding of CB
      1. ‘challenging behaviour’ rather than ‘challenging service’
      2. Seclusion and physical restraint
      3. Staff training

2. **Service provision**
   1. Inadequate services for CB and multiple diagnosis
   2. Closures
   3. Inadequate training of staff

**3. Relationship with staff**

1. **Undervalued**
   1. Pay
   2. Outcome driven
      1. Pressures
      2. Expectations

2. **Unsupported**
   1. Inadequate training
   2. Inadequate supervision
      ‘Blame culture’
Appendix 11  Extracts from the research log

14.08.2007  (Discussion with senior practitioner in the service)
X was interested in research, particularly from the angle of examining the impact of the wider service on staff. The two components (NHS and Social Services) of the LD service are being integrated, and people are unhappy about this and things are unsettled. X feels that this is partly because it’s created a lot of uncertainty about jobs (both role changes, and stability of job). X seemed to think that focusing more on the wider service would be helpful, suggested some of the problems experienced may be attributable to way services are set up.

17.9.2007  (Thoughts recorded when reading the literature)
Reading more journals, and many studies criticise Weiner’s model and say that it doesn’t seem to be reliable in its application in this field. This is concerning as I was intending to look at staff attributions and I don’t feel like I can justify using this model given the evidence against it. Even so, I still feel staff beliefs are important to look at, particularly in the wider context. Seems more sensible to focus more generally on ‘beliefs’ than ‘attributions’.

19.12.2007  (Thoughts recorded after second interview)
Interestingly, the focus of the interview again seemed to shift away from the vignette quite quickly, despite doing the CHABA first this time. Other staff were spoken about a lot, as were service issues. I’m wondering whether this may reflect the state of the service? Or a split between direct and indirect staff? Will be interesting to see if the theme persists.
Again, little emotion expressed in relation to vignette or when discussing work – only really in past tense i.e. when first started.

28.01.2008  (Thoughts recorded after seventh interview)
Again struck by how focus of the interviews shifted away from vignette. In the initial bit of interview X seemed to be in role – again wondering if this was because they did CHABA first? Lots of reflection as to why other staff may have different views, reflected on impact of culture and how people may just develop views almost to fit in with rest of team.
X seemed to be going through a hard time due to practice issues, so some emotion expressed, but still not as much as would expect. Seemed matter of fact in discussing this but also very assertive. Seemed aware of own responsibilities and limitations (coping?)

18.03.2008  (Thoughts recorded after twelfth interview)
Many of the same themes reoccurring again: other staff, the service, coping, narratives of LD also mentioned. Emotion to CB discussed in past tense. Feel like I’m reaching saturation point, though this may be due to interviewing mostly nurses recently. Interviewing someone from social services (social worker?) may provide different themes. Again spoke about transition to community and role being completely different – doing extra training to feel competent.

06.04.2008  (Thoughts recorded during initial stages of analysis)
List of codes seems too big, and a bit lacking in meaning. Seem a bit too descriptive, and don’t really do justice to the processes observed in interviews. Be careful when recoding to pay more attention to this and to try and capture the essence of the interviews more. Also need to cut down number of codes – so will have to collapse some.
Appendix 12  
Supporting Quotes

Theme one:  
Knowledge and training

2. Experience

Working in the community as well as residential services:
“… coming into the community it gives you a lot more opportunity to sort of expand yourself, you know, further training and stuff like that. Whereas in residential unfortunately, it should be the other way round, but in residential because you’re so busy caring for people you don’t often have that time, and there’s so many other pressures”  (Transcript 1, line 135)

Experience of other diagnoses:
“I think there’s only one experience that I had where we worked with somebody who’d got personality disorder who was, you know, difficult as people with personality disorders can be to manage”  (Transcript 3, line 291)

Knowing clients well:
“Because of the place I worked, I didn’t move from place to place, I mean there were certain people you worked with, and there were people I worked with for 8 or 9 years, and you got to know them really well, and it was sort of almost like, yes you’re caring for them but you know them fairly well, it’s almost like a friend, you know, they might see you as the nearest thing they have to family”  (Transcript 1, line 264)

3. Supervision

Reflection:
“I mean I can think back now about people that I was sort of helping to care for and was wondering what it was that was causing their behaviours and I can reflect back on it and think, well it was that, but I didn’t know at the time”. (Transcript 1, line 128)
Theme two: Emotional response

Example of first experience of CB

“I think I was quite petrified the first time, I mean one of my first placements where there was any challenging behaviour and I just wanted to run away, I didn’t want to be there at all, because you just feel so ill equipped to sort of deal with the situation.” (Transcript 13, line 446)

Self harm:

“I think it affects different things in people and I think the, getting the balance about what’s acceptable in order to stop this becomes very blurred because, you know, what’s better, that they, you know, what’s worse I suppose really, you know, what’s worse that they are able to do that to themselves or that I hold their hands or whatever to stop them doing it. Whereas I think when it’s directed towards somebody else, you know, there are other things you can do, you can duck, you can get out of the way, you can whatever, whereas if the person’s doing it to themselves you feel that that whole cycle is much harder to break into. So I think it is different in that respect.” (Transcript 5, line 771)

Seeing clients being poorly cared for:

“I don’t like to see people in that situation, it makes me feel ill” (Transcript 2, line 86)

1. Client Contact:

Perhaps if I had to you know directly manage that person when they’re slapping their face six times in a minute I might find it a bit harder. But I’m, I’m one step removed aren’t I? I suppose. You know, and I talk to carers and I’m thinking about one or two specific individuals and they’re saying ‘I could just cry’ or whatever and you think well I can understand how you might feel if you, you know because I suppose the other key thing about it is it’s the emotional attachment you have with that person really and I suspect when I was … delivering hands on care I had much more emotional attachment with erm the people that I was supporting than I probably do now, because you’re almost one step removed because you’re not delivering that direct care are you you’re just, yeah.” (Transcript 11, line 668)
Other diagnoses:

“But he’s defined as personality disorder, which is another problem area because supposedly there’s no treatment for personality disorder, but we’ve got such a lot of these people around” (Transcript 12, line 262)

Predictability:

“But it is those situations I think where I feel, you do feel vulnerable because you don’t know the person and you don’t know what they might do next” (Transcript 5, line 399)

Risk:

“I think most of it is the most of the stress with this kind of thing is about responsibility and risk and have you covered all the angles and have you got everybody involved and erm have you left anyone at risk” (Transcript 14, line 459)

2. Support
Availability of support:

“And I think it’s quite lonely sometimes as well working in the community, you know, it’s just you going in and trying to solve everybody’s problems and everybody’s relying on you, whereas at least residential you are in a team, it’s not just you and you have got, sort of, that back up and support. Although we do, you know, you can bring things back to the team, when you’re actually there and in it you’re on your own really so you have to just get on with it, it’s a bit scary sometimes.” (Transcript 13, line 141)

3. Knowledge of CB
Depersonalising CB:

“Just knowing that there are many many reasons for whatever this behaviour is and that, you know, not to take it personally as such, you know, it doesn’t actually mean they don’t like me, there could be 150 other things going on that could have been, you know all sorts of reasons why this person is behaving in this way” (Transcript 5, line 457)
Ability to predict and manage CB:
“I think I would have, some of the fear that you have is about the unknown, not knowing why someone is being like that and also just about fear of personal attack which does happen from time to time, but touch wood it hasn’t happened yet. But, so it’s about some sort of confidence that, you know, you can sense when somebody’s going to be aggressive” (Transcript 8, line 56)

Theme Three: Coping
2. Job role

Limitations of the role:
“I’m quite realistic about what I am capable of and what I’m not capable of so you know. You know I suppose I think well no-one’s got magic a magic wand anywhere really and you know I can see that you’re you know I can see that the carer is distressed, I can see that they’ve had you know no sleep for however long because they’re up all night banging about or whatever but, but there’s practical things we could do about that but you know like you could have respite you know three nights out of seven or something you know there there’s practical things that you can perhaps influence a bit of change with but I suppose I’m not somebody who would then take on all that carer’s angst, take it all on board and think I’ve got to worry about that and I’ve got to do you know you can do what you can do can’t you and, and that’s where it is.” (Transcript 11, line 578)

Varied caseload:
“I think another strategy can be to mix up your sort of case work if you can do that so that you’re not always working with the same kind of person, because too much of one thing, if you’re always working with someone with the label of personality disorder or borderline maybe, whether you call it that or you call it attachment issues, they’re very hard to work with and the dynamics of that are very hard to deal with I think because you can feel really rubbed. So if you’re always working with someone like that then I think that’s very difficult so you need good supervision, reflection and self awareness and all those things” (Transcript 8, line 475)
Experiencing successes:

“I’m not saying that, you know, it’s right that people have those attitudes, but, you know, perhaps you understand a bit more where they come from, you know, where mine has changed over the years, and also because I’ve seen so much success with people by putting some of the things that again, we know often aren’t rocket science, you know, and putting some of those things in place and changing environments and changing the way that you talk to somebody or getting communication systems in place have so much value for an individual”  (Transcript 3, line 146)

3. Support

Supervision:

“Oh yeah there’s supervision yeah, having said that supervision yes there’s always somebody to talk to and that’s nice. If you’ve got a problem or anything or something’s happened and you just want to like you know just have a talk and you know have a you know just in case something happened oh you should have done this like this you know just for somebody to turn round and say ‘yeah you’ve done everything fine that’s fine don’t worry don’t worry about it’. Yeah, or you know or somebody else is in the room and says ‘oh yeah that happens don’t worry about it that’s how you know he does it and he’s not taking anything personally out on you’, and so yes you get that and you get that support here and that’s quite good yeah”  (Transcript 10, line 498)

MDT working:

“I don’t think it’s always the answer just to have one discipline involved. Sometimes, just for maintenance when everything is sorted out, but I think when you’re initially working with people you can never have too many people involved really. Because, you know, somebody might be able to just provide what’s needed”.  (Transcript 13, line 295)

Service:

“Are you going to put energy into changing and doing it differently and learning new techniques and learning whatever, you know. You’ve got to be a very enthusiastic person in order to do that because you’ve got to do it, it feels like off your own bat in order to learn those things and take those things on board and change things. You’re
going to get paid the same amount of not very much money if you just stay the same and do the same and do it in the same old way you always have done. So, not much incentive to change. Fortunately there are very many people who are enthusiastic and have got their own motivation to improve things, but you can understand those who haven’t really. It definitely impacts on the change.”  (Transcript 5, line 670)

“Yeah you’ve only got to look at all the closures happening, how the staff feel now, they’re very very demotivated because of it, because they’ve got no idea what’s happening to them. If they know what’s happening they’d be able to focus spend the time focusing more on what they can do for everybody else rather than thinking what have I got to do for myself to protect myself.”  (Transcript 9, line 448)

4. Distance

Emotional:
“You’ve got to be able to put it in a compartment, go home and be a wife, a neighbour and not to let, it’s not that you can do it, but not let it drift into your personal life too much. But I think coping and being able to dig out the positives from anything helps you get through”  (Transcript, line 478)

Theme 4  Confidence
1. Knowledge and experience

Developing practices:
“If you’re working with patients you should always be open to in my opinion new ways of looking at things and new ways of working as it’s gonna help the patient and ultimately the health and safety of everyone who’s in the unit whether it’s other residents or whether it’s staff”  (Transcript 7, line 377)

Appropriate training:
I’m very practical, so if I’m taught practical skills I’m much more likely to, you know, remember them that I am somebody probably standing and, you know, spewing out from an OHP or PowerPoint all day, so, then again I think we lose that, you know, we don’t marry the two back in the areas, you know, we tend to take staff out and do a teaching session and then they go back and, you know, it’s about making sure that the theory practice gap’s closed really”  (Transcript 3, line 404)
“I think it’s a shame that more training isn’t more practical, because I think, especially as nurses, it’s a very practical profession, so, and I guess people are sort of scared off a bit. Especially because they’ve made so many courses, you know you have to do it at degree level now, which people don’t particularly want a full degree, they just want to learn something about a particular subject and increase their ability to work better with that group of people at that particular time”

(Transcript 13, line 362)

**Theme five Optimism**

2. **Staffs control over interventions and outcomes**

**Attitudes of other staff**

“I hate it when I hear people say that and implying not acceptable to behave like that. It just really grinds on me. But, and I think that’s around, I think that annoys me because when you hear that, that’s the staff really saying I’m not taking any responsibility for the way you’ve just behaved, and you just tell the person they can’t behave like that again. And I think to be an effective member of the staffing team you need to be able to look back at an incident and say what did I do and what was going on in the situation that contributed to that.”

(Transcript 6, line 562)

3. **Service factors**

**Staff feel unempowered:**

“I don’t know why people get stuck sometimes, but if they don’t see any need to change they won’t will they. Or if they don’t agree with it they won’t change, and sometimes I feel they’re so stressed everywhere. The last few years have been a terribly stressful time in the service, and if someone can’t cope or look after themselves, if they’re not being supported themselves, then they find it hard to support other people too.”

(Transcript 8, line 298)

**Staff feel unvalued:**

“Yeah you’ve only got to look at all the closures happening, how the staff feel now they're very very demotivated because of it because they’ve got no idea what’s happening to them. If they know what's happening they’d be able to focus spend the time focussing more on what they can do for everybody else rather than thinking what have I got to do for myself to protect myself. It’s a similar scenario it’s just if you
don’t know what’s going to happen to you how can you know manage somebody else.” (Transcript 9, line 448)

**Inadequate training provisions for staff:**
“A lot of patients I get are cared for by people who’ve not had very much experience or training or education, or been taught to care for people properly”
(Transcript 4, line 141)

**Inadequate service provisions for clients:**
“I think his service needs were very different to where he was placed personally. I mean we sometimes say there’s no such thing as challenging behaviour, it’s challenging the service and I utterly agree” (Transcript 2, line 580)

**Service depersonalising clients:**
Yeah and it does come across quite clearly when you speak to a manager who’s very concerned about the quality of the care and then another and then sometimes we’ll have conversations with managers and you just think we really are well you’re talking about money here” (Transcript 14, line 308)
The accompanying thesis submitted for fulfilment of the Doctorate in clinical Psychology titled ‘A qualitative analysis of the factors influencing staff beliefs about the challenging behaviour exhibited by adults with a learning disability’ is based on work conducted by the author in the Department of Clinical Psychology at the University of Leicester between September 2006 and July 2008.

All the work recorded in this thesis is original unless otherwise acknowledges in the text or by references.
The *British Journal of Clinical Psychology* publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

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