What challenges do staff in psychiatric inpatient settings face? The development of the Staff Emotions, Attributions, Challenges & Coping Scale (SEACCS)

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ABSTRACT

**Background:** Psychiatric inpatient staff members work with arguably the most challenging service users. However, reference to these challenges often does not go beyond ‘challenging behaviour’, offering no insight into the actual presentation, thus preventing formulation of the perceived challenges, or subsequent interventions. Moreover, studies have shown that staff responses to challenging presentations can impact on both the staff member and the service user. In particular, staff causal attributions have been shown to impact on their therapeutic response (Apel & Bar-Tal, 1996), as well as being associated with staff emotions (Colson et al., 1987). In turn, the emotional response has been found to be associated with coping, both of which have also been found to affect staff behavioural response, as well as staff members’ psychological well-being (Wykes & Whittington, 1998). However, there have been limited studies assessing these relationships with psychiatric inpatient staff. This may be due to the lack of assessment tools developed for this staff group to measure these particular domains. A specifically designed tool would enable consistent assessment to take place to build on our theoretical knowledge of psychiatric inpatient staff members’ perceived challenges, and their responses to them, as well as highlight specific areas within these domains where further staff training and support is required.

**Aims:** The first aim of the study was to explore psychiatric staff’s views on the challenges they faced when working with service users in inpatient settings, their emotional responses, attributions, and coping strategies about those challenges and then to develop a measure which would accurately capture these (the SEACCS). The second aim was to assess the reliability of the new scale as well as explore relationships within the SEACCS. Finally, the third aim was to assess content and face validity, as well as conduct preliminary psychometric investigations of the construct validity of the newly developed measure.

**Method:** The study was conducted using various methods across three phases. In order to generate items for the SEACCS, a systematic review of the relevant literature and semi-structured interviews took place during the first phase. Secondly, the results of Phase I were combined in order to develop and construct the SEACCS. The third phase involved a postal survey of the SEACCS (including re-test), followed by psychometric investigations to scrutinise the items, explore the reliability, and construct validity of the SEACCS.

**Results:** Twenty three studies were included in the systematic review. The results highlighted inconsistent measurement and findings of the domains concerned. Seven multi-disciplinary staff interviews took place. Thematic analysis was used to conduct four separate analyses focusing on each of the research questions. Several themes and sub-themes were found. Themes such as: ‘Engagement’, ‘Attributions of controllability’, and ‘Behavioural responses’. Findings from the review, thematic analyses, and consultation groups (content and face validity) were combined in order to develop the 64 item SEACCS. A total of 76 multi-disciplinary psychiatric inpatient staff members completed the SEACCS, 15 of which completed re-tests. No items were removed following item scrutiny assessments. Preliminary psychometric investigations indicated good reliability, significant relationships across domains within the SEACCS, and partial construct validity with the GHQ-28.

**Conclusion:** The results of the current study provide the first step in the development and construction of a clinically relevant tool that can be used to assess these domains. The methodological limitations and clinical implications are considered, and future directions for research in this area are suggested.
DECLARATION

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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CHAPTER ONE: INTRODUCTION

1.1 Overview

In order to develop a measure of psychiatric inpatient staff members’ experiences of working with a challenging client group, namely the Staff Attributions, Emotions, Challenges and Coping Scale (SEACCS), several research methods are employed across three conceptual phases. The introduction begins by outlining the definitions and concepts relating to psychiatric inpatients and staff’s perceptions of working with challenging presentations. An overview of the theory relating to each domain, namely challenges, attributions, emotional and coping responses is then provided, including the available literature exploring respective relationships. An outline of available measures follows a similar format, with a critique of their adequacy for the assessment of staff’s experiences in the four domains. The introduction then presents the rationale for developing the SEACCS measure, followed by an outline of the aims, objectives and design of the present study.

While the study rationale is outlined in this chapter, the main body of relevant literature is provided in Chapter Two, the systematic review.

1.2 Severe mental illness

1.2.1 Definition of severe mental illness

The National Service Framework (NSF) for Mental Health (Department of Health, 1999) differentiates between severe mental illness (SMI) and common mental health problems. Examples of SMI include schizophrenia, bipolar affective disorder, organic mental disorder (dementia) and severe anxiety disorders. More recently, the NSF stated that a SMI must comprise the following:

- A mental health disorder designated by a mental health professional, and either;
- A score of 4 (very severe problem) on at least one, or a score of 3 (moderate) on at least two of the Health of the Nation Outcomes Scales (HoNOS; Wing, et al., 1998) items 1 – 10 (excluding physical illness or disability problems) during the previous six months, or;
- A significant level of service usage over the past five years, shown by at least one of the following:
  - A total of six months in a psychiatric ward or day hospital
Three admissions to hospital
Six months of community psychiatric care involving the need for more than one worker.

The most common form of SMI in National Health Service (NHS) mental health services is psychosis.

1.2.2 Definition of psychosis

The term ‘psychosis’ refers to a mental state which involves a loss of contact with reality (Bentall, 2003). It may be characterised by positive symptoms such as disordered thinking, delusions and hallucinations, or negative symptoms such as apathy, social withdrawal, and flattened affect. Psychotic states occur within a variety of diagnostic disorders noted above, including schizophrenia, schizoaffective disorder, bipolar affective disorder, psychotic major depression, delusional disorder, and brief psychotic disorder (American Psychiatric Association, 1994). Although the utility and validity of diagnostic categories has been debated, (Bentall, 2003; Read, 2004) the existing literature on psychosis or SMI broadly relates to individuals diagnosed with schizophrenia.

1.2.3 Prevalence of SMI

In 2002, the Department of Health (DoH) reported that around 630,000 people in England and Wales were in contact with a specialist service for SMI. Often people who suffer from SMI require hospitalisation, with around 50,000 people under a Section of the Mental Health Act (1983) annually (DoH, 2002) as well as voluntary admissions.

1.2.4 SMI and psychiatric inpatient services

In modern mental health services, the preferred treatment setting has shifted from psychiatric hospitals to the community. In 1954, there were 154000 psychiatric inpatients in the UK. In 1961, the Hospital plan for England and Wales encouraged closure of large psychiatric hospitals and development of community services. By 1998 the number had fallen to 40000 inpatients. A new group of 'long-stay' service users remain in hospital, but the era of community care continues.

Although well intentioned, admission is restrictive. Paradoxically, the emphasis on community care has occurred in tandem with a greater use of coercion in hospital settings as only the most severe cases result in hospitalisation (Cleary, Hunt, Walter & Robertson, 2009).
Conditions on wards have been strongly criticised. In 1998, Ford, Durcan, Warner, Hardy, and Muijen reported that UK psychiatric inpatient wards were characterised by rapid staff turnover, extensive use of bank or agency staff, and low morale. More recently, these issues may have worsened. In 2008, the Mental Health Act Commission reported that busy acute wards ‘appear to be tougher and scarier places than we saw a decade ago’ (DoH, 2008). In this report, the Commission and nursing staff considered some staffing levels unsafe. Service users complained that staff shortages reduced opportunities for escorted leave and that it was difficult to develop rapport with ever-changing staff.

As the Commission highlighted, patients detained under Mental Health Act powers are in a different situation from other NHS in-patients as they have not agreed to admission, may not accept the need for admission, and cannot self-discharge from a ward they may find intolerable.

Another consequence of the emphasis on psychiatric community care has involved the focus of professional, political, managerial, and media attention on the consequences and alleged failures of community care rather than on inpatient services. Hence, service users and staff who remain in hospital may have become a relatively neglected group.

1.3 Challenging presentations

The shift of emphasis to community mental health care also implies that remaining or current psychiatric admissions display some of the most complex and challenging presentations. However, much of the literature on challenging presentations has focussed on people with intellectual disabilities. In this literature, challenging behaviour is defined as “‘culturally abnormal behaviour 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 use of, or result in the person being denied access to, ordinary community facilities’” (Emerson & Bromley, 1995). Severely challenging behaviour, “‘renders the individual liable to seriously injure her/himself or others and for whom appropriate services are difficult to find’” (Tarbuck & Thompson, 1995, p. 30). More recently, Emerson et al. (2001) added “socially unacceptable behaviour, such as sexually inappropriate behaviour.” However, these definitions focus primarily on the physical safety of service users and carers, whereas challenging presentations can include a magnitude of presentations perceived as challenging to the
individual or others. The term can have very different meanings and connotations depending on the service user’s presentation, needs, environment, and the resources available. Moreover, these definitions do not indicate the presentation’s function or more specifically, the function attributed by others.

The ‘challenging’ or ‘difficult’ service user is a commonly used term in psychiatric inpatient services, with the term “challenging behaviour” frequently used in staff meetings and written in clinical records. This usage seems to indicate a well-known or distinguished group of service users or presentations. However, challenging psychiatric inpatients are hard to describe and characterise as a group. To understand the causes of perceived challenges in order to reduce difficulty experienced by the service user or staff member, one would first need to establish the specific presentation. An early attempt to assess challenging characteristics among psychiatric in-patients with a SMI took place over 25 years ago (Colson et al., 1985), and led to the development of the Hospital Treatment Rating Scale (HTRS; Colson et al., 1985). Since then however, there have been few studies assessing the perceived challenging characteristics of this client group.

Although the terms ‘challenging’, ‘difficult’, and ‘challenging behaviour’ are often used in the literature, this study is only concerned with challenges perceived by psychiatric inpatient staff. The challenge may not necessarily involve behaviour, e.g. the service user may require a number of medications to be administered. Therefore, the term ‘challenging presentation’ will be used throughout this thesis to encompass all of the above terms.

1.3.1 Staff responses to challenging presentations

According to previous intellectual disabilities studies (Hastings, 2005; Lambrechts, Kuppens, & Maes, 2009; Lambrechts, Petry & Maes, 2008; Rose, Jones & Fletcher, 1998; Willner & Smith, 2008), staff attributions, emotions, and stress regarding challenging presentations can influence staff responses. For example, Oliver (1995) found that staff often respond to the demands of the immediate situation in ways that reduce the frequency, duration, and severity of challenging presentations. However, avoidance of short term consequences often leads to long-term reinforcement. Oliver (1995) described this relationship as dynamic, with cycles of reciprocal reinforcement. This illustrates how staff responses can contribute to the maintenance and possible increase of unwanted presentations, thus impacting further on staff-service user relationships.
The role of psychiatric inpatient staff has generated studies which acknowledge variability in the course and outcome of SMIs, with researchers seeking to identify possible carer factors which provoke or maintain challenging presentations, or indeed the illness. However, this research has mainly stemmed from familial carers of individuals with SMI or formal carers in intellectual disabilities studies. Therefore, studies investigating challenging presentations across SMI, particularly within inpatient settings, are lacking. Also, attributional, emotional, and coping responses may vary across types of challenging presentation (Colson, et al., 1986; Heresco-Levy, Ermilov, Gilsinsky, Lichtenstein & Blander, 1999; Rossberg & Friis, 2003). Considering these factors together, challenging presentations may not only impact upon staff responses to the service user and the delivery of care (e.g. Bromley & Emerson, 1995), but on the staff-service user relationship, the subsequent clinical outcome of the service user (e.g. Butzlaff & Hooley, 1998); and the psychological well-being of staff members (e.g. Duff, Redhead, Paxton, Iceton, & Rochester, 2006). The literature exploring these factors is introduced below, with further detail provided in the systematic review.

1.4 Attribution theory

Attribution theory views cognitive factors as significant components of an individual’s perception of the reality in which they live and act. According to Heider (1958), we look for causal explanations of happenings to predict future events. Brewin (1988) highlighted that causal explanations are particularly noticeable with unusual, unwanted or unpleasant events. Munton, Silvester, Stratton and Hanks (1999) reviewed the dimensions and definitions of attributions which may inform the development of causal beliefs. They proposed four attributional dimensions:

1. Internal-External
   Internal attributions locate the origin of the perceived cause within the individual.
   External attributions locate the origin outside the individual, in the surrounding environment.

2. Stable-Unstable
   Stable attributions relate to perceived causes that are unlikely to change over time or across environments. Unstable attributions refer to perceived causes for events occurring due to a temporary state.
3. Global-Specific

Global attributions refer to perceived causes which influence a wide range of environments and situations. Specific attributions are perceived to impact on discrete situations.

4. Controllable-Uncontrollable

Controllable attributions refer to perceptions of some personal influence over the cause, link or outcome. Uncontrollable attributions involve no perceived personal influence over the cause.

It may be anticipated that staff members caring for inpatients with SMI, prone to challenging presentations, may draw on such dimensional explanations to rationalise such experiences.

1.4.1 Associations between attributions and emotions

One of the most influential models of attribution theory was developed by Weiner (1980; 1985, 1986). Weiner (1980) suggested a temporal sequence of ‘attribution-emotion-action’ by drawing on the results of six studies exploring the relationship of causal attributions and emotions to judgements of help-giving. His theory proposed that helping behaviour was caused primarily by emotional reactions, such as sympathy and anger, which in the former case promoted the tendency to help or in the latter case, to reduce it. Moreover, Weiner stated that the primary determinant of emotional reactions were attributions of controllability. Thus, if a presentation is perceived as uncontrollable, it is more likely to result in a sympathetic response, which in turn increases the likelihood of helping behaviour.

Weiner then presented the influence of motivation (1985; 1986). This theory highlighted the importance of ‘stability’ in expectations of success or failure. Thus, if a challenging presentation is attributed to a stable cause, the individual may be less likely to help due to low expectations of the successfulness of intervention.

1.4.2 Alternative model of associations between attributions and emotions

As there is a notable lack of research in the area of attributions and emotional responses in the psychiatric inpatient literature, it is important to consider alternative models and theories which may offer insight and guidance, particularly for the development of a measure to explore these domains. An alternative model to Weiner (1980; 1985) is the
cognitive neo-associationistic model, initially developed by Berkowitz (1983). The model postulates that aversive stimulation (e.g. challenging presentation) produces a general negative affect, which in turn is associated with particular somatic, expressive, motor, and cognitive reactions. Thus, in contrast to attributional analysis which is sequential and causal, cognitive processing may occur in parallel with a particular emotional experience. According to Berkowitz & Heimer (1989), an individual’s reaction to a negative experience may be moderated by factors such as focusing attention on their emotions, awareness of the unpleasant consequences an aggressive / negative response may have for them, or indeed an awareness of the inappropriateness of their angry feelings in the situation. Berkowitz and Heimer (1989) have also claimed the possibility that experienced caregivers are likely to be more aware of their role and appropriate behaviour, which means they may activate control mechanisms which enables them to regulate the influence of their negative affect. In contrast to Weiner’s attribution model, it does not imply that there would be any difference to the staff member’s response, depending on controllability, internality or stability as in all cases, the initial inclination of all caregivers would be to respond negatively, with professional experience being the only moderating factor (Apel & Bar-Tal, 1996).

1.4.3 Associations of staff attributions and emotions

Several intellectual disability studies have supported Weiner’s model by investigating care staff attributions of challenging presentations and their emotional responses to it. For example, Dagnan, Trower, and Smith (1998) found that attributions of control were positively associated with negative emotions including; anger, disgust, anxiety, and depression. Similarly, Stanley and Standen (2000) found that lower levels of controllability were associated with increased positive affect and willingness to help. Hill and Dagnan (2002) found internal and stable attributions were associated with feelings of sympathy. However, Bailey, Hare, Hatton and Limb’s (2006) study did not provide support for Weiner’s model as they found no clear relationship between staff attributions, emotions and willingness to help.

Among the limited studies assessing psychiatric inpatient staff, Sharrock, Day, Quazi, and Brewin (1990) tested Weiner’s theory within a medium secure setting. Findings indicated that staff were less optimistic or likely to help when challenging presentations were perceived as internal, uncontrollable and stable. Although they found staff sympathy was negatively associated with controllability, in contrast to Weiner’s model, they did not find any association between emotional reactions and helping behaviour.
Apel and Bar-Tal’s (1996) explored Berkowitz and Heimer’s (1989) model by assessing staff responses to hypothetical service users’ violence. They found that when a service user’s presentation was perceived as uncontrollable, it elicited a more sympathetic and therapeutic response from staff members, thus providing evidence against Berkowitz & Heimer’s model, but providing further support for Weiner’s attributional model of helping behaviour.

Although Dagnan et al. (1998) and Stanley and Standen (2000) provided support for Weiner’s attribution model, the findings from Sharrock and colleagues (1990) and Bailey et al. (2006) suggest that Weiner’s (1980; 1985; 1986) theories do not apply to every situation, and clearly more research is required. The appropriateness of attribution theory may depend upon the specific presentation. Weiner’s attribution model was intended to apply to low-frequency behaviours (Weiner 1986), and may be less applicable to regular, frequent challenging presentations that staff members may experience and may habituate to (Sharrock et al., 1990; Wykes & Whittington, 1998). Alternatively, Wanless and Jahoda (2002) criticised Weiner’s linear model and proposed that staff may hold multiple attributions and emotions regarding challenging presentations. Another criticism of Weiner’s model is that it is too restrictive to explain the complexity of behaviours. Hence, differing temporal perspectives are overlooked as well as consideration of attributions as possible coping strategies (Cudre-Mauroux, 2010).

Considering the above findings, with the exception of Bailey et al.’s (2006) study, there appears to be consistent evidence of an association between staff attributions and emotional responses to challenging presentations. The inconsistent findings may be due to the study of different challenging presentations, or the lack of a shared definition of attributions and emotional responses. This inconsistency hinders valid comparisons of the findings.

**1.4.4 Associations of attributions and expressed emotion**

Expressed emotion (EE) originated from research investigating the association between clinical outcomes from SMI and service users’ relationships with close family members. The construct was developed by Brown, Carstairs & Topping (1958) and refers to expressed hostility, criticism, and emotional over-involvement of the caregiver towards the individual with SMI. Associations have been found between the role of attributions and expressed emotion (e.g. Brewin, 1994; Greenley, 1986). Within a psychiatric inpatient
setting, Barrowclough et al. (2001) found that increased negative feelings expressed by staff towards service users were associated with more challenging presentations; specifically, more frequent aggressive incidents displayed at follow-up. Moreover, staff attributions revealed a tendency to attribute greater controllability to the service users they felt more critical towards. Similar findings were reported by Moore, Ball & Kuipers (1992) who assessed day hospital staff. Both studies suggest that staff attributions significantly influence the therapeutic relationship (the behaviour of staff towards the service user and vice-versa) and the associated clinical outcome.

1.5 Staff emotional responses to challenging presentations

The studies above refer to a limited number of emotions in association with staff attributions. Thus, the full repertoire of emotions associated with challenging presentations and indeed attributional responses is unknown.

Much of the literature exploring the emotional responses of staff has been carried out in intellectual disability studies. Bromley and Emerson (1995) asked staff members in intellectual disability services about the emotional reactions experienced by themselves and colleagues. Staff reported feelings such as despair, annoyance, fear, and disgust in relation to episodes of challenging presentations. Hastings (1995) reported similar findings and also found different negative emotional responses evoked by different types of challenging presentation. In relation to psychiatric inpatient staff, Colson et al. (1986) reported similar findings, and a range of emotional responses have been found in the limited qualitative studies of this group, including feelings of anger, frustration, sadness and sympathy (Bowers, et al., 2006; Kindy, Peterson & Pakhurst, 2005; Sun, Long, Boore, & Tsao, 2006).

Individual emotions may be associated with different types of attributional and behavioural responses and ability to cope with challenging presentations. Hastings (2002) proposed that challenging presentations lead to daily negative emotional reactions by staff, which accumulated over time and impacted upon the well-being of staff as measured by stress and burnout. Therefore, staff emotional reactions to challenges are proposed to mediate the impact of challenging presentations on staff psychological well-being. Considering these findings, it is vital to identify which emotional responses staff experience.
1.5.1 Staff stress and burnout

Psychological or emotional exhaustion may lead to chronic stress, which can result in a negative shift in responses to others, oneself, and one’s achievements (Maslach, 1982). Therefore, increased levels of stress in the working environment can lead to staff ‘burnout’ where staff members have high levels of emotional exhaustion (Prosser et al., 1999). This can also result in feelings of frustration, ‘stuckness’, and dissatisfaction. In contrast, low levels of burnout and high rates of job satisfaction are associated with higher quality client care (Jenkins & Allen, 1998; Rowe & Sherlock, 2005). Stressed staff are less likely to interact with service users (Rose et al., 1998), indicating that staff stress is directly associated with the clinical outcome of service users. Research exploring negative emotions, including stress could be used to develop strategies to minimise them, in order to improve the well-being of staff members as well as the therapeutic relationship and clinical outcome of the service user.

1.6 Coping theories

Lazarus and Folkman (1984) have been very influential in the general coping literature, and therefore their theories will be the main focus of this section. They proposed that in order for a psychosocial situation to be stressful, it must be appraised as such. Thus, cognitive processes of appraisal are central in determining whether a situation is a challenge. Personal and environmental factors influence this primary appraisal, which then triggers the selection of coping processes. Problem-focused coping is directed at managing the problem, while emotion-focused coping processes are directed at managing the negative emotions.

Secondary appraisal refers to the evaluation of resources available to cope, and may alter the primary appraisal of stressfulness. Furthermore, coping is flexible in that the individual generally examines its effectiveness. If it is not considered effective, one will generally try further strategies (Lazarus & Folkman, 1984).

More recently, Folkman, Lazarus, Dunkel-Schetter, DeLongis and Gruen (1986) expanded on this theory by distinguishing eight groups of coping strategies: ‘confrontive coping’ (aggressive efforts to alter the situation); ‘distancing’ ‘self-controlling’ (to regulate one’s feelings and actions); ‘seeking social support’; ‘accepting responsibility’ ‘escape/avoidance’; ‘planful problem-solving’; and ‘positive reappraisal’ (focus on personal growth).
Carver, Scheier, and Weintraub (1989) criticised Lazarus & Folkman’s (1984) and Folkman et al.’s (1986) theories, as being too simplistic. They stated that problem and emotion-focused coping functions have to be further distinguished between ‘trait coping’ (dispositional) and ‘state coping’ (situational). To address these issues, Carver and colleagues developed diverse scales and formed the COPE inventory, details of which are provided in Section 1.7.4.

1.6.1 Staff coping strategies associated with challenging presentations

Staff coping strategies and styles have been explored in staff stress research focused on services for people with intellectual disabilities and general nursing literature, but there is a dearth of research in psychiatric inpatient settings. Resultantly, most of the findings outlined below are based on intellectual disability services.

Hastings (1995) interviewed 19 staff members working in units for adults with intellectual disabilities. Staff reported three challenging presentation-related coping strategies: detachment, support from other people, and taking time out (including using sickness and other forms of leave to regain energy).

The coping strategies of psychiatric inpatient nurses following a violent incident were assessed by Whittington and Wykes (1994). They found that all the coping strategies described by Folkman (1986) were reported, with the exception of positive reappraisal and accepting responsibility.

With the use of the situational format COPE inventory (Carver et al., 1989) of different coping strategies, Mitchell and Hastings (2002) found that staff in intellectual disabilities services used various coping methods related to aggressive presentations, including: adaptive strategies, denial, and disengagement. The latter was found to predict emotional exhaustion and less positive feelings of personal accomplishment. These findings seem to indicate that individual coping mechanisms in response to challenging presentations can directly affect the psychological well-being of staff.

Hill and Dagnan (2002) were the first to explore staff coping styles in addition to attributional, emotional, and helping responses. Assessing staff working with individuals with intellectual disabilities, their findings indicated a positive relationship between practical problem solving and the likelihood of offering effort in helping. Similarly,
Hastings (2002) found that a depersonalising attitude led to depersonalising treatment of clients and that emotional exhaustion resulted in general avoidance of interaction. This lends support to the idea that the staff emotional reactions to challenges influence the level of care service users receive. These findings highlight the importance of the assessment of staff coping, not only due its association with staff well-being but for its relationship with the care and the subsequent clinical outcome of the service user.

Bonner, Lowe, Rawcliffe and Wellman (2002) found that psychiatric inpatient staff reported that social and practical support were useful coping strategies. Similarly, Howard and Hegarty (2003) found that the staff team could be a valuable source of support following a violent incident on inpatient wards for individuals with intellectual disabilities and SMIs. However, if the team support was ineffective, this was a major source of frustration and anger. It was proposed that if staff received peer support and were able to express their emotions, they became more committed to their role during subsequent incidents. The reverse was found if the support was absent or ineffective.

Hastings and Brown (2002) found that increased behavioural knowledge can lead to less reported depression and anger in relation to challenging presentations, and reduced emotional response immediately following an incident. It has been proposed that training in the phenomenology of mental illness and challenging presentations helps reduce the likelihood of burnout, and that further training on managing challenging behaviour, counselling skills, or anger management may also be helpful (Chung & Corbett, 1998).

Only one study has assessed the relationship of staff behavioural knowledge across staff attributions, emotions and confidence in their work in a psychiatric inpatient setting (Berry, Barrowclough & Wearden, 2009). Berry et al. (2009) implemented a pilot training programme based on psychological formulations of service users’ difficulties with psychosis, and assessed the differences of staff attributions before and after this programme. They found a significant increase in staff attributions of the degree of control service users and themselves had over problems, an increase in the degree of effort they felt service users were making in coping, reductions in blame, and more optimism about treatment. Staff also reported an increase in understanding of service users’ problems, more positive feelings towards service users, and an increase in confidence in their work. Although a pilot study, it highlighted the relationship between these domains and the
importance of identifying and measuring what these actually are, in order to indicate how they can be positively modified through staff training.

1.7 Measures used to assess staff perceived challenging presentations, attributional, emotional and coping responses

In order to explore the four topic domains, various forms of assessment (such as hypothetical vignettes, observational studies, self-report and informant questionnaires, and exploratory semi structured interviews) and designs (including; cross sectional, longitudinal, experimental, retrospective and prospective studies) have been employed. The most prominent instruments and methods of assessment in care staff are summarised below. Measures specifically applied to psychiatric inpatient staff members are referred to in more detail in Chapter two.

1.7.1 Measures assessing challenging presentations of psychiatric inpatients

The Nurses’ Observation Scale for Inpatient Evaluation (NOSIE; Honigfeld & Klett, 1965) is a 30 item self-report scale completed by inpatient nurses, based on a psychiatric service user’s ward behaviour. The NOSIE was designed to measure change in long-stay SMI service users by recording the frequency of 30 designated behaviours during the previous three days on a Likert scale. This measure does not assess how challenging the behaviours are perceived by the nurse.

Colson et al. (1985) developed the 25 item self-report Hospital Treatment Rating Scale (HTRS) using multi-disciplinary staff members. This tool was designed to assess the perceived challenges in terms of treatment difficulty.

Due to the lack of validated measures, other studies have also developed their own questionnaires to assess perceived challenging presentations (e.g. Modestin, Greub, & Brenner, 1986).

Alongside qualitative semi-structured interviews (Gallop & Wynn, 1987) and the use of clinical records (Allen et al., 1986; Colson et al., 1986; Modestin, et al. 1986), the measures above appear to be the only tools assessing challenging presentations. None are validated and only one evidenced acceptable reliability. Several measures have also been used to assess specific aspects of pre-determined challenging presentations. For example, aggression (e.g. Overt Aggression Scale; Silver & Yudofsky, 1991); anger (e.g. Ward
Anger Rating Scale; Novaco, 1994); and social functioning and behaviour (e.g. Social Behaviour Scale; Wykes & Sturt, 1986: Social Functioning Scale; Birchwood, Smith, Cochrane, Wetton, & Copestake, 1990: Social Behaviour Assessment Schedule; Platt, Weyman, Hirsch & Hewett, 1980).

1.7.2 Measures assessing staff attributions

Sharrock et al. (1990) was the first to assess staff attributions of challenging presentations in a psychiatric inpatient setting using a modified version of the Attributional Style Questionnaire (ASQ; Peterson et al., 1982; Peterson & Villanova, 1988). Staff members rated 14 challenging presentations on Likert scales of internality, stability, controllability, and global-specific.

The Challenging Behaviour Attributions Scale (CHABA; Hastings, 1997) was designed to assess attributions by care staff of challenging behaviour. Staff rated the relevance of 33 items across six sub-scales of causal models of challenging behaviour: learned positive, learned negative, biomedical, emotional, stimulation, and physical environment.

The Challenging Behaviour Perception Questionnaire (CBPQ; Williams & Rose, 2007) is a self-report scale developed from the Illness Perception Questionnaire (Weinman, Petrie, Moss-Morris & Horne, 1996). Staff rate their perceptions of challenging presentations and their emotional responses. However, both the CHABA and the CBPQ were specifically developed for the use in intellectual disabilities services. Therefore, the challenges referred to and the attributions assessed are unlikely to be suitable for psychiatric inpatient staff.

Vignettes describing hypothetical service users and challenging presentations have been used to assess care staff attributions in psychiatric inpatient settings (e.g. Apel & Bar-Tal, 1996) and intellectual disability services (e.g. Hastings & Remington, 1995; Hill & Dagnan, 2002)

Instead of assessing attributions based on hypothetical situations, the Leeds Attributions Coding System (LACS; Stratton, Munton, Hanks, Heard, & Davidson, 1986) has been used in psychiatric inpatient studies (e.g. Barrowclough et al., 2001). The LACS extracts attributions from the speech of participants discussing their own experiences. Attributions are then rated for internality, universality, controllability, and stability. As participants are
speaking about their own lives, the attributions are considered to be more meaningful and more closely mirror the participant's real-life attributional patterns.

1.7.3 Measures assessing staff emotional response and stress

The Emotional Reactions to Challenging Behaviour Scale (Mitchell & Hastings, 1998) was developed to assess the emotional responses to aggressive challenging presentations of staff working in intellectual disability services. Staff rated the frequency of their experience of 15 negative emotions on a Likert scale. Two sub-scales indicate ‘Feelings of Fear/Anxiety’ and ‘Feelings of Depression/Anger’. Jones and Hastings (2003) later added positive emotions.

The Feelings Word Checklist-58 (FWC-58; Rossberg, Hoffart & Friis, 2003) is a self-report measure of staff emotional reactions towards challenging service users rated on a Likert scale. The FWC-58 was adapted from the general Feelings Word Checklist (FWC; McWhyte, Constantopoulos & Bevans, 1982) to include items, such as “being invaded” and “devalued”, which experienced therapists found were lacking in the original FWC.

More studies have focused specifically on the assessment of psychiatric inpatient staff stress and burnout rather than investigating actual emotional responses to challenging presentations. However, as noted above, constant experience of negative emotions may lead to emotional exhaustion – staff burnout (Hastings, 2002), indicating the importance of both factors. The Maslach Burnout Inventory (Maslach & Jackson, 1986) is generally recognised as the most valid and reliable measure of occupational burnout syndrome (Schaufeli, Enzman & Girault, 1993). It contains three sub-scales including: Emotional Exhaustion, Depersonalisation, and Personal Accomplishment.

Several studies have also used the self-report General Health Questionnaire-28 (GHQ-28; Goldberg & Williams, 1988), which is one of the most widely used, reliable, and valid psychiatric screening measures worldwide (Bowling, 1995). Although the GHQ-28 is a general measure, several studies have used it to assess psychiatric inpatient staff distress (e.g. Carpenter, Ring, Sangster, Cambridge & Hatzidimitriadou, 2000; Carson et al., 1999a; Fagin et al., 1996; Wykes & Whittington, 1998). Further details on the GHQ-28 are outlined in Section 5.2.2.2.
1.7.4 Measures assessing staff coping response

Folkman & Lazarus (1988) used the eight coping strategies reported in Folkman et al.’s (1986) study above to develop the 60 item self-report Ways of Coping Questionnaire (WCQ). This measure has been criticised as these categories are only loosely related to the two basic coping functions: emotion-focused and problem-focused (Carver et al., 1989). Parker and Endler (1992) also noted one of the difficulties with the instrument was that the number of extracted factors changed from sample to sample or from stressor to stressor. They reported that this seemed to be a general problem with most coping measures, suggesting that coping measures should perhaps be tailored to the sample and situational factors.

A shortened version of the WCQ was developed by Hatton and Emerson (1994). The Shortened Ways of Coping–Revised Questionnaire (SWC–R) is a 14-item version of the questionnaire designed to measure the two, largely independent, coping styles of ‘practical coping’ and ‘wishful thinking’.

The COPE inventory developed by Carver et al. (1989) subdivides problem-focused and emotion-focused coping functions and distinguishes between ‘trait coping’ (dispositional) and ‘state coping’ (situational). There are 13 scales of four strategies, such as: ‘Active coping’, ‘Planning’, and ‘Suppression of competing activities’.

Although the WCQ, SWC-R and the COPE inventory have been used to assess care staff coping strategies, they are however general measures. One coping measure has been developed specifically for ward based psychiatric staff members, the DeVillers Carson Leary Stress Scale (DCL; Carson et al., 1996a). The DCL is a 30 item self-report measure.

1.7.5 Adequacy of existing methods of assessment of staff perceived challenging presentations, attributional, emotional and coping responses

The evidence presented above suggests that there are a range of presentations that staff members may perceive as challenging. Furthermore there seems to be a range of attributions that may determine staff perceptions of the causes of these presentations, as well as leading to different emotional and coping responses. However, there does not appear to be any studies assessing all of these relationships with one another. One possible exception may be the study by Hill & Dagnan (2002) who assessed attributions, emotions and coping responses of intellectual disability staff. However, this was based on general challenging presentations only. Crucially, as the evidence above indicates, there are very
few measures which have been developed specifically for ward based psychiatric staff. 

Most of the studies assessing these domains have been conducted and designed for 
intellectual disability services. Although, there will undoubtedly be parallels of 
experiences among these samples, those measures would not be appropriate for inpatient 
staff as they are not based on their actual experiences. For example, the term ‘challenging 
presentations’ can have very different meanings and connotations depending on the service 
user’s needs, environment, and the resources available.

Also, the lack of consistency of measurement makes it very difficult to draw comparisons 
between studies. For example, although the WCQ and the COPE are two of the most 
widely used instruments in the field of coping (Schwarzer & Schwarzer, 1996), and it 
could be argued that they share similarities; there are however, many significant 
differences. Therefore, the use of both measures on the same sample could produce 
significantly different results. This indicates that there is a need for consistency among 
these measures, as well as a need for the development of a meaningful measure relevant to 
the sample, in order for results to be comparable and to expand on our theoretical 
knowledge of the experience and responses of psychiatric inpatient staff.

Most of the studies investigating any of the four domains of inpatient staff have used 
qualitative methods. This may be due to the fact that this method may lend itself to more 
exploratory investigations. However, the nature of this environment including; staff 
shortages, staff turnover, and ‘over-worked’ staff, suggests that the use of often timely 
interviews may not be appropriate, not just from a research point of view but from a 
clinical perspective. It would therefore seem more viable for a scale to be developed and 
used for both research and clinical purposes.

1.8 Study rationale

There appear to be relationships between the four domains which impact upon the 
behavioural response of staff towards service users, and in turn, upon the clinical outcome 
of the service user, and the psychological well-being of staff. Considering these 
relationships, a positive feedback loop appears to operate where the challenging 
presentations of service users impacts on staff, barriers to effective management of 
challenging presentations are created, and the situation is perpetuated.
To date, the four domains have not been assessed together with psychiatric inpatient staff. Inquiry is needed on the context of the workplace and the day-to-day responses staff make regarding service users’ challenging presentations. Therefore, these domains need to be explored to establish what this samples’ actual experience of these domains are and to explore the relationships across the domains. This is crucial in order to find meaningful ways of altering staff responses, to reduce the negative impact of both the clinical outcome and staff well-being. Indeed, behavioural interventions based solely around the needs of the service user may be ineffective. The attitudes and attributions of staff members should also be considered to help them remain optimistic about service users’ progress, to process their emotional experiences, and to develop more useful coping strategies.

The lack of a single assessment investigating all four domains has resulted in various tools being used across different studies often assessing individual domains, in particular the actual types of perceived challenging presentations. The development of one measure assessing all four domains would ensure that all factors were considered, rather than at best, one to three of them. Moreover, the holistic approach advocated above addresses research purposes as well as clinical purposes to explore the interplay between the four domains. The SEACCS measure, which will be specifically designed from the investigation of ward based psychiatric staff experiences, will hopefully offer a meaningful tool that is quick to administer and re-administer to assess change, and more likely to be administered in a busy inpatient environment.

1.9 Aims and objectives

1.9.1 Aims

The first aim of the study was to develop a meaningful population-specific measure in order to assess:

- What are the challenges service users present with perceived by psychiatric inpatient staff?
- What are staff members’ attributions regarding these challenging presentations?
- What are the emotional responses associated with the challenging presentations?
- What are the coping responses associated with these challenging presentations?
The second aim of the study was to carry out preliminary psychometric investigations of the newly developed measure, including test re-test reliability. The working title of this measure, used throughout this thesis, was the SEACCS.

The SEACCS measure was intended to be self-administered, based on staff members’ own ratings of their experience of challenging presentations, quick, and easy to complete. It was hoped that it would be more clinically relevant than the general tools based on individual domains or tools designed for other populations. It was not intended that the measure would be used as a full assessment of staff experiences and responses in relation to challenging presentations, but as a screen of the challenges experienced, their perceived severity, and the attributional, emotional, and coping response associated with these challenges. The intention was to identify issues for further assessment as well as aid behavioural interventions regarding challenging presentations and staff training and support where required. It was also anticipated that the SEACCS could monitor change over time, and it was hoped that it would be possible to easily adapt the measure for the assessment of staff experiences of general service user presentations or individual service user presentations.

The aims of the study were to be achieved by meeting a number of objectives informed by guidance regarding the methodological issues related to the development of measurement scales. However, it was recognised that addressing all of these issues was beyond the scope of the current study, which would provide only preliminary evidence regarding the psychometric properties of the SEACCS measure. Therefore, cross-cultural issues or all aspects of validity would not be addressed.

1.9.2 Objectives

The following objectives were set to achieve the study’s first aim:

- A systematic review of the available literature of perceived challenging presentations, attributions, emotions, and coping responses among psychiatric inpatient staff members will inform the development of the SEACCS.
- Qualitative interviews of multi-disciplinary psychiatric inpatient staff members to inform the item generation, as well as discussion groups with staff to assess the face and content validity of the items.
- Statistical methods as well as clinical judgement to select items for the SEACCS
The following objectives were set to achieve the study’s second aim:

- Examination of the relationships between the SEACCS and demographic and clinical variables. Hypotheses regarding the SEACCS ability to discriminate between staff groups were not made due to methodological difficulties inherent in defining ‘known groups’ (Streiner & Norman, 2003).
- Reliability of the four domains in the SEACCS, internal consistency of the scale / sub-scales would be assessed and test-retest analysis would be carried out.
- As well as face and content validity, construct validity of the SEACCS would also be investigated. It is predicted that all four domains would be associated with staff distress. Therefore, exploration of how the SEACCS relates to a well-defined measure of psychiatric distress would occur.

1.10 Study design

The study employed a mixed design, incorporating both qualitative and quantitative methods. Qualitatively, an interview based, thematic analysis design was used. Quantitatively, a cross-sectional, correlational design was used. The methodology involved a number of stages in three phases outlined below and in Figure 1.

**Phase I – Initial development of SEACCS**

The first phase of the study was divided into two stages. Firstly, a systematic review was carried out for the purpose of identifying key themes which might relate to scale items. This involved reviewing and appraising the relevant literature. The final stage of the first phase involved carrying out qualitative interviews with psychiatric staff in order to generate themes relating to the four areas.

**Phase II – Further development of SEACCS**

During the second phase, qualitative data / themes generated from the interviews were combined with the results from the systematic review in order to generate a pool of possible items. These items were then reduced in number, put into questionnaire format, and pre-tested by consultation group and individual interviews, both involving mental health workers trained and experienced in working in a psychiatric inpatient environment. This resulted in the assessment of the preliminary content and face validity of the draft measure.
**Phase III – Postal survey & preliminary psychometric investigations**

Following the collection of data from postal surveys, the third phase involved selection of items for the final version of the instrument. In addition, the re-test data was employed to complete preliminary investigations of reliability for the new measure, and construct validity was explored alongside a common measure of psychiatric distress.

**Figure 1: Study design**

<table>
<thead>
<tr>
<th>Phase I: Initial Development</th>
<th>Systematic Review</th>
<th>Interviews</th>
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<tr>
<td>Phase II: Further Development</td>
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<tr>
<td>Phase III: Postal survey &amp; Preliminary psychometric investigations</td>
<td>Item generation</td>
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<td>↓ Item reduction</td>
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<td></td>
<td>↓ Questionnaire construction</td>
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<td></td>
<td>↓ Content &amp; face validity</td>
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<td></td>
<td>↓ Questionnaire distribution</td>
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<td></td>
<td>↓ Reliability</td>
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<tr>
<td></td>
<td>↓ Construct validity</td>
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</tbody>
</table>

**1.11 Thesis structure**

Following much consideration, the layout of the thesis is as such in order to produce clarity to the reader of the processes involved in each stage of the study. The method, results, and discussion of each stage of the study are placed in individual chapters.

**1.12 Ethical considerations**

The study gained ethical approval from The University of Manchester Committee on the Ethics of Research on Human Beings and a local NHS Research Ethics Committee. The study also gained approval from two NHS Trust Research and Development (R&D) departments. An application to a third NHS Trust R&D department was submitted, and
declined. This committee stated that the study was scientifically sound but that the number of participants required could be obtained from the first two Trusts alone. However, they did add that this decision would be re-considered should there be any recruitment difficulties with the first two Trusts.
CHAPTER TWO

Phase I, Stage I – Systematic review

This chapter begins by outlining the aims and objectives of the systematic review (see Chapter One for introduction and rationale), including a definition of terms. Following a description of the method, the results are presented, which detail the measures and key findings under each of the four outcomes, as derived from the four objectives below. Finally, the results and methodological consideration of the review are discussed.

2.1 Aims and objectives

The aims and objectives of this review are to present the best available evidence of challenging adult psychiatric inpatients on:

- Characteristics of challenging psychiatric inpatients i.e. what makes a psychiatric inpatient be described by staff as ‘challenging’?
- Staff attributions of those challenges described
- Staff emotional reaction associated with challenging service users
- Staff coping responses associated with the emotional reaction of challenging service users

2.2 Definition of terms

Psychiatric inpatient services include acute psychiatric wards, long stay psychiatric wards, forensic unit, and rehabilitation units. Clients admitted to these wards suffer from a SMI. Most of these clients suffer from a psychotic disorder (schizophrenia, schizoaffective disorder) or personality disorder (mainly borderline personality disorder). Clients also suffer from affective disorders including bipolar disorder and major mood disorder.

2.3 Method

2.3.1 Types of participants

The review considered studies which included adult psychiatric inpatients (18-65 years) who had a SMI, which included one or more of the following diagnoses: a psychotic disorder, including schizophrenia and schizoaffective disorder; personality disorder; affective disorder, including bipolar disorder and major depressive disorder; and eating
disorder. Studies which included staff members who worked in adult psychiatric inpatient services (18-65 years) caring for inpatients with the aforementioned diagnoses, were also considered.

2.3.2 Guidance materials

The researcher familiarised herself with available guidelines for conducting a systematic review, using the Centre for Reviews and Dissemination’s (CRD) guidance for undertaking reviews in health care handbook (CRD, 2009) and the Joanna Briggs Institute (JBI) Researchers’ Manual (JBI, 2008).

Methods for compiling the results of qualitative studies for systematic reviews are relatively new and limited (Khan, ter Riet, Glanville, Sowden, & Kleijnen, 2001; CRD, 2009). Therefore, eligibility forms were generated to verify quantitative studies (Appendix 1) and qualitative studies (Appendix 2). These forms were generated by the researcher using guidelines from the CRD handbook (2009) and JBI Researchers’ Manual (JBI, 2008). It was agreed amongst the research team that if one inclusion / exclusion criteria item was not verified, eligibility judgements were agreed upon independently by the research team.

2.3.3 Search materials

2.3.3.1 Review topics

Topics of interest for the systematic review were grouped into four key areas:

- Characteristics / descriptions of challenging patients
- Staff attributions towards patients’ described as challenging
- Staff emotional responses
- Staff coping responses

Each of the outcomes had one or more specific outcomes or sub-areas which are presented in the results section.

2.3.3.2 Inclusion & Exclusion criteria

2.3.3.2.1 Inclusion criteria

Search criteria were developed and refined by the researcher and her two supervisors in order to avoid the selection of studies according to whether their results reflect a favoured
conclusion (CRD Handbook, 2009). Strict adherence to the criteria had to be met in order to focus on the research aims and to encapsulate all of the relevant literature available. However, the inclusion criteria were further refined during the search process due to the lack of relevant studies initially obtained. For example, the original search period between 1990 and 2009 was backdated to 1980.

2.3.3.2.2 Rationale for inclusion of qualitative studies

There is growing interest in the contribution of qualitative research findings to the assessment of healthcare effectiveness (Murphy, Dingwall, Greatbatch, Parker & Watson, 1998). As a result, qualitative and quantitative methods are increasingly being used together in primary evaluative research (CRD, 2009 pg 222). Due to the usefulness of both methods and the small number of solely quantitative designs found, it was agreed among the research team that both types of studies would be included.

It has been suggested that a systematic review containing staff and / or patient views should not exclude studies on the basis of methodological design unless they are deemed impossible to understand (Bee et al., 2008). Qualitative research is concerned with the subjective world. It offers insight into social, emotional, and experiential phenomena in health care to determine the what, how and why (Giacomini & Cook, 2000). Qualitative studies can enhance the quality and salience of systematic reviews. Such findings may aid definition of outcomes and contribute to the choice of outcome measures (e.g. Bee et al., 2008). However, the science of incorporating qualitative research within systematic reviews of effectiveness is still in its infancy. Therefore, it is essential to obtain specific advice about these issues from an expert, in this case from academic supervisors, a Research Fellow (see Section 3.5.3) with experience of incorporating both methods, and reference to the CRD Handbook (2009, pp.219-238).

2.3.3.2.3 Exclusion criteria

Exclusion criteria comprised studies which were: published before 1980; non-English language; involved patients and / or staff who were not in adult psychiatric inpatient settings, including: community mental health settings, child and adolescent psychiatric inpatient settings, inpatients with intellectual disabilities, neuropsychological inpatient settings, and specialist units aimed to treat one diagnosis, for example, eating or personality disorder units.
2.3.3.3 Electronic searches

In order to ensure the appropriate methods were used to obtain the optimum search results, the researcher received training from an electronic database specialist at the University of Manchester library for all the electronic search engines employed, namely: PSYCINFO, MEDLINE, EMBASE, PUBMED, AMED, CINAHL, and Cochrane DSR between 1980 and 2009 inclusive.

2.4 Procedure

2.4.1 Electronic search sets

Please see Table 1 below for the terms related to each search set.

**Table 1: List of terms for each search set**

<table>
<thead>
<tr>
<th>1st Psychiatric inpatients</th>
<th>2nd Challenging inpatients</th>
<th>3rd Staff attributions</th>
<th>Staff emotional and coping reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric units</td>
<td>Client characteristics</td>
<td>Health personnel attitudes</td>
<td>Occupational stress</td>
</tr>
<tr>
<td>Psychiatric patients</td>
<td>Difficult patient</td>
<td>Mental health personnel</td>
<td>Stress reactions</td>
</tr>
<tr>
<td>Psychiatric inpatient</td>
<td>Difficult client</td>
<td>Psychiatric hospital staff</td>
<td>Stress management</td>
</tr>
<tr>
<td>Psychosis</td>
<td>Behaviour problems</td>
<td>Nurses</td>
<td>Staff stress</td>
</tr>
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<td>Psychoses</td>
<td>Challenging behaviour</td>
<td>Staff attributions</td>
<td>Distress</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Challenging client</td>
<td>Therapeutic alliance</td>
<td>Stress reactions</td>
</tr>
<tr>
<td>Severe and enduring mental illness</td>
<td>Difficult behaviour</td>
<td>Staff-patient relationship</td>
<td>Stress management</td>
</tr>
<tr>
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<td>Nurse-patient relationship</td>
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<td>Staff burn-out</td>
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<td>Distress</td>
<td>Staff morale</td>
</tr>
<tr>
<td>Problem client</td>
<td>Staff views</td>
<td>Emotional states</td>
<td>Confidence</td>
</tr>
<tr>
<td>Staff challenges</td>
<td>Staff appraisal</td>
<td>Emotional responses</td>
<td>Overcome difficulties</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Coping strategies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Staff expressed emotion</td>
</tr>
</tbody>
</table>
Individual search terms were always linked with the ‘OR’ instruction and ‘Map terms to Subject Heading’ (MeSH) was used to search for related terms. The ‘AND’ instruction was used to link search sets together and the exclusion of duplicates option was applied. The search terms were noted in the abstract in order for them to be included.

Search sets one to three were used to review all outcomes of the review. The fourth search set was included to review the emotional and coping responses of staff.

2.4.2 Non-electronic searches

Reference lists and bibliographies of retrieved articles were reviewed to identify further studies. Whenever there was uncertainty around study design, unsuccessful attempts were made to contact the authors of six studies to clarify design.10-14, 18

2.4.3 Search results

The search produced 299 articles. Inclusion / exclusion criteria was applied to the references, abstracts and where necessary, the full text. Decisions to include a publication for appraisal were made independently by the researcher following evaluation of the full text of all retrieved papers. Any uncertainty was resolved by addressing the criteria forms for both qualitative and quantitative studies and by consultation with both of the researchers’ supervisors.

To the researcher’s knowledge, there have been no systematic reviews based on challenging service users in the psychiatric inpatient setting. Koekkoek, Van Meijel, Hutschemaekers, (2006) undertook a systematic review of the literature on challenging service users in the general mental health setting. Moreover, this focused on general explanations (not necessarily attributed by staff) of challenging service users and the therapeutic intervention, rather than staff attributions or emotional reaction.

2.4.4 Data synthesis

Data was sub-classified according to the review topics outlined above. Following respective quantitative and qualitative analysis within each category, the results were integrated into a single narrative synthesis aimed at answering the study objectives. Due to heterogeneity in study design and review topics, a formal meta-analysis was not performed. All qualitative data were extracted and presented according to the primary study’s reporting framework; this descriptive was used to identify prominent themes, the
results of which were then used to generate items for the SEACCS scale, as described in Chapter four.

2.5 Results

2.5.1 Overview of studies

Over 85% of the 299 studies did not meet initial criteria; leaving 41 studies. Twelve of these did not fulfil criteria on the eligibility forms. The researcher was uncertain about seven of the remaining 27 articles; consensus was reached with the researcher and her supervisors that three of those should be included. An example of one of the four studies excluded at this point was a study assessing challenging presentations and expressed emotion (Heresco-Levy et al., 1999). Although types of challenges were investigated, and thus relevant to this review, those characteristics were only identified as challenging in terms of their associations with staff expressed emotions, and therefore were deemed unsuitable for this review. The final number of articles that met inclusion criteria was 23. All included studies are presented in Appendix 3, with a summary of the measures employed and key findings. Quantitative (N = 15), qualitative (N = 5), and combined method studies (N = 4) are referenced numerically in the review. Nine of the research studies were carried out in the UK,1-9 eight in the USA,10-17 and single studies from: Canada;18 Israel;19 Norway;20 Switzerland;21 Australia;22 and Taiwan.23 As indicated, the majority of the studies took place in Western cultures which may affect their generalisation.

2.5.2 Methodological findings

2.5.2.1 Quantitative studies

2.5.2.1.1 Design features

The majority of quantitative studies employed a cross-sectional design (N= 12); a common criticism of this design is that it lacks evidence for the continuing existence of the concepts measured. These designs also used statistics of association, for example correlation or regression analyses, which cannot determine cause and effect relationships. Two studies used quasi-experimental designs,6 16 one of which used within and between subjects design.6 One study used a case control design.21 Although this design requires few participants which increases the availability of resources for each participant, a major drawback is exposure to both sampling bias and observation and recall bias (Mann, 2003).
2.5.2.1.2 Demographic features

Eight of the quantitative studies were multi-site.\textsuperscript{6, 10, 11, 12, 14, 19, 20, 23} It was unclear from one of the studies whether it was multi-site.\textsuperscript{3} It was not possible to determine how many service users and staff were sampled across the studies, as the extent to which authors report data on the same sample was not always clear. However, where the number is specified, nine studies used under 100 participants (18-86 participants).

The majority of psychiatric inpatient participants had a diagnosis of schizophrenia or personality disorder. Staff participants were from a range of professional backgrounds, although the most frequently sampled profession were nurses. Only two studies reported response rates\textsuperscript{2, 14} which ranged from 81 – 100%. Few studies reported the age, duration of professional experience, or duration of illness of length of stay on ward of service user participants. Where reported: mean age of staff ranged from 31.3 years to 43.5 years, mean experience on the ward ranged from 1 year to 9 years, mean age of service users ranged from 26.7 years to 51.0 years, and mean length of stay on the ward ranged from 7 days to 10.6 years. Staff samples ranged from whole staff populations to limited samples of day-shift workers only.

2.5.2.2 Qualitative and mixed design studies

2.5.2.2.1 Design features

The majority of qualitative and mixed design studies employed a cross sectional design (N = 7). The remaining two studies used a repeated measures design. All of these studies used the method of semi-structured interviews, four of which referenced their analysis procedure\textsuperscript{8, 9, 17, 23} and six of which provided quotes from the data as evidence of themes / categories.

2.5.2.2.2 Demographic features

Samples were mainly drawn from psychiatric inpatient staff. Staff participants were from a range of professional backgrounds, although the most frequently sampled profession were nurses. Where reported: mean age of staff ranged from 33.02 years to 39 years, mean experience on the ward ranged from 1.25 years to 7.40 years, and the number of staff participants ranged from 6 – 56. Three studies also sampled inpatients, ranging from 6 – 29 participants, the majority of whom had a diagnosis of schizophrenia or personality disorder. Their mean age ranged from 30.55 to 39.50 years. Their duration on the ward was not provided. Two studies were multi-site,\textsuperscript{7, 22} although these studies had a smaller
sample size than the quantitative studies with some as few as 6 participants. It is generally accepted that smaller numbers may still be reliable and valid (if continued until data is saturated) due to the richness of the data (Streiner & Norman, 2003).

A meta-analysis for this review could not be undertaken as there was considerable variation in the review topics identified. Hence, data is presented in narrative summary. For the remainder of this chapter, studies will be reviewed in terms of appropriate themes, rather than methodology used. This format aims to improve readability and to allow useful conclusions to be drawn. In order to fulfil the objectives of this review, results will be restricted to the measures employed and findings reported which relate to perceived challenges, attributions, emotions, and coping strategies of staff.

2.5.3 Outcome findings for Research Question 1: What do psychiatric staff members perceive as the challenges service users present with?

2.5.3.1 Studies

Of the twenty three studies, seven aimed to explore what the characteristics of challenging service users were from a staff perspective, as opposed to the remaining sixteen studies which explored factors relating to pre-determined challenges set by the authors.

Five of the studies exploring the characteristics of challenging service users were from the same authors,10-14 four of which used the same sample based on participants’ descriptions of 127 service users with each detailing different aspects of findings from one large study. It is unclear whether the fifth study (Allen, Colson, Coyne, Deering & Jehl,13 1987) employed a sub-sample of 57 service users extracted from the original Colson et al.10 (1985) study of 127 inpatients.

2.5.3.2 Measures

2.5.3.2.1 Rating Scales

Colson et al.10 (1985) developed the 25 item Hospital Treatment Rating Scale (HTRS) using multi-disciplinary staff members from five psychiatric hospitals to assess 127 service users identified by the authors. This measure was used in five of the eight studies.10-14 The HTRS was developed from a pilot study of interviews conducted with clinicians in relation to their most challenging service users. However, the interview methodology, data analysis and subsequent scale development was unclear. In addition, clinician participant
and rater samples were unspecified. The service users were rated by four clinicians from their treatment team. Inter-rater reliability was assessed via the correspondence of clinicians’ ratings. Reliability varied across item-team combinations, although the actual levels of agreement were not provided. The authors reported that items rated by the majority of the teams retained an acceptable level of reliability.

The above studies also reported global ratings produced in Colson et al.’s\(^\text{10}\) (1985) study: overall extent of treatment difficulty, prognosis, and progress in treatment, although the method of obtaining ratings was not provided in the latter measure. It was unclear whether Allen et al.\(^\text{13}\) (1987) used the same ratings produced in the previous studies but the authors did administer the global assessment scale (GAS) using clinical records to compare with staff ratings of treatment difficulty. The reliability and validity of these ratings was unspecified. Ratings in the above studies\(^\text{10-14}\) were based on the previous two-months. This period reportedly avoided fluctuations in functioning over short periods of time and provided a representative sample of behaviour in the context of long-term treatment.

Modestin et al.\(^\text{21}\) (1986) also developed two questionnaires exploring perceived challenges of 26 service users. One consisted of two questions: “did you consider this patient as a problem patient?” and “if so, why?” The statements obtained from eight nurses and ten physicians were classified into 12 groups. The second questionnaire was constructed by the authors in order to perform a follow-up investigation. This questionnaire was completed on the basis of a semi-structured interview with discharged service users and primarily assessed three main areas: re-hospitalisation frequency, suicide frequency, and psychosocial adaptation.

2.5.3.2.2 Clinical Records

Four of the studies exploring the clinical characteristics of challenging service users used clinical records as a measure alongside rating scales.\(^\text{11-13, 21}\) Clinical records were used to measure levels of treatment,\(^\text{11, 12}\) types of incident, and total number of special controls (e.g. precautions against suicide). Allen et al.\(^\text{13}\) (1987) also used records to complete the GAS. Clinical records give information of sufficient reliability and validity provided they are properly kept (Csernanskey, Yesavage, Maloney & Kaplan, 1983). Only one study reported methods used to ensure the reliability of the clinical records\(^\text{21}\) by checking the service users’ personal data during the follow-up investigation and considering the use of unequivocal statements from the records.\(^\text{21}\) Across the four studies, rater samples and inter-rater agreements were unspecified.
2.5.3.2.3 Semi-structured Interviews

One study undertook semi-structured interviews, Gallop & Wynn\textsuperscript{18} (1987), with 25 nurses across five different psychiatric wards. A general discussion of service users that staff found challenging was followed by discussion of one service user whom they found particularly challenging and one specific incident. Content analysis was used to analyse the data. Reliability, validity, and analyst samples were unspecified.

2.5.3.3 Overall findings of exploratory challenging presentation studies

Across the seven studies, there was no single characteristic that determined staff perceptions of service users as challenging. Six studies found that challenging service users were more likely to suffer from psychosis or a personality disorder\textsuperscript{10-14, 21} including Modestin et al.\textsuperscript{21} (1986) whose findings were compared to a control group. Gallop & Wynn\textsuperscript{18} (1987) reported that staff rated service users with similar diagnoses as challenging; however, no specific diagnoses were reported. As indicated below, across the seven studies exploring perceptions of challenging service users, a lack of therapeutic progress was highlighted as particularly challenging.

Colson et al.\textsuperscript{10} (1985) employed factor analysis to identify four factors of perceived challenging patient characteristics: ‘withdrawn psychoticism’, ‘severe character pathology’, suicidal depressed behaviour’, and ‘violence-agitation’, in decreasing order of influence. Each factor was significantly related to perception of overall treatment difficulty (i.e. challenging). The HTRS items which significantly loaded onto one of the four factors are outlined in Table 2 below.
Table 2: List of Factors, HTRS items and corresponding identified challenges

<table>
<thead>
<tr>
<th>Factors†</th>
<th>HTRS Items10-14, ‡</th>
<th>Categories14, ‡</th>
<th>Themes &amp; sub-themes10, ‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>Character pathology</td>
<td>Excessive or inappropriate demands</td>
<td>Open resistance (breaks the rules, manipulates other patients in a destructive way) *</td>
<td>High affect*</td>
</tr>
<tr>
<td></td>
<td>Plays one person against another</td>
<td>Other problematic behaviour (patient is elusive, unreliable, unpredictable, uncanny)*</td>
<td>High intensity/demanding attention</td>
</tr>
<tr>
<td></td>
<td>Manipulative and controlling</td>
<td></td>
<td>Arrogant</td>
</tr>
<tr>
<td></td>
<td>Verbal hostility and anger</td>
<td></td>
<td>Evil</td>
</tr>
<tr>
<td></td>
<td>Sabotage treatment with disruptive behaviour*</td>
<td></td>
<td>Exploitive</td>
</tr>
<tr>
<td></td>
<td>Wide variability in mood</td>
<td></td>
<td>Manipulative</td>
</tr>
<tr>
<td></td>
<td>Regressed, neglects basic needs</td>
<td>Resistance to therapy (persistence of psychopathology, hospitalisation gets too long)</td>
<td>Chronic unresponsive</td>
</tr>
<tr>
<td></td>
<td>Slow to change</td>
<td>Passive behaviour (patient withdraws, does not participate in the therapy)</td>
<td>No motivation</td>
</tr>
<tr>
<td></td>
<td>Not involved in treatment</td>
<td></td>
<td>Non-compliant</td>
</tr>
<tr>
<td></td>
<td>Bizarre behaviour</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Isolation and withdrawal from people</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychotic symptomatology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence-agitation</td>
<td>Violence towards people</td>
<td>Aggressive behaviour</td>
<td>Very anxious</td>
</tr>
<tr>
<td></td>
<td>Violence towards property</td>
<td>Open resistance</td>
<td>Threatening harm on others</td>
</tr>
<tr>
<td></td>
<td>Poor impulse control</td>
<td></td>
<td>High affect*</td>
</tr>
<tr>
<td></td>
<td>Agitation and anxiety</td>
<td></td>
<td>Frequent hitting</td>
</tr>
<tr>
<td></td>
<td>Sabotage treatment with disruptive behaviour*</td>
<td></td>
<td>Frequent screaming</td>
</tr>
<tr>
<td>Suicidal-depressed behaviour</td>
<td>Suicidal behaviour</td>
<td>Suicidal behaviour</td>
<td>Frequent swearing</td>
</tr>
<tr>
<td></td>
<td>Self-abuse</td>
<td></td>
<td>Blood-letting</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regression after progress</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

†Factors generated from HTRS item ratings, adapted from Colson et al.10 (1985)
‡Categories generated from staff statements, adapted from Modestin et al.21 (1986)
§Themes and sub-themes generated from staff interviews.
*Subtype placed in two domains by the researcher or loaded onto two factors.

Alongside the HTRS items,10 Table 2 also displays the relevant categories of staff challenges formed by Modestin et al.21 (1986), and the relevant themes and sub-themes developed by Gallop and Wynn18 (1987). Due to the variance in methods and measures applied, the list-wise comparisons are hypothetical but were deemed by the researcher to correspond in a useful manner.
As well as therapeutic progress, Modestin et al.\textsuperscript{21} (1986) found participants’ main reasons for identifying challenging service users were: behavioural pathology, and difficulties of staff in relationship with service users. The ‘other problematic behaviour (patient is elusive, unreliable, unpredictable)’ category shown in Table 2 received the most statements from both nurses and physicians. Compared with the control group, challenging service users were prescribed more medication, had longer hospitalisations, and the suicide proneness of challenging patients was high. Among 42\% of the identified challenging service users there was unanimous agreement of identified challenges and in only 12\% of the cases there was participant agreement less than 70\%.

In the study by Gallop & Wynn\textsuperscript{18} (1987) 24 of the 25 challenging service users identified by nurses were remembered as ‘hitting’, ‘screaming’, ‘moaning’, ‘swearing’, ‘slashing’, ‘bloodletting’, and ‘threatening’ during interviews, as indicated in Table 2. These behaviours were frequent, unpredictable, and unremitting. Themes of no progress were labelled as chronic. Responsiveness was highly valued by nurses (e.g. acknowledge communication, acting on their advice) as seven patients were perceived as unresponsive.

2.5.3.3.1 Specific findings of challenging presentations associated with other factors

Challenges and degrees of progress, prognoses and treatment difficulty

Although therapeutic progress was found to be challenging in other studies,\textsuperscript{18, 21} only three studies\textsuperscript{10-12} measured therapeutic progress and prognoses.

Colson et al.\textsuperscript{10} (1985) found that the withdrawn psychoticism category was positively correlated with perceived progress and prognoses. Higher withdrawn psychoticism was associated with less progress and poorer prognoses. The higher the overall treatment difficulty (i.e. the more challenging), the lower the perceived progress was found.\textsuperscript{10}

Colson et al.\textsuperscript{11} also used hierarchical grouping analysis to form profile groups (labelled A-J) of challenging characteristics, such as ‘withdrawn psychoticism’ with and without severe character pathology, ‘suicidal depressed’, and ‘violence-agitation’. Group ‘A’ was labelled ‘Pansymptomatic’ and concerned service users who were the most challenging to treat. This group required the most special controls, tended to be highly symptomatic, were perceived as too slow to change, and had the most restrictive level of responsibility. Groups ‘I’ and ‘J’ (‘low difficulty’) stood out as being significantly different from all other
groups. Group I was distinct in having the best prognosis, exhibited the least perceived behavioural disturbance and required the least special controls. Interestingly, this group included a high proportion of patients with a diagnosis of schizophrenia and other forms of psychoses (N = 14). This was a similar finding to Gallop & Wynn\(^\text{18}\) (1987) who referred to psychotic service users as “much easier” to manage. Despite overall significant differences, no single group differed significantly from all others in number of incidents and each group presented a distinct form of challenge.

Allen et al.\(^\text{12}\) (1986) found that challenges categorised as ‘violence-agitation’ posed particular problems for teamwork.

**Challenges and clinical outcome**

Allen et al.\(^\text{13}\) (1987) found that two of the four treatment challenges were inversely related to clinical improvement; ‘withdrawn psychotism’ and ‘violence agitation’. Along with the authors’ previous findings,\(^\text{10-12}\) this suggests that ‘withdrawn psychotism’ not only presents the greatest overall treatment difficulty, but also relatively poor prognoses. Taken together, these findings\(^\text{10-13}\) suggest that treatment challenges or challenge severity do not signal poor clinical outcome. Rather, it is the type of challenge that indicates the degree of improvement.

**2.5.4 Studies using specific / pre-determined challenges**

Most of the studies involved one or more pre-determined challenges; thirteen of which concerned aspects of service user violence and / or aggression as the presenting challenge. However, only eight studies measured violence and / or aggression. Five studies provided a definition of the particular violence and / or aggression they were concerned with, most of which varied considerably.

All of the pre-determined challenges, which were measured using various tools, are outlined below. However, seven of the pre-determined challenges were not actually measured,\(^\text{4, 5, 7, 8, 9, 15, 23}\) as the focus was often on the assessment of attributions, emotions and coping in relation to the specific challenges. Therefore, the key findings of these studies will be discussed in the appropriate subsequent sections.
2.5.4.1 Violence and aggression (including self, others & environment)

2.5.4.1.1 Measures

2.5.4.1.1.1 Rating scales

The Overt Aggression Scale (OAS; Silver & Yudofsky, 1991) contains 25 items designed to assess observable aggressive or violent behaviour and classifies aggression according to type. One study which employed this measure also provided a definition of physical aggression. Whilst Gillig, Market, Barron and Coleman’s (1998) study was retrospective, with reference to the past two weeks as well as incidents spanning the entire career, Nolan, Shope, Cirome and Volavka (2009) monitored aggression prospectively using the OAS.

The scoring system of the OAS has been criticised as it has been suggested that it produces large variance and skews results (Mattes, 2010). Frequencies are multiplied by severity ratings and there is no upper limit on frequencies. Consequently, many episodes of relatively mild irritability can produce a higher score than more severe but less frequent aggression.

The Social Dysfunction and Aggression Scale (SDAS; Wistedt et al., 1990) is an 11 item scale intended to assess aggressive cognitions and behaviour in individual patients over the past month. The inter-observer reliability has been found to be adequate between the outward directed aggression variables, whereas inward and outward aggression were not found to be inter-correlated (Wistedt et al., 1990). The scale was completed by one of the researchers, using information from staff. However, it was not specified exactly how many staff members informed this process, raising questions about the accuracy of the ratings.

2.5.4.1.1.2 Semi-structured interview

The Aggressive/Assaultive Incident Form (Barlow, Greyner & Ilkiw-Lavalle, 2000) was completed by staff members immediately after an aggressive incident, defined as any act of verbal or physical aggression towards self or others, irrespective of outcome. Severity was rated using Morrison’s hierarchy of aggressive and violent incidents (Morrison, 1992). Reliability and validity was unspecified for the use of this form and it was unclear how immediacy of form completion was ensured.
2.5.4.1.3 Clinical records and incident registers

Clinical records were used as a follow-up measure to assess the frequency of ‘challenging behaviour’ incidents in the 7 months following initial assessments. Three types of incidents were included: harm to self, threat/harm to others, and threat/harm to the environment. The search was conducted by two assessors, and checked by a third assessor (independently) with a high level of agreement reported.

The severity of violent incidents on staff was assessed by reportedly independent and experienced raters using a scale devised by Fottrell (1980). A violent incident was defined by the authors as one in which aggressive physical contact took place between a service user and a member of staff, thus excluding verbal aggression and perceived threats without physical contact.

One study drew data from the hospital violent incident register to record physical assaults on participants during the period between their first and second assessments of emotional reactions. The incidents were defined as service-user initiated where physical contact took place between a nurse and service user, and the nurse perceived the contact as hostile or threatening. Verbal aggression was also excluded from the study.

2.5.4.2 Symptoms of mental illness

One study measured symptoms of mental illness among the service users involved.

2.5.4.2.1 Measures

2.5.4.2.1.1 Rating scale / standardised structured interview

The Positive and Negative Syndrome Scale (PANSS; Kay, Fiszbein & Opler, 1987) is a 30 item clinical interview rating the patient with psychosis on a 7-point scale. The scale ranges from ‘absent’ to ‘extreme’. Service users’ aggression risk was assessed using the violence potential assessment criteria of the PANSS manual. It has been found to have excellent inter-rater reliability (Kay et al. 1987).

2.5.4.3 Social functioning and social behaviour

One study measured aspects of social functioning and social behaviour.
2.5.4.3.1 Measures

2.5.4.3.1.1 Rating scale / standardised semi-structured clinical interview

The Social Functioning Scale (SFS; Birchwood et al., 1990) was originally designed to guide and assess the outcomes of family interventions with service users with schizophrenia. It is a 79 item measure assessing abilities and performance in areas such as; social engagement / withdrawal, interpersonal behaviour, and independence-competence. Informants record items as being ‘present’ or ‘absent’ using a check-box approach. This avoids evaluative decisions having to be made by informants (Birchwood et al., 1990). However, this method is subject to bias selection and cannot deliver individualised accounts. The Social Behaviour Scale (SBS: Wykes & Sturt, 1986) is a semi-structured interview completed by the researcher based on staff observations of 21 social behaviours rated on a Likert scale across four areas: social mixing, inappropriate behaviours, reduced activity, and personal hygiene.

2.5.5 Outcome findings for Research Question 2: Staff attributions of challenging service users

2.5.5.1 Studies

Eight studies claimed to have directly assessed staff attributions of perceived challenging presentations. However, staff attributions are implicit in several other studies, whereby the authors claim to be assessing other domains. For example, Table 2 above shows that some of the classes / items are concerned with attributions that are made by staff about service users presentations which are determined as challenging, as opposed to – what the authors have claimed to assess\(^ {10, 21}\) - specifically challenging presentations. Examples include; ‘manipulative and controlling’\(^ {10}\) and ‘open resistance – manipulates other patients in a destructive way’.\(^ {21}\)

2.5.5.2 Measures

2.5.5.2.1 Rating Scales / Coding system

The Attributional Style Questionnaire (ASQ; Peterson et al., 1982; Peterson & Villanova, 1988) was used on one study.\(^ 1\) It assesses staff attributions of challenging inpatient behaviours, with reference to a target service user. Staff members record the major cause of 14 typical challenging inpatient behaviours, such as hostility to another service user; and absconding, along four 7-point bipolar scales: internal-external to the service user, stable-unstable, global-specific, and controllable-uncontrollable. Reliability of the four sub-
scales was reported as satisfactory. A seven point scale similar to that of Weiner (1980) was also employed to measure helping behaviour, where staff rate how much extra effort they would exert in helping a target service user.

Vignettes of arbitrary and non-arbitrary violence were used to rate the choice of three possible staff reactions, ‘violent’; ‘therapeutic’; and ‘vigilant’. The vignettes were developed by Apel and Bar Tal (1996) to represent real-life nurse – patient situations. Face validity was ensured by seven experts. Reliability of the vignettes was ensured by assessment of the arbitrariness and non-arbitrariness.

The use of vignettes to assess attributions has been criticised. Wilner and Smith (2008) described the assessment of staff attributions of causality in relation to vignettes as somewhat arbitrary. Unlike the situation of a real challenging incident, where judgements of controllability and stability are based on knowledge of the individual involved and the environment, the basis on which these judgements are made in relation to a vignette is wholly obscure, and it is likely that different participants use different strategies to reach a decision. The error of measurement is unknown, and may vary between studies, individuals, and measures (Wilner & Smith, 2008). One study that has directly compared staff responses to real incidents versus vignettes reported that emotional responses to real incidents were more intense, and the relationships between attribution dimensions and helping responses were somewhat stronger with real incidents, but otherwise, the two situations were qualitatively similar (Wanless & Jahoda, 2002).

Gillig et al.15 (1998) developed an unnamed 5-point scale to assess participants’ perceptions of the extent to which causes, such as “possessions of weapons by some patients/some staff” and “giving medicines to patients who don’t need it” contributed to physical aggression. Staff also ranked the degree to which they believed twelve items were “important causes of physical aggression on the unit.” Reliability and validity data was not provided.

Staff causal attributions about challenging presentations were drawn from spontaneous attributions made in the Camberwell Family Interview2 (CFI; Vaughn & Leff, 1976). An attributional statement was defined as a one which explains or explores the reasons or causes for negative patient outcomes, behaviours, or situations. The Leeds Attributional Coding System (LACS; Stratton et al., 1986) was used by trained raters to rate the
attributional statements in conjunction with Brewin’s guidelines (Brewin, MacCarthy, Duda & Vaughn, 1991). Following extraction, the statements were given binary ratings for the following causal dimensions: ‘internal-external’, ‘personal-universal’, ‘controllable-uncontrollable’, and ‘stable-unstable’. Statements that could not be scored as predominantly one or the other end of a dimension were excluded. Very good inter-rater agreement was reported on all dimensions. However, this method of extraction could be criticised for making assumptions about what attributions were made, as people may not be consistent or logical in their beliefs about the causes of challenges.

2.5.5.2.2 Semi-structured interviews

Ilkiw-Lavalle & Greyner (2003) used a semi-structured interview to explore staff perceptions of service user aggression within one week of an aggressive incident. Staff members were asked about their perception of the cause and how they thought similar incidents could be avoided. Transcripts were analysed using “phenomenological bracketing of the author’s expectations” (Jennings, 1986). The two authors separately determined the meaning of each significant statement before organising them into themes. The meaning of themes were discussed and verified with some of the participants to ensure validity.

Sun et al. (2006) also used semi-structured interviews on 15 female nurses to assess: the nursing care for and communication with suicidal service users, difficulties encountered, and why people attempt suicide. The transcripts along with field notes and observations were analysed using grounded theory (Glaser & Strauss, 1967). Inter-rater agreement was unspecified.

2.5.5.3 Overall findings of staff attribution studies

Types of casual attributions for challenging presentation reported across the studies are displayed in Table 3. For convenience, the researcher has divided them, where possible, into internal and external attributions. However, this differentiation should be considered with caution due to the hypothetical nature. Studies that reported attribution type (e.g. ‘internal’ or ‘controllable’) rather than specific attributions^{1,2,19} are not included.
Ilkiw-Lavalle & Grenyer\textsuperscript{22} (2003) found that many (unspecified number) of the 29 staff members perceived the service user’s illness as the cause of aggression. Similarly, Nolan et al.\textsuperscript{16} (2009) found that staff cited more internal factors (including psychotic symptoms and tension) than external factors as causes of aggression.

Barrowclough et al.\textsuperscript{2} (2001) also found that most of the attributions made were internal and personal. Most attributions concerned illness symptoms (38%) and aggression (30%), with 15 percent focusing on interpersonal problems, ten percent behavioural excesses, and just six percent on negative symptoms. However, the actual attributions made under these categories of challenging presentations were not specified.

Gillig et al.\textsuperscript{15} (1998) found that the majority of staff attributed the presence of psychosis to increasing the likelihood of physical aggression. However, patient intoxication was also cited, and learned behaviour was attributed as the most frequent cause of physical aggression.

A similar theme of service user control, or indeed choice, was echoed in findings by Sun et al.\textsuperscript{23} (2006), who found that many of the nurses attributed suicidal presentations as being attention seeking and foolish behaviour, and that service users were choosing not to accept responsibility for their lives, as can be seen from Table 3.

### Table 3: List of internal and external attributions\textsuperscript{1, 10, 15, 16, 18, 21, 22, 23}

<table>
<thead>
<tr>
<th>Internal attributions</th>
<th>External attributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental illness (general)\textsuperscript{1, 15, 22}</td>
<td>Relationship problems on the part of the therapist (cannot empathise, does not understand patient)\textsuperscript{21}</td>
</tr>
<tr>
<td>Psychotic symptoms\textsuperscript{15, 16, 22}</td>
<td>Mistakes of the therapist (use of incorrect/insufficient therapy)\textsuperscript{21}</td>
</tr>
<tr>
<td>Tension / upset\textsuperscript{16}</td>
<td>Use of unpopular/questionable methods\textsuperscript{21}</td>
</tr>
<tr>
<td>Attention seeking\textsuperscript{23}</td>
<td>Asked/order to do something by staff\textsuperscript{16}</td>
</tr>
<tr>
<td>Choosing not to accept responsibility\textsuperscript{23}</td>
<td>Asked ordered to do something by peer\textsuperscript{16}</td>
</tr>
<tr>
<td>Deliberately deciding not to improve\textsuperscript{18}</td>
<td>Request refused by staff\textsuperscript{16}</td>
</tr>
<tr>
<td>Choosing to sabotage their treatment\textsuperscript{10, 18}</td>
<td>Request refused by peer\textsuperscript{16}</td>
</tr>
<tr>
<td>Manipulative\textsuperscript{10, 21}</td>
<td>Ward rules\textsuperscript{16}</td>
</tr>
<tr>
<td>Using their symptoms\textsuperscript{18}</td>
<td>Provoked by staff\textsuperscript{16}</td>
</tr>
<tr>
<td>Learned behaviour\textsuperscript{15}</td>
<td></td>
</tr>
<tr>
<td>Intoxication\textsuperscript{15}</td>
<td></td>
</tr>
<tr>
<td>Felt crowded\textsuperscript{16}</td>
<td></td>
</tr>
</tbody>
</table>

Ilkiw-Lavalle & Grenyer\textsuperscript{22} (2003) found that many (unspecified number) of the 29 staff members perceived the service user’s illness as the cause of aggression. Similarly, Nolan et al.\textsuperscript{16} (2009) found that staff cited more internal factors (including psychotic symptoms and tension) than external factors as causes of aggression.

Barrowclough et al.\textsuperscript{2} (2001) also found that most of the attributions made were internal and personal. Most attributions concerned illness symptoms (38%) and aggression (30%), with 15 percent focusing on interpersonal problems, ten percent behavioural excesses, and just six percent on negative symptoms. However, the actual attributions made under these categories of challenging presentations were not specified.

Gillig et al.\textsuperscript{15} (1998) found that the majority of staff attributed the presence of psychosis to increasing the likelihood of physical aggression. However, patient intoxication was also cited, and learned behaviour was attributed as the most frequent cause of physical aggression.

A similar theme of service user control, or indeed choice, was echoed in findings by Sun et al.\textsuperscript{23} (2006), who found that many of the nurses attributed suicidal presentations as being attention seeking and foolish behaviour, and that service users were choosing not to accept responsibility for their lives, as can be seen from Table 3.
Sharrock et al.\textsuperscript{1} (1990) found that internal attributions were significantly related to attributions of controllability. The actual internal attributions were not specified. Similarly, Apel and Bar-Tal\textsuperscript{19} (1996) found nurses felt that an arbitrary violent scenario was less predictable and less controllable than a non-arbitrary scenario. In addition, staff members were more inclined to attribute the service user’s violent behaviour to their mental illness in the arbitrary scenario, and to perceive this as more severe. Gallop and Wynn\textsuperscript{18} (1987) also found that implicit in the nurses’ reports of lack of therapeutic progress was the service users’ deliberate decision not to improve. Eleven of the twenty five challenging service users were also seen as actively choosing to “sabotage their treatment” or “used their symptoms”.

2.5.5.3.1 Specific findings of attributions associated with other factors

\textit{Attributions internal to staff (external to service users)}

As can be seen from Table 3, three of the external attributions reported across the studies were causal attribution classifications generated by Modestin et al.\textsuperscript{21} (1986), specifically related to staff factors rather than service users.

\textit{Attributions, staff optimism and response}

Sharrock et al.\textsuperscript{1} (1990) found that staff causal attributions about challenging presentations were related to staff optimism in service users’ accomplishments, the idea that they could beneficially intervene, as well as anticipated helping behaviour. Results on ratings from the Staff Optimism Scale modified from the optimism subscale of Optimism-Pessimism Scale (Moores & Grant, 1976) and the modified ASQ. Staff optimism had high and significant negative correlations with stable, internal, and controllable attributions. Therefore, the more internal, stable and controllable attributions staff had, the less optimism they had. Gallop & Wynn\textsuperscript{18} (1987) found similar results, in that a theme between the nursing staff was that nothing they do “would make any difference” to the service users’ challenging presentations. Kindy et al.\textsuperscript{17} (2005) also found that most of the 10 nursing staff perceived “minimal hope of change”. These findings suggest that the nurses believed these presentations were stable and that they could not intervene beneficially.

Apel and Bar-Tal\textsuperscript{19} (1996) reported that staff found it much easier to respond with therapeutic behaviour to a situation in which the service user’s presentation was attributed as being arbitrary (N = 81). Inversely, the most frequent response for a non-arbitrary
scenario, when their violence was perceived as more controllable and ‘normal’, was ‘violent’ (N = 70).

2.5.6 Outcome findings for Research Question 3: What are the emotional reactions / psychological difficulties associated with these challenges?

2.5.6.1 Studies

Fourteen studies assessed the emotional impact of challenging presentations, including distress and physiological effects. Studies ranged from solely measuring distress to assessing 58 different feelings; therefore, findings are not directly comparable. The main measures used and key findings are outlined below.

2.5.6.2 Measures

2.5.6.2.1 Rating scales

Colson et al. (1986) developed a self-report rating scale to assess staff affective responses to identified challenging service users. Sixteen responses, such as ‘frustration with the patient’ and ‘helpless’ were recorded on a five point Likert scale of severity. No reliability or validity data was provided. Gallop & Wynn (1986) developed a similar scale to assess an adjective checklist of staff member’s feelings, such as confused or caring, in response to a challenging incident. The number of items was not reported and no psychometric properties were reported for this scale. Gillig et al. (1998) also used a five point scale where staff rated statements pertaining to the emotional impact of physical aggression. Statements included “I have been worried enough about violence on the inpatient unit to have trouble sleeping” and “… to have feelings of anger or rage.” No reliability or validity data was reported for this scale and all responses include “worrying” as an emotional impact. However, primary feelings such as anger may not necessarily stem from worry and this format may lead to response bias.

To test some of Weiner’s (1980) predictions about affect, attributions and helping behaviour, Sharrock et al. (1990) used four 7-point Likert bipolar scales to assess emotions evoked by the identified challenging service user, including: anger, disgust, sympathy, and pity. The authors found high correlations between anger and disgust and between pity and sympathy; therefore scores were added respectively to produce anger and sympathy scores. Reliability and validity of the measure was not reported.
The Feelings Word Checklist-58 (FWC-58) is a self-report measure of staff emotional reactions towards challenging service users, rated on a five point Likert scale. The FWC-58 was developed by Rossberg et al. (2003), as an adaptation of the Feeling Word Checklist-30 (McWhyte et al., 1982) to include items such as being invaded, idealized, devalued, which experienced therapists found were lacking in the original FWC. In the original study, factor analysis identified two positive (e.g. ‘confident’) and five negative (e.g. ‘rejected and on guard’) subscales. The authors reported that the subscales had satisfactory internal consistency and described meaningful emotional profiles of the different psychiatric wards and the individual service users.

Barrowclough et al. (2001) used two 5-point Likert scales for key-workers to rate their current feelings towards the service user (expressed feelings) and their perception of the service user’s feelings toward them (perceived feelings). Service users also rated the same scales in order to assess staff-patient relationships. The scale was originally developed by Lebell et al. (1993) in order to assess patients’ perceptions of their close relative.

The State Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg & Jacobs 1983) was used in three studies. It comprises two separate 20-item, self-report rating scales for measuring state and trait anxiety. State anxiety (A-State) is conceptualised as transitory feelings that vary in intensity and fluctuate in time as a reaction to perceived threatening circumstances. The items for the A-State scale require a respondent to describe the intensity of a feeling at a particular time using a 4-point Likert scale and have been found to be a sensitive indicator of changes in transitory anxiety. Trait anxiety (A-Trait) refers to relatively stable individual differences that are impervious to situational stress. The A-Trait scale probes how a respondent generally feels by rating the frequency of his or her feelings of anxiety on a 4-point Likert scale. Good discriminant validity has been found (Spielberger et al., 1983).

All the measures below have been reported to have good reliability and validity across a range of settings, including psychiatric staff.

The State-Trait Anger Expression Inventory (STAXI, Spielberger, 1988) used by Wykes and Whittington (1998) is a 44-item questionnaire and is extensively utilised in research on anger. The Beck Depression Inventory (BDI; Beck, 1967), one of the most widely used instruments to assess the severity of depression, is a 21 item self-report measure using a
four-point Likert scale of intensity. The Impact of Events Scale (IES; Horowitz, Wilner & Alvarez, 1979) is a 15 item scale, used in two studies. It was originally developed for the study of bereaved individuals but was later used for exploring the psychological impact of a variety of traumas. The General Health Questionnaire-28 (GHQ-28; Goldberg & Williams, 1988) is a 28 item scale, comprising four subscales (somatic, anxiety and insomnia, social dysfunction, and depression) that requires respondents to indicate if their current “state”, based on the past two weeks, differs from their usual state. The GHQ-28 has been abbreviated to the GHQ-12 (Goldberg & Williams, 1988).

In two studies participants were assessed (including interviews) on three occasions using the above measures. The first assessment took place within three days of a physical assault. The remaining two assessments took place 7-10 days and 21 days following the incident. In the follow-up study, the design incorporated comparisons of both within and between subjects using three groups. These groups were assessed at two stages. In the first phase, there was a ‘baseline group’ consisting of nurses who had been assaulted. This group was included in order to assess changes in distress before and after an assault. In the second phase an ‘assault group’ and a ‘control group’ (had not been assaulted in previous 6 months) were assessed twice, first within 10 days of assault (Time 1), then a month after (Time 2).

2.5.6.2.2 Interviews

As noted above, Sun et al. (2006) used a semi-structured interview to measure perceptions and experiences of staff in the care of suicidal patients. The Operant Philosophy and Policy Interview (Bowers et al., 2006) was also a semi-structured interview developed to assess staff members’ emotional response to serious untoward incidents defined as: suicide, homicide, suicide attempt, serious assault, and absconding of high risk service users. The analysis, performed by three of the authors, was unspecified. Bonner et al. (2002) developed an interview to assess the subjective experience of physical violence and physical restraint of staff members. Independent coding and analysis, performed by three of the authors, used an unnamed technique by Miles and Huberman (1984). Kindy et al. (2005) gave staff two printed questions for the interview exploring nursing staff members’ emotional and coping experience working with high risks of assault: “Please describe your experience working in an environment with a daily risk of verbal and/or physical assault, including your feelings, thoughts and emotions” and “Describe an actual assault experience you have had, including what you think the causes were, events during it, how the event ended, resolution and your emotions, thoughts and
feelings as this occurred and afterward.” Phenomenological Analysis generated themes which were reported as similar among the three researchers. However, inter-rater reliability was unspecified for this study or indeed the three previous interview-based studies.

2.5.6.4 Overall findings of staff emotion studies

Table 4 lists the emotions identified in each study assessing this domain. However, it should be noted that many of these studies measured specific emotions, therefore an emotion may have been reported simply because it was measured (e.g. using BDI, STAI). Equally, the absence of other reported emotions may be due to the lack of a corresponding measure. Considering these biases, the results should be considered with caution.
### Table 4: List of emotional responses corresponding to individual challenges

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Emotional response</th>
<th>Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple</td>
<td>‘Angry-provoked’</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>‘Helpless and confused’</td>
<td></td>
</tr>
<tr>
<td>Multiple</td>
<td>Overwhelmed</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Guilty</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Helpless</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drained</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Engulfed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘Absolutely incompetent’</td>
<td></td>
</tr>
<tr>
<td>Violence and aggression</td>
<td>Anger</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Violence (leading to restraint)</td>
<td>Anger</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Distress</td>
<td></td>
</tr>
<tr>
<td>Suicidal behaviour, serious assault, absconding</td>
<td>Shock</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demoralisation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Upset</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Loss and grief</td>
<td></td>
</tr>
<tr>
<td>Physical assault</td>
<td>Fear</td>
<td>17</td>
</tr>
<tr>
<td>Suicidal behaviour</td>
<td>Anger</td>
<td>23</td>
</tr>
<tr>
<td>Physical assault</td>
<td>Varying degrees of:</td>
<td>4-6</td>
</tr>
<tr>
<td></td>
<td>Anger</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td></td>
</tr>
<tr>
<td>Threats of and actual violence</td>
<td>Varying degrees of distress</td>
<td>3</td>
</tr>
<tr>
<td>Multiple</td>
<td>Anger</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sympathy</td>
<td></td>
</tr>
<tr>
<td>Multiple</td>
<td>Expressed negative feelings</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Expressed positive feelings</td>
<td></td>
</tr>
<tr>
<td>Aggression &amp; suicidal behaviour</td>
<td>Positive</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>‘Important’ (empathic, caring, enthusiastic)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘Confident’ (relaxed, objective, calm)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘Rejected’ (disliked, disparaged, stupid)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘On guard’ (anxious, cautious, threatened)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘Bored’ (aloof, indifferent, empty)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘Overwhelmed’ (surprised, confused, invaded)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘Inadequate’ (sad, distressed, helpless)</td>
<td></td>
</tr>
</tbody>
</table>

As can be seen from Table 4, the emotional response most frequently associated with challenging presentations across the studies was anger, although dissimilar forms of assessment and / or analyses were employed. The findings of each study are also outlined under the relevant categories below.
Colson et al.\textsuperscript{14} (1986) employed principle component factor analysis to identify five affective responses to challenging presentations (‘treatment difficulty’). The emotional responses can be found in Table 4. The ‘angry-provoked’, ‘helpless and confused’, and ‘fearful’ factors were all associated with greater overall treatment difficulty ratings, i.e. staff found them more challenging to treat, whereas positive engagement was unrelated to overall treatment difficulty.

Gallop & Wynn\textsuperscript{18} (1987) found that 13 out of 25 nurses described themselves as feeling ‘absolutely incompetent’ during incidents of challenging presentations. Feeling overwhelmed, guilty, helpless, drained, and engulfed was also strongly reported. Sixteen per cent of staff in the study by Gillig et al.\textsuperscript{15} (1998) reported increased feelings of anger or rage within the emotional impact of aggression. Staff also reported increased depression and sadness, as well as physical disturbances affecting sleep and appetite. Bonner et al.\textsuperscript{9} (2002) also found that nursing and medical staff experienced feelings of anger, distress, and frustration both at themselves and towards the service user.

As can be seen from Table 4, Bowers et al.\textsuperscript{7} (2006) found that staff reported several emotional responses to some challenging presentations, including feelings of shock, depression, and anxiety. Kindy et al.\textsuperscript{17} (2005) highlighted a great sense of fear following an assault. In relation to nursing care of suicidal service users, Sun et al.\textsuperscript{23} (2006) identified ‘judgemental care’, which included feelings of anger and hatred towards the service user and ‘non-judgemental care’, which included feelings of sympathy and a caring attitude.

High levels of anger were found by Wykes & Whittington\textsuperscript{6} (1998), which indicated that only the control of anger (STAXI) scores were significantly different following an aggressive assault. In addition, the ‘victim’ group scored significantly higher than the ‘control’ group on the GHQ-28. More than one third of ‘victims’ reported significant psychological distress on the GHQ-28, and seven nurses reported mild to moderate depression as measured by the BDI. Following initial assessment within ten days of the assault, all measures of psychological distress, anger, and depression had decreased by the one month assessment, suggesting an initial elevation of psychological difficulties immediately after an assault.
Of the one or more distressing incidents of threatened or actual violence, Wildgoose, Briscoe and Lloyd (2003) found that 32% found it ‘very stressful’, 37% ‘moderately stressful’ and 31% found it ‘mildly stressful’. In addition, nurses were much more likely than other professions to experience such incidents. Those who experienced incidents were significantly more likely to report psychological distress as indicated by caseness on the GHQ-12. Those who experienced several or more incidents had significantly higher mean GHQ-12 and IES scores than those who only experienced one or two. However, there was no discrimination made by the authors between actual or threatened violence and there was no definition of either provided. Ratings were based retrospectively on the previous year; therefore, results were heavily reliant on staff recall which may have affected the accuracy of incidents reported and the accounts of their emotional responses.

Similarly, Wykes & Whittington (1998) found that psychological distress (measured by IES, GHQ-28) was higher following assaults resulting in physical injury. However, staff members who were repeatedly assaulted reported either significantly higher or significantly lower distress than those assaulted once. The authors suggested this may indicate early differentiation into violence-distressed and violence-habituated staff groups.

Whittington & Wykes (1994) found that average levels of staff anxiety following assault were unremarkable as measured by STAI scores. However, a small group of assaulted staff experienced severe anxiety in the absence of serious physical injury. Some of the staff (unknown number) also reported higher levels of anxiety than a group of male inpatients hospitalised with anxiety disorders (Spielberger et al., 1983).

2.5.6.4.1 Specific findings of emotions associated with other factors

Emotion and staff profession

Colson et al. (1986) examined relationship between staff emotional responses and various staff disciplines. A considerable degree of independence was evident between disciplines for patterns of affective responses. The greatest difference occurred with the ‘angry-provoked’ factor, which was significantly inter-correlated for each discipline (r ranged from 0.30 to 0.62) and most highly related for psychiatrists and social workers. ‘Violence-agitation’ (one of the four treatment difficulty factors found in a previous study) evoked different affects across disciplines. It was associated with helplessness for psychiatrists, fearfulness for social workers and nurses, and anger for activity therapists. It was also associated with positive engagement for social workers.
Emotion and type of challenging presentation

Colson et al.\textsuperscript{14} (1986) found significant correlations between types of treatment difficulty/challenging presentation factors\textsuperscript{2} and staff emotional responses. ‘Character pathology’ (e.g. highly demanding, manipulative, and hostile) was most strongly associated with staff anger; whereas, ‘withdrawn psychoticism’ (e.g. highly symptomatic, slow to change) was most strongly associated with feelings of helplessness.

Barrowclough et al.\textsuperscript{2} (2001) used clinical records to assess critical incidents at 7 month follow up. These were associated with greater staff negativity on the measure of staff expressed feelings. When the service user’s psychopathology (as measured by the PANSS total score) was controlled for, the association between critical incidents and expressed staff negativity increased and when social functioning scores (SFS) and total PANSS scores were controlled for, the association showed a significant trend.

Rossberg and Friis\textsuperscript{20} (2003) found that staff reported positive feelings about service users much more frequently than negative feelings. However, they also found that patients’ challenging characteristics revealed much more of the variance in negative feelings than in positive feelings. Outwardly expressed aggression explained an average of 22\% of the variance in scores of the 5 negative dimensions of the FWC-58. Suppressed aggression explained an average of 12\% more of the variance in scores of 5 negative dimensions. Service user aggression and suicidal behaviour explained a large proportion of the variance in negative feelings experienced by staff. However, aggressive behaviour was more strongly associated with negative feelings than suicidal behaviour.

In contrast, Ilkiw-Lavalle & Grenyer\textsuperscript{22} (2003) found no association between the type of aggression displayed and whether staff experienced a negative emotion following the incident.

Emotions and attributions

Sharrock et al.\textsuperscript{1} (1990) found that sympathy was negatively associated with attributions of controllability, suggesting that staff felt less sympathy for service users whom they believed had more control over their presentations. However, no association was found between the emotional ratings and helping behaviour, optimism (most related to helping behaviour), or controllability.
The association of emotions and attributions of controllability was also found by Barrowclough et al.\textsuperscript{2} (2001). The more negative staff expressed feelings were, the greater the tendency to attribute challenges as being within the service users’ control (rho = 0.71, p < 0.01).

In classifying staff statements of causes of challenging presentations, Modestin et al.’s\textsuperscript{21} (1986) highlighted ‘frustration of the therapist’ which included statements regarding the therapist feeling overwhelmed, helpless, uncertain, hostile, and exhausted.

\textbf{2.5.7 Outcome findings for Research Question 4: What coping strategies are used in association with challenges and emotional reactions?}

\textbf{2.5.7.1 Studies}

Eight studies explored aspects of staff coping. Three of the quantitative studies were by the same authors and sample.\textsuperscript{4-6} and one\textsuperscript{5} was a re-analysis of previous findings.\textsuperscript{4} The remainder of the studies mainly used qualitative analyses. The measures used and key findings are outlined below.

\textbf{2.5.7.2 Measures}

\textbf{2.5.7.2.1 Rating scales}

The Maudsley Strain Questionnaire (MSQ, Whittington & Wykes 1989) was devised specifically for the investigation of assaults at work. Four sub-scales measure total number of: direct signs of poor processing, indirect signs of poor processing, overall level of emotional processing, and signs of strain. The authors\textsuperscript{4} claimed that construct validity was evidenced by the high correlations with the STAI noted above. Good reliability and validity were reported, though psychometric properties were not provided.

\textbf{2.5.7.2.2 Interviews}

As noted previously, three studies conducted semi-structured interviews including emotional and coping responses of staff members.\textsuperscript{7,9,17} Cutcliffe\textsuperscript{8} (1999) carried out semi-structured interviews with six nurses to explore the experience of living with violence on the ward. Details of method and analysis were provided, including the use of Hermeneutic phenomenological thematic analysis (Bergum 1991), and reliability findings.
An interview schedule was devised by Wykes and Whittington\textsuperscript{4} (1991) in order to investigate staff coping with an assault. It consisted of two parts based on Horowitz et al.’s (1979) findings on post-traumatic stress disorder (PTSD). The first section is open-ended, whereby staff members spontaneously report anything they had done to deal with the effects of the incident. The second part probes for two main types of coping strategy using prompts: denial of the event (refusing to consider the event) and re-experiencing the event (talking about, thinking about the incident). Responses were only coded as coping strategies if they were under voluntary control. All data was coded using content analysis by a single rater.

A re-analysis of the coping interview schedule\textsuperscript{4} was carried out in a later study by the same authors.\textsuperscript{5} Responses were coded according to the eight coping strategies proposed by Folkman et al. (1986), such as ‘confrontive coping’, ‘seeking social support’, and ‘planful problem-solving’. Content analysis was used to re-code the responses. Inter-rater agreement on the categorisation of coping strategies was high.

\textbf{2.5.7.3 Overall findings}

Table 5 below identifies the coping responses reported across the studies. Again, direct comparisons cannot be made as different methods and forms of measurement were used, and also some of the strategies were coded using pre-determined types of strategies, e.g. Folkman (1986, see Section 2.5.7.2.2). Also, the strategies assessed are mainly in relation to violence, therefore the results should be considered with caution. Table 5 indicates that the range of coping responses reported varies significantly across the studies. However, it is clear that seeking some form of support and taking time away (from service user or job) appear to be the most frequently reported strategies.
### Table 5: List of coping responses corresponding to each challenge

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Coping response</th>
<th>Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical violence</td>
<td>Talking to others about the incident</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Thinking about the incident</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wanting/taking time away from the job</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoiding thinking about the incident</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Just getting on with the job</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Planning for next time</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Filling in an incident form</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Planning to leave the job</td>
<td></td>
</tr>
<tr>
<td></td>
<td>{ re-experiencing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>{ denial</td>
<td></td>
</tr>
<tr>
<td>Physical violence</td>
<td>Distancing</td>
<td>5-6</td>
</tr>
<tr>
<td></td>
<td>Seeking social support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Escape/avoidance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>‘Confrontive’ coping</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Planful problem-solving</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-control</td>
<td></td>
</tr>
<tr>
<td>Threats of and actual violence</td>
<td>Time off work</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Time away from the service user</td>
<td></td>
</tr>
<tr>
<td>Violence (leading to restraint)</td>
<td>Social and practical support (‘helping each other out’)</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Good teamwork</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policies in place to support and guide decisions</td>
<td></td>
</tr>
<tr>
<td>Suicidal behaviour, serious assault, absconding</td>
<td>Thoughts of what they could have done differently</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Re-assuring self nothing else could have done</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Managerial support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More rigorous documentation and form filling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased vigilance</td>
<td></td>
</tr>
<tr>
<td>Physical violence</td>
<td>Withdraw or shut down</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Desire to leave job</td>
<td></td>
</tr>
<tr>
<td>Violence</td>
<td>Use incident as chance for learning</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Feel equipped (through experience &amp; training)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Being prepared</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support</td>
<td></td>
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</tbody>
</table>

As can be seen from Table 5, Wykes and Whittington⁴ (1991) identified eight classes of coping from spontaneous reports, such as ‘thinking about the incident’, ‘just getting on with the job’, and ‘planning to leave the job’. They found that over the three interviews with staff, ‘talking to others about the incident’ was the most frequently reported strategy used to cope (58% of staff group). The authors divided some of these strategies into ‘re-
experiencing’ and ‘denial’ as shown in Table 5. However, there was a great variation amongst individual staff and number of strategies adopted. The number of strategies used ranged from 0-5 and different strategies were used at the three different stages of the study. For example, talking and thinking about the incident (re-experiencing) were more frequently reported at initial interview, whereas later, there was an increase in the use of avoiding thinking about the incident. Overall, the number of strategies used decreased over the three interviews, particularly ‘re-experiencing the event’. When spontaneous and prompted categories of coping were paired, there was only partial agreement, which reduced over the three interviews. By the third interview, there was only agreement for 55% of denial (avoiding thinking about it, taking time away from it) and 33% of re-experiencing.

Following re-analysis of the data from their previous study, Whittington and Wykes (1994) found that 6 of the 8 coping strategies described by Folkman (1986) were used by staff. These strategies can be found in Table 5. ‘Positive reappraisal’ and ‘accepting responsibility’ were not used as coping strategies. The most frequently reported strategy was ‘distancing’ which refers to cognitive methods such as detaching oneself from feelings about the incident, carrying on as if nothing had happened, making light of the situation, or accepting fate.

Wildgoose et al. (2003) found that 9% of participating staff members took time off work following their most distressing incident.

2.5.7.3.1 Specific findings of coping associated with other factors

Coping and emotion (psychological difficulty)

Bowers et al. (2006) reported that staff found their processing of the emotional impact was hindered by the pace of the ward life, a lack of external support, and management investigations.

Bonner et al. (2002) found that several staff members reported a re-awakening of distressing memories of previous traumatic events following the violent incident and resultant physical restraint. In order to cope, staff reported the use of social and practical support (‘helping each other out’), good teamwork, and having policies in place to support and guide decisions. As can be seen from Table 5, similar findings were reported by Cutcliffe (1999).
Kindy et al.\textsuperscript{17} (2005) found that following an assault, some staff reported having a desire to leave the job. They also described a need to withdraw or shut down out of concern that they would either simply ‘burn out’ from the overwhelming feelings of stress or that service users would sense fear and take advantage of it. The latter indicates the attribution of controllability in the service user’s behaviour.

\textit{Number of coping strategies and emotion (psychological difficulties)}

Wykes and Whittington\textsuperscript{4} (1991) found that the higher the level of psychological difficulties experienced as measured by STAI and MSQ, the more coping strategies were reported. Most staff reported using palliative strategies that affect the emotion felt rather than problem solving or ‘direct action’ strategies which affect the stressor. The authors also found that total number of strategies used at initial interview was positively related to a reduction in strain and anxiety scores, although only two strategies were significantly increased: reduction in emotional processing problems and reduction in direct emotional processing problems.\textsuperscript{4}

\textit{Type of coping strategies used and emotion (psychological difficulty)}

Wykes and Whittington\textsuperscript{4} (1991) found that levels of anxiety were not associated with any coping measure. However, higher levels of strain (MSQ) were associated with several combined coping strategies which accounted for a significant amount of the variance (16-67\%) in all the interviews. The relationship was different at three interviews. The highest amount of the variance was accounted for in the direct processing problems at Time 1. Three strategies (planning to leave the job, take time away from work, and talking about the incident) accounted for 67\% of the variance. The use of one or more of these strategies was significantly related to reporting at least one direct processing problem.

A two way analysis of variance between coping strategies and change in psychological difficulties indicated that, even when the initial level of strain was controlled for, decreases in psychological difficulties were significantly related to the adoption of denial as a coping strategy. This finding indicates that when denial was employed immediately after an assault, there was more likely to be a reduction in strain over a three week period.\textsuperscript{4}
Whittington and Wykes (1994) found that participants who used distancing, escape/avoidance, or seeking social support reported lower levels of anxiety (STAI) two weeks after the assault compared with three days after. In contrast, staff who employed ‘confrontive’ coping reported higher anxiety at two weeks compared with three days post-assault.

Attributions and coping

Cutcliffe (1999) found that the more equipped nurses felt, the less likely they were to view violence as an entirely negative, destructive, or ruinous activity. This indicates an association between available coping strategies, such as feeling prepared and formal training with the attributions of challenging presentation. The theme of ‘feeling equipped’ also referred to the length of work experience.

In contrast, Nolan et al. (2009) found that responses to aggressive incidents did not take staff and patient causes of aggression into account. Rather, their findings indicated the importance of type and severity of aggression.

2.6 Discussion

2.6.1 Summary of key findings

As the findings indicate, most of the studies have focused on pre-determined challenges rather than exploration of what perceived challenging presentations are. The majority of the studies concerned forms of violence and aggression, suggesting these presentations are most challenging for psychiatric inpatient staff. Interestingly however, ‘violence-agitation’ was perceived as one of the least challenging presentations related to treatment difficulty. Suicide was second least challenging in a major study and absent in another. Despite these findings, most of the subsequent literature has explored violence/aggression and suicide. This discrepancy may reflect a bias (partly influenced by media attention) towards the impact of challenges upon staff safety and sick leave rather than the therapeutic relationship. However, Allen et al. found that challenges categorised as violence-agitation posed particular problems for teamwork. This may partly justify the focus on violence as a disruptive team may be more noticeable than challenges which impact on individuals.
Wildgoose et al. (2003) found that staff members reported higher stress following multiple (more than two) violent incidents, although the methodology did not discriminate between actual or physical violence. Although this finding indicates a cumulative effect, Wykes and Whittington (1998) suggested that there may be two different types of response groups: violence distressed or violence-habituated staff, indicating that staff attributions, emotional, and coping responses may be the crucial factors impacting on stress. However, these studies were based on violence and aggression only; therefore conclusions can only be based on these challenges. When investigating general challenges, Allen et al. (1986) and Allen et al. (1987) found that no single group of treatment difficulty was significantly different in terms of the frequency of challenging incidents. Taking these findings together, the greater impact of repeated incidents may only concern violence and aggression, though one possibility may be that the perceived severity of challenges is an important factor to consider.

Sharrock et al. (1990) found that sympathy was negatively associated with attributions of controllability. As referred to in Chapter one, this finding would be predicted by Weiner (1980). Several other studies indicated the impact of attributions (particularly controllability) of service users’ challenging presentations on emotional response, behavioural response, and coping response, reflecting the importance of the assessment of staff attributions.

It appears that different types of challenging presentations elicit different emotions, although only one study specified the different types of challenge and the actual types of emotional response. It would seem plausible then, that different types of challenges may also result in different attributions and coping strategies. However, that is impossible to deduce from this review as most of the studies concerned violence and aggression.

Colson et al. (1986) also found differences in emotional responses to challenging presentations among different types of professions. This may be due to the length of time, the type of therapeutic work / interaction and / or type of training received among the disciplines. This highlights the importance of assessing these domains on multi-disciplinary staff members, not just nursing staff, as has been the case in most of the studies in this review. Further results of the relationships between staff demographics across any of the four domains could not be identified due to the lack of studies assessing them.
A range of emotions have been reported across various studies in response to challenging presentations, with the greatest appearing to be that of anger. Due to the fact that most of the studies assessed one or two emotions, it was difficult to draw any conclusions or make many comparisons between studies. Exceptionally, Rossberg and Friis’ (2003) employed the FWC:58 to assess a range of positive and negative emotions on a quantitative basis. Although several qualitative studies investigated the emotional experience of staff, the nature and variety in methodologies prevented the process of drawing direct comparisons.

In contrast, the studies focusing on staff coping responses assessed a range of strategies. However, these studies often drew on different theories and varying numbers of strategies, in addition to being based entirely on violence and aggression; therefore making comparisons and conclusions difficult to form and impossible to construct across different types of challenges presentations. It did appear however, that staff tended to utilise different strategies at different time points following challenging presentations, suggesting that coping strategies vary over time. Associations were also found between types of coping strategies used and emotional response, with one study indicating that ‘denial’ immediately after an incident resulted in less strain after three weeks. The number of strategies used was also an important factor, with a greater range associated with a greater reduction of reported staff strain. These findings also suggest that when staff members are assessed may be a significant factor to consider and could result in a number of different strategies being reported at different time-points post challenge. Moreover, this reflects the need for measures of staff coping to be repeated to assess any of the above changes and to explore potential differences in the impact of other responses, namely emotions and attributions. Assessment of coping could also indicate areas where staff members require support and further training to help develop useful coping strategies.

2.6.2 Methodological considerations

2.6.2.1 Limitations of included studies

Several features need consideration before drawing generalisations from these studies. Very few quantitative articles used inferential statistics to compare if the differences were significant and nine of those studies had sample sizes under 100. Also, where reliability and or validity was referred to as ‘acceptable’, ‘good’ or ‘excellent’, these results and specific psychometric properties were often unreported, thus data quality for some studies was questionable. The variety of different, often unnamed analyses used on qualitative
studies, as well as unreported reliability and validity of these methods, also questions the quality of these findings. Modestin et al. 21 (1986) did critique their methods but attributed this to the fact that there was no workable definition of a challenging service user, or indeed validated measures which could identify the challenges, hence the development of the questionnaires in order to explore this definition.

A major difficulty of the review was to draw comparisons and to be able to report actual types of challenges presentations, attributions, emotions, and coping strategies across the included studies. This was due to the different forms of assessment and the results reported across the studies. For example, Table 2 indicates only hypothetical comparisons of challenging presentations found by studies.

2.6.2.2 Limitations of the review

The decision to limit the inclusion criteria concerning participants and settings may have excluded some studies that would have offered valuable literature in all of the four domains. For example, there are many studies in the intellectual disabilities literature which may have significantly added to this review. However, the main objective of the review was to inform the development of an adult inpatient psychiatric service scale, therefore it was deemed appropriate by the research team to limit the search criteria. The research team also restricted the search terms by choosing not to name specific challenges, for example not to add ‘violence’, ‘self-harm’, ‘substance misuse’ etc, as the aim was to investigate the exploration of challenges, not to review the researcher’s pre-determined challenges. Also, the results of expressed emotion e.g. the association of EE and staff attributions found by Barrowclough et al. 2 (2001) were not included in the review findings, as EE was considered to be an expression of interpersonal relationships rather than an emotional response. The researcher acknowledges that these factors may have limited the number of studies and results produced. In fact, the inclusion criterion was extended at the early stages of the review to include qualitative as well as older studies due to the dearth of studies in these domains. The use of older studies meant that the authors were usually unavailable when contacted by the researcher. This lack of further information or clarification of these studies may be considered another limitation of this review.

The process of reviewing both quantitative and qualitative studies was difficult as the science of incorporating qualitative research into systematic reviews, particularly alongside quantitative studies, is very much in its infancy. Therefore, the results of this review
should be considered with caution. However, in line with the guidance from the CRD Handbook (2009, pp.219-238) the researcher did obtain professional advice from her supervisors and a Research Fellow (see Section 3.5.3) who has experience of incorporating both methods, in order to increase the methodological rigour of the review.

Due to the intertwining of two or more of the domains (specified and unspecified by the authors), the researcher also found it difficult to truly separate the four topic domains. Although agreement was reached by the research team, the researcher acknowledges that some of the findings may have been appropriately referenced under different categories.

2.6.3 Clinical implications

It is very difficult to make comparisons between studies as there are such a large variety of measures and analyses used. The varying degrees of reliability and validity presented, including studies with no psychometric properties reported, reflects the lack of standardised measures available. The large number of studies purely based on violence and aggression is counter-intuitive from previous studies\textsuperscript{10-13} which highlighted a number of other perceived challenges as more problematic. Although links have been established between three of the domains (challenges, attributions, emotions and coping), there have been very few studies outlining this and none of the quantitative studies have investigated all four domains in the same study. This may be due to the fact that there are no consistent measures of each domain, or one scale that measures all of these areas. In addition, only one reliable measure has been developed to assess perceived challenging presentations in psychiatric inpatients from a staff perspective (HTRS) and this was developed in the USA over two decades ago. Therefore, the scale may not be culturally appropriate for a UK sample or reflect the changes which have taken place in psychiatric inpatient wards over the intervening period, including the roles of staff. This review has highlighted a gap in the literature and therefore provides further rationale for the current study to provide an up to date and meaningful population-specific measure, developed using a UK sample.
CHAPTER THREE

Phase I, Stage II - Qualitative interviews with staff members

This chapter details the second stage of the first phase of the study, the aims of which are outlined below.

3.1 Aims and overview of method

This section aimed to develop a semi-structured interview to explore the four research questions:

- What features/behaviours do service users present with that are considered as particularly challenging to psychiatric staff?
- What are psychiatric staffs’ attributions about these challenges?
- What are psychiatric staffs’ emotional reactions to these challenges?
- What are psychiatric staffs’ coping strategies associated with these emotional reactions?

Deriving the content of a measure from participants who are representative of the target population ensures that only relevant topics are included and that areas important to staff challenges are not omitted (Doward et al., 2003). In addition to identification of themes, the aim was to produce rich qualitative data which could provide terminology that was meaningful to staff. This could then be incorporated into items for subsequent quantitative examination using a larger sample (Peters, 2010). For this purpose, themes were identified using the qualitative method of thematic analysis. The rationale for selecting this method is described below, followed by an account of the pilot study, recruitment to the main study, the interview process, analysis, subsequent results, and a brief discussion of the outcomes.

3.2 Qualitative methodology

Qualitative research involves the analysis of text data rather than numerical data (Carter & Little, 2007) and offers certain advantages in the investigation of human experiences. Whereas quantitative research aims to verify the validity of specific hypothesis derived from prior research, qualitative research entails an examination of open questions about social phenomena so that they may be understood in their natural contexts (Carter & Little, 2007; Elliott, 1995) and captures complex information about individual experiences and
meanings; making qualitative methodologies applicable to complex, specialised health care settings (Pope & Mays 1995a). We therefore use qualitative research methods to 'understand and represent the experiences and actions of people as they encounter, engage and live through situations' (Elliott, Fischer & Rennie, 1999, p216).

Qualitative methodologies buttress exploratory research by engendering theories and hypotheses about previously unstudied phenomena. They enhance the suitability of quantitative research data because qualitative accounts describe the personal perceptions and real life actions behind the formal public accounts yielded by quantitative research (Pope & Mays 1995b). Flick (2009) suggests that strict adherence to methodological rigour within experimental research; where contextual factors are controlled, may cause abstract findings that reduce applicability.

Stiles (1993) refers to further advantages and argues that qualitative research enables consideration of non-linear causation when analysing complex data because it provides a context within which data has been gathered, enabling an evaluation of the validity of interpretations. Qualitative methods also consider the personal, cultural attributes of participants and researchers and acknowledge the researcher's empathic responses to the participant thereby enhancing the reader's understanding of the participant's world view. Finally, qualitative methods benefit the interests of participants rather than vested interests as they are encouraged to be involved in the construction of interpretations.

3.2.1 The variety of methods of qualitative analysis

Braun & Clarke (2006) suggest that qualitative analysis can roughly be divided into two camps. Firstly, those stemming from a theoretical or epistemological position, including; Interpretative Phenomenological Analysis (IPA, e.g. Smith & Osborn, 2003) and conversation analysis (e.g. Hutchby & Wooffitt, 1998) have a goal to describe, interpret and understand the meanings of experiences at both a general and unique level. Studies conducted using this stance (mainly IPA) aim to demonstrate both the transferable general qualities of the experience and variety of descriptions across unique contexts. However, Braun & Clarke (2006) argue that there is limited flexibility in how this method is applied. Other methods include: grounded theory (Glaser & Strauss, 1967), discourse analysis (DA; e.g. Burman & Parker, 1993; Potter & Wetherell, 1987; Wilkinson, 2000) or narrative analysis (Murray, 2003; Riessman, 1993) which are still within the same theoretical framework but have more flexibility in that different manifestations of the methods can be used (Braun & Clarke, 2006). Secondly, there are methods that are essentially independent
of theory and epistemology and can be applied across a range of theoretical and epistemological approaches, allowing a broad and detailed account of the data and therefore a more flexible approach. Such methods include thematic analysis.

3.2.2 Thematic analysis: An overview

It has been argued that thematic analysis is not a specific method, but indeed a tool used across different methods (Boyatzis, 1998; Ryan & Bernard, 2000). Burnard (1991) stated that it combines elements of content analysis with aspects of the grounded theory approach (Glaser & Strauss, 1967). Brown and Locke (2008) also stated that thematic analysis shares close links with content analysis in that both are concerned purely with the topic, but that it is less concerned with representing frequency of participant themes (Brown & Locke, 2008). Braun and Clarke (2006) reported on the disagreement that exists about thematic analysis and the lack of clarity that exists around it. They argued that it is indeed a distinct method but is often used without it being explicitly named as thematic analysis. They provided examples of instances where it has been named as discourse analysis or content analysis (Braun & Clarke, 2006, p80) or not named at all, simply referred to as data ‘subjected to qualitative analysis for commonly recurring themes’ (Braun & Wilkinson, 2003, p30). Braun and Clarke (2006) interpret this method as:

‘Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail. However, frequently it goes further than this, and interprets various aspects of the research topic.’

(Braun & Clarke, 2006, p.79)

Braun and Clarke (2006) highlight the flexibility of this method as it can be used within different theoretical frameworks as well as within an essentialist, constructionist or contextual constructionist method. It also allows flexibility depending on the research aims in that the analysis can be inductive or deductive, searching for semantic or latent themes. Although not constrained by these limits, Braun and Clarke (2006) provide guidelines to allow flexibility but also for it to be theoretically and methodologically acceptable.

3.2.2.1 Rationale for using thematic analysis

This method is increasingly being used in psychological research (Brown & Lock, 2008). Brown and Locke (2008) suggest that researchers are using this method above others such
as IPA and grounded theory in order to reduce the risk of over-complication of analysis in areas of research where practical outcomes are required (e.g. in the development of a questionnaire). As noted above, thematic analysis can also be used flexibly without being tied to a theoretical model allowing a broad and detailed account of the data (Braun & Clarke, 2006). This study did not aim to generate a theory about staff perceptions of challenging service users. Rather, the aim was to explore the thematic commonalities (and differences) between staff members’ experiences within a pre-determined time-frame. For these reasons, thematic analysis was considered the most appropriate method for this stage of the study to elicit a broad understanding of the participants’ experiences in order to provide practical and realistic items for the development of the SEACCS measure.

3.2.3 Methodological rigour

Qualitative research is sometimes criticised for lacking scientific rigour. Mays and Pope (1995) identify the most common criticisms. Firstly, it is sometimes argued that qualitative research is a collection of anecdotes and personal perceptions which are of course subject to researcher bias. Furthermore, it has been argued that it is difficult to reproduce qualitative research as this research is so personal to the researcher that a different researcher may arrive at very different conclusions. Finally, it is said qualitative methods produce large amounts of detailed information about a small number of topics so that qualitative research lacks generalisability.

In light of these criticisms Mays and Pope (1995) suggested qualitative researchers must create a clear explanation of the phenomenon being examined, and a clear account of the method and data that stands alone so that another researcher can analyse the same data and reach the same conclusions.

Guidelines are therefore required in order to ensure methodological rigour. Many researchers have developed guidelines (for example Stiles 1993; Cresswell & Miller, 2000; Lincoln & Guba, 1985; Mays & Pope, 1995) and demonstrated these in reports (e.g. Elliott et al., 1999; Yardley, 2000).

3.2.3.1 Reliability & Validity

The study aimed to meet the principles of transparency, rigour and coherence in order to demonstrate an appropriate level of quality, in accordance with the guidelines set out by Yardley (2000) for qualitative research. Rigour was demonstrated by purposive sampling,
ensuring that all participants in the study were appropriate to the research. Transparency and coherence was demonstrated by outlining the stages that were used in analysing the data gathered through the interviews, in addition to stating how the participants were selected, how the interview was conducted, and what steps were taken to undertake the analysis. Furthermore, in identifying themes that emerged from the transcripts, discussions and comparisons took place between the researcher and the research supervisors to provide further understanding of the data and how interpretations of the data could be justified. In addition, whilst the data may have potentially produced several themes, the final themes ensured that the research questions were addressed. Therefore, whilst other themes may have been developed, they were not used if they lacked impact, importance or relevance to the research questions.

3.2.3.2 Reflexivity

The adoption of a reflexive stance by researchers is implicit in several of the techniques designed to preserve methodological rigour (Cresswell & Miller, 2000). Due to the data analysis being subjective to the researcher, it is important that qualitative researchers acknowledge their influences and are reflective on their approach during data collection and analysis to increase the transparency of the research (Burr, 1995; Elliot et al., 1999). The researcher used a reflective diary for these purposes (see Section 3.4.3).

3.2.3.3 Initial Biases

A brief description of the experiences of the researcher is now provided, to provide transparency about the beliefs, values, and assumptions which may have affected the interpretation of the data. This will help the reader to understand how the process of the analysis was shaped by the researcher.

The researcher is a trainee clinical psychologist, in the final year of her doctoral training at The University of Manchester. The research was undertaken in part fulfilment of clinical training. At the beginning of the study, the researcher also undertook a clinical placement. In this placement, the researcher employed a systemic and cognitive behavioural therapy framework to provide assessment, consultation, and therapy to children, adolescents, and carers in a looked after and accommodated children multi-disciplinary community service. The researcher had previous experience of thematic analysis from a service evaluation project conducted during an earlier stage of training.
Prior to and during training, the researcher had regular clinical contact with individuals with SMI. The researcher worked as part of multi-disciplinary team in a maximum secure forensic inpatient setting as an assistant psychologist, and in a psychiatric rehabilitation inpatient setting as a trainee. Across both settings, the researcher was involved with multi-disciplinary assessment, formulations, and providing consultation to nursing staff. Although the researcher had worked closely with ward staff, she was never based on an inpatient ward and therefore did not fully experience, or was part of, the ‘ward culture’.

Due to these experiences, the researcher was not only aware of the challenges she faced herself working with this client group within an inpatient setting, but was also aware of other staff members’ views in relation to these areas including: the varying styles of staff approaches towards inpatients, the emotional impact, common attributions, and types of coping strategies used. During the researcher’s experience, she was exposed to negative and positive attributions voiced from staff about inpatients’ presentation. Often, staff who expressed negative attributions in relation to a challenging presentation also reported negative emotions and increased difficulty in coping with such challenges compared with patients whom they perceived as less challenging. Based on her clinical experience and theoretical knowledge, the researcher held the expectation that thematic overlaps would be found in participants’ accounts of challenges, attributions, emotions, and coping.

### 3.3 Participant sample

#### 3.3.1 Sample size

While there are no clear guidelines in the literature regarding the number of informants who should be interviewed in the process of generating items, it has been suggested that interviews should meet the criterion of ‘interviewing until redundancy’; that is, interviewing participants until no new themes emerge (Streiner & Norman, 2003, p.16). It was believed that interviews with five to ten psychiatric staff would most likely meet this criterion.

#### 3.3.2 Homogeneity and heterogeneity of sample

Qualitative analysis can be employed when a researcher wishes to consider similarities and differences within a particular phenomenon (Mays & Pope, 1995). In order to do this, the researcher should attempt to recruit a homogenous sample, so that the phenomenon can be studied across a small but similar group of participants. The researcher can then aim to make some claims about this particular group of people, whilst acknowledging these
claims may not transfer across all populations (Smith & Osborn, 2003; Willig, 2001). Attempts to recruit a homogenous sample will however to some extent depend on the topic explored. For this study, the researcher decided to recruit participants who were professionally qualified staff, involved with NHS mental health services in a psychiatric inpatient setting. It was believed by the research team that this would help obtain homogeneity within the sample. This latter setting criterion has been applied in previous psychiatric staff research (e.g. Cutcliffe, 1999; Kindy et al., 2005). Although both qualified and unqualified staff would have had relevant experience, qualified staff have more training in working with and engaging with patients than their unqualified counterparts, therefore this group was chosen for the interview stage in order to increase homogeneity. Psychiatric staff from forensic units were excluded as the criminality element of these service users and settings may have resulted in significant differences in the experiences discussed from their non-forensic counterparts.

Although qualitative analysis looks to find themes regarding ‘shared’ experiences, it is acknowledged that experiences are subjective and so within this type of analysis it is possible to pay close attention to differences. Soong and Soobratty (2007) reported in their study on staff-patient relationships that future research needed to adopt a more holistic approach. Therefore, the research team decided to deviate from a homogenous profession, and conduct multi-disciplinary interviews in order to encapsulate similarities and differences between professional psychiatric staff across the disciplines. It was anticipated that this heterogeneity would increase the accuracy of the newly developed scale to measure multi-disciplinary staff experiences.

3.3.3 Inclusion criteria

The following inclusion criteria were employed:

- Qualified staff working with inpatients with SMI across two local NHS Trusts.
- A minimum of 10 hours contact with inpatients per week.
- A minimum of 3 months experience with service users on an inpatient ward.

It should be noted that it was assumed that all potential participants would be English speaking as they were all staff members in the North West of England.
3.3.4 Recruitment

3.3.4.1 Pilot interviews

Following approval from a local research ethics committee and NHS Trust research and development (R&D) committees, the researcher conducted pilot interviews with two clinical psychologists who worked on psychiatric inpatient wards and had links with the University of Manchester.

3.3.4.2 Further interviews

The researcher was provided with details of potential participants through her supervisors, two of whom were accessible through the University of Manchester. In relation to local inpatient sites, the researcher contacted clinical service managers to provide the research protocol and Participant Information Sheet-Interview (PIS-I; Appendix 4) and obtained approval to approach staff members. Once approval was sought, ward managers at that site were contacted to discuss their participation and methods to identify and recruit research participants. One of the researcher’s supervisors had provided input to one particular ward, which may have increased the likelihood of recruitment. Ward managers agreed to notify staff and the PIS-I was distributed to all qualified staff. The researcher attended a staff meeting to further inform staff. Staff members who expressed interest in the study at this time were contacted by the researcher following 24 hours of consideration time, whereby interviews were arranged. The researcher was aware that six participants had links with either one of her supervisors. The impact of which is discussed in Section 3.9.2.4.

3.4 Materials

3.4.1 Demographic information

Participants completed a brief demographic questionnaire (Appendix 5), comprising items on: age, gender, ethnicity, job role, duration working in mental health services, duration working on the psychiatric ward, and presence of professional qualification.

3.4.2 Semi-structured interview

The systematic review of the research literature and the review of existing measures (as identified in Chapters one and two) were used for the heuristic purpose of aiding the development of a semi-structured interview guide comprising a list of possible open questions regarding the experience of challenging psychiatric inpatients. Such a schedule
guides and facilitates discussion of the central research questions by asking open questions about the topic areas without overly limiting their focus (Smith, 1995). Questions should be phrased as neutrally as possible and used flexibly in response to the information from the participant (Legard, Keegan & Ward, 2003). Smith (1995) also suggests that the researcher should avoid using professional jargon and instead attempt to use the interviewee’s own terms.

The semi-structured interview schedule used in this study (Appendix 6) was further developed through discussion between the researcher and her supervisors and was based around five main areas designed to facilitate broad discussion of the topics. In the first section, participants were asked to briefly discuss the kind of service users they work with (i.e. diagnoses, presenting symptoms, severity of symptoms). This aimed to set the background and attempt to relax the participant into the interview.

This section also requested the participant to think of one service user they found particularly challenging, a method used in a similar study by Gallop and Wynn (1987). This allowed identification of participants’ views of the most challenging aspects of service users’ presentation enabling subsequent topics to be discussed with more ease, depth, and fluidity, and focused on specificities (i.e. attributions, emotions, coping strategies used) in relation to only one service user. At an early point, participants generated a pseudonym to use throughout the interview.

The second topic involved questions about the therapeutic relationship between the participant and the service user in order to explore any changes in their relationship, reasons provided, and feelings towards the service user.

Thirdly, participants were asked about the service users’ background and specific challenges. Prompts about the participants’ attributions about those challenges were used at this juncture in the interview.

The fourth area was concerned with the work undertaken with the service user and to explore coping strategies used and any suggested improvements about ways of working with the service user and to aid coping with the challenges and resultant emotional impact of them.
Finally, participants were asked to think of challenges experienced with other service users. This was to maximise the likelihood of capturing all of the perceived challenges from each participant. At the end of the interview, participants were given the opportunity to provide any additional comments and specifically asked if they had experienced distress during the interview.

### 3.4.3 Reflective diary

A reflective diary (Appendix 7), comprising issues emanating during recruitment and research interviews, was employed to acknowledge the researcher’s presumptions, personal beliefs or bias which may have influenced her manner. The diary also provides a context for the reader's understanding of the circumstances affecting the researcher's interpretation of the data.

### 3.5 Procedure

Prior to the interview, participants were sent a PIS-I. Before commencing the interview, the researcher checked the participant’s understanding of what they were undertaking. They were then asked to sign a consent form (Appendix 8) and complete the demographic questionnaire. Interviews took place over a two month period.

#### 3.5.1 Pilot interviews

Prior to formally beginning the research, two pilot interviews were conducted to provide the researcher with experience of the interview schedule and techniques in order to pre-empt problems (Holloway, 1997; van Teijlingen & Hundley, 2001). The pilots also established the schedule’s ability to generate relevant data and to gauge its acceptability to participants.

It is recommended that pilot participants should be as similar as possible to participants in the main study (van Teijlingen & Hundley, 2001). Hence, the research team agreed that the pilot interviews comprise the same inclusion criteria as the main interviews. Additionally, if there were no apparent problems or changes required, the pilot interviews could be included within the main study.

Two clinical psychologists were recruited and the interviews took place in private rooms in the University of Manchester. Feedback was sought from both participants following the interview. Both participants reported that there were no problems with the interview.
questions and reported that they appreciated the opportunity to reflect on their work. The researcher felt comfortable with the interview schedule and the use of prompts. From the reflective diary, one reflection concerning the pilots led to a slight modification of the interview schedule:

‘...it’s clear that questions should refer to ‘challenging patients’ as opposed to ‘difficult patients’ or patients that are ‘difficult to manage’. Both participants seemed to struggle with the term ‘difficult’, requiring further clarification. I did want to avoid the term ‘challenging’ as I think it is too closely related to the term ‘challenging behaviours’ (which is very common terminology on wards without specificities) and I wanted to explore all difficulties including external factors related to the patient, not necessarily attributed to their behaviour, however, ‘challenging’ was a more acceptable and appropriate term to the participants. This should be noted when developing the SEACCS measure also. Both terms should perhaps be piloted when it’s developed’ (Reflective diary, following pilot interviews).

Following discussion with her supervisors, it was agreed that no further modifications to the interview schedule were required and both interviews were employed in the main study. Final procedural details of the interviews are outlined below.

3.5.2 All semi-structured interviews

All interviews took place in a private room, four at the University of Manchester, and three on the ward. Two of the interviews had to be cancelled at short notice due to incidents on the ward. Interviews were recorded with a digital recording device and efforts were made to ensure that interviews were quiet and free from interruptions. However, four of the interviews were interrupted by other staff members and this often seemed to break the participants’ train of thought. When privacy was regained, the researcher repeated the most recent discussion to refresh memory and the recording was resumed. The impact of these interruptions is discussed in Section 3.9.2.4. The length of interviews ranged from 40 minutes to 1 hour and 11 minutes.

Each recording was assigned a participant code number and the content was transcribed. Due to time constraints, the interviews were transcribed verbatim by an individual independent of the study. The researcher then read through the transcript whilst listening to the recording to verify accuracy. Where not already done, people’s names were
replaced with pseudonyms. Place names were substituted with words which preserved the meaning of the text. A confidentiality contract was also signed by the transcriber.

3.5.3 Service user input

A service user was recruited for consultation purposes through the service user reference panel (SURP) to the Mental Health Act Commission (MHAC). This panel is unique in that a large proportion of its members are currently detained and being treated as inpatients. Almost all the membership is comprised of individuals who have been treated as inpatients, both formally detained and as voluntary inpatients.

One SURP member was recommended by the MHAC due to her relevant experience. To safeguard her interests, she was contacted via MHAC and agreed to be contacted by the researcher. The service user subsequently agreed to offer advice and consultation to the researcher on certain areas of this study (outlined below). In order to protect her identity, she will be referred to throughout the study using the pseudonym ‘Sally’. Sally had previously been a psychiatric inpatient and a ward based staff nurse. Additionally, Sally had expertise in qualitative research methods – being involved in many published qualitative studies with a focus on staff-patient relationships. She was a Research Fellow, who offered professional advice to many researchers involved in large national research projects. For these reasons, it was agreed amongst the research team that her advice and opinions would be extremely valuable to the study. Sally was consulted on both the qualitative phase of the study (see Section 3.7) and the item reduction part of the questionnaire construction stage (see Section 4.2.2). Sally was paid per hour for consultation by the researcher.

3.6 Data analysis

The process of analysis was informed by the guidelines for thematic analysis described by Braun and Clarke (2006). These authors note that a single, prescribed method for analysis does not exist; rather, the method consists of a set of ‘common processes’ flexibly applied according to the analytic task. Four individual analyses were carried out in order to focus on each individual research question. The process was predominantly deductive, in that the themes identified were strongly linked to the researcher’s analytic interest and were therefore theoretically driven. Also, the themes were semantic, in that they were identified within the explicit or surface meanings of the data and the researcher did not attempt to infer anything beyond what a participant had said. In order to achieve the primary aim of
the study, resultant themes would be utilised in developing the SEACCS. Data was often preserved in its raw form to provide meaningful terminology to staff which could be incorporated into question items. However, an interpretive process was used to organise and summarise the data to identify patterns and attempt to theorise the significance of the patterns, their broader meanings, and their implications in relation to previous research. The extracts were also checked to ensure that they matched the analytic claims. During each analysis process, the researcher continually considered whether the analysis provided a convincing and well-organised representation of the data and the topic. The outline of the analytic method below will enable the reader to understand the process by which the research team arrived at their interpretations.

- Stage 1 – Familiarising yourself with the data

Following transcription of the first interview, the researcher read the transcript several times, simultaneously listening to the interview recording on one occasion. This had two purposes. This allowed the researcher to become immersed in the data and enter the participant’s world. During the process of reading and re-reading the transcript, the researcher began to make notes in the left-hand margin regarding semantic content and language. At this stage, all of the material was treated as data and the researcher made notes about anything which struck her as interesting or significant in the participant’s speech.

- Stage 2 – Generating initial codes

Codes identify a feature of the data (semantic content or latent) that appears interesting to the analyst, and refer to ‘the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon’ (Boyatzis, 1998: 63). Coding refers to the creation of categories in relation to data; the grouping together of different instances of datum under an umbrella term that can enable them to be regarded as ‘of the same type’. Sometimes these codes directly use the words of participants, and are known as ‘in vivo’ codes. The analysis proceeded at a fine level of detail to the text, in a line-by-line coding of the concepts represented in the data. New data was then compared with early codes and later codes compared with earlier data and with other codes to refine the conceptualisation of the actions and processes that occurred in the data. This process is
similar to that used in grounded theory, which is referred to as ‘constant comparison’ (Glaser & Straus, 1967).

All data extracts were coded and matched with other extracts that demonstrated that code. This involved copying extracts of data and collating each code together in separate computer files. Coded extracts of data were kept as inclusive as possible, as a common criticism of coding is that the context can be lost (Bryman, 2001).

- Stage 3 – Searching for themes

The development of themes grounded in the data yet sufficiently abstracted to be conceptual is summarised by Braun and Clarke (2006, p.89):

“Essentially, you are starting to analyse your codes and consider how different codes may combine to form an overarching theme.”

Names of each code were recorded along with a brief description on a separate document before organisation into theme-piles. Some codes form themes, whereas others form sub-themes. Others, which did not seem to belong to a cluster and were not relevant to the central research questions, were discarded. The resulting themes were therefore the product of both the participant’s speech and the researcher’s interpretations. An example of the noting of emergent themes in the right-hand column is provided in Appendix 9.

- Stage 4 – Reviewing themes

Firstly, the collated extracts for each theme were read to consider their coherence. Themes were prioritised on the basis of prevalence, the richness of the passages from which they were derived and their capacity to deepen the understanding of other transcripts. Once the researcher was satisfied that all themes captured the essence of the coded data, a “thematic map” was produced. Secondly, individual themes were considered in relation to the entire data set. The researcher continually held the research questions in mind and regularly alternated between development of themes and checking accurate representation of the data. The researcher repeatedly reviewed and refined the coding until a satisfactory thematic map was produced. Once no new substantial themes were produced, re-coding
was stopped. Otherwise, the themes could increase “ad infinitum” (Braun & Clarke, 2006, p.92).

- Stage 5 – Defining and naming themes

The final stage of thematic analysis was undertaken by the researcher as summarised by Braun and Clarke (2006, p.92) below:

“At this point, you then define and further refine the themes you will present for your analysis, and analyse the data within them. By ‘define and refine’, we mean identifying the ‘essence’ of what each theme is about (as well as the themes overall), and determining what aspect of the data each theme captures.”

3.7 Credibility checks

The use of supervision and peer discussion ensured that the researcher’s interpretations seemed viable and grounded in the data. Consultation was also sought from Sally. All those involved in the research planning were consulted regarding the potential themes to ensure that the interpretations and implications were relevant and that there were no perceived omissions. Participants were also offered copies of their typed transcripts to allow expansion on any issues before analysis began.

The purpose of these credibility methods required some consideration dependant on the epistemological stance of the researcher. A contextual or ‘social’ constructivist approach was adopted which states that the meanings reached during the analysis were subjective and that universal ‘truths’ were unattainable (Seale, 1999). Thus, the purpose of credibility checks was not to reach different or more reliable interpretations, rather to ensure the themes were relevant to the population and that the researcher’s method of interpretation could be understood from the data presented. The researcher acknowledges that other interpretations were possible.

3.8 Results

3.8.1 Participants

Consent was received from eight staff members to participate in the study. However, following discussion by the analysis team, it was agreed that data saturation had been
reached with the seventh participant and the process was discontinued. A brief description of each participant and the diagnosis of the service user they found to be the most challenging is provided in Table 6 below. This should enable the reader to place each participant in context and to understand the experiences which inform their perspectives.

Table 6: Participant demographic information and service user diagnosis

<table>
<thead>
<tr>
<th>Name</th>
<th>Service User</th>
<th>Staff Member</th>
<th>Role</th>
<th>Years in MH</th>
<th>Type of current ward</th>
<th>Months in Current ward</th>
<th>Name &amp; Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Mary'</td>
<td>‘Peter’</td>
<td>33</td>
<td>White British Clinical Psychologist</td>
<td>12</td>
<td>Rehabilitation, Acute psychiatric (male &amp; female)</td>
<td>24</td>
<td>(young) Schizophrenia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>'Mary’s Previous Experience:</td>
<td>Clinical input to various rehabilitation psychiatric wards: (mixed and single sex); Training and supervision; Clinical research</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>'Ivy'</td>
<td>‘Greg’</td>
<td>47</td>
<td>White British Clinical Psychologist Professor</td>
<td>21</td>
<td>Rehabilitation, Acute psychiatric (male &amp; female)</td>
<td>6</td>
<td>(young) Schizophrenia and Substance Misuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>'Ivy’s Previous Experience:</td>
<td>Clinical input to various forensic, rehabilitation &amp; acute psychiatric wards (mixed &amp; single sex); Training and supervision; Clinical research</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>'Alan'</td>
<td>‘Anne’</td>
<td>43</td>
<td>White British MH Nurse Psychological Therapist</td>
<td>23</td>
<td>Inpatient &amp; Outpatient; dual diagnosis</td>
<td>36</td>
<td>(middle-aged) Schizophrenia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>'Alan’s Previous Experience:</td>
<td>Various psychiatric wards</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>'Chris’</td>
<td>‘Julie’</td>
<td>43</td>
<td>White British MH Nurse Assistant Ward Manager</td>
<td>16</td>
<td>Acute psychiatric</td>
<td>84</td>
<td>(young) Bipolar Disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>'Chris’s Previous Experience:</td>
<td>Acute psychiatric wards</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>'Kate’</td>
<td>‘Simon’</td>
<td>29</td>
<td>White British MH Nurse</td>
<td>10</td>
<td>Acute psychiatric (mixed sex)</td>
<td>3</td>
<td>(young) Bipolar Disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Kate’s Previous Experience:</td>
<td>Psychiatric male rehabilitation wards</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>'Eric’</td>
<td>‘Paul’</td>
<td>42</td>
<td>White British Consultant Psychiatrist</td>
<td>18</td>
<td>Rehabilitation (both male &amp; female only)</td>
<td>36</td>
<td>(young) Schizophrenia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Eric’s Previous Experience:</td>
<td>Various psychiatric wards; Consultant of community rehabilitation service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>'Jane’</td>
<td>‘Bob’</td>
<td>37</td>
<td>White British MH Nurse Ward Manager</td>
<td>19</td>
<td>Male rehabilitation</td>
<td>24</td>
<td>(young) Schizophrenia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Jane’s Previous Experience:</td>
<td>Various psychiatric wards</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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3.8.2 Overview of results

The aim of this stage of the study was to gain detailed insight of the four domains. To explore the respective research questions, a separate qualitative analysis was carried out across seven transcripts each focusing on one of the four individual research questions. The principles of thematic analysis facilitated the development of a number of core themes for each question: five, seven, two, and two respectively. Across the analyses, each core theme comprised sub-themes, outlined in Table 7 below.

**Table 7: Themes and sub-themes for each analysis**

<table>
<thead>
<tr>
<th>Focus of Analysis</th>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenges</td>
<td>Mental &amp; physical health problems</td>
<td>Positive symptoms of psychosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low mood</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Poor self-care / physical health</td>
</tr>
<tr>
<td></td>
<td>Engagement</td>
<td>Lack of engagement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unpredictable &amp; changeable engagement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Apparent lack of motivation</td>
</tr>
<tr>
<td></td>
<td>Boundaries</td>
<td>Demanding &amp; intrusive behaviour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Sexually inappropriate’ behaviour</td>
</tr>
<tr>
<td></td>
<td>Therapeutic progress</td>
<td>No / slow change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Stuck’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of (displayed) insight / understanding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-adherence to medication</td>
</tr>
<tr>
<td></td>
<td>Risk issues</td>
<td>Violence &amp; aggression</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Substance misuse</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Absconding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-harm</td>
</tr>
<tr>
<td>Causal Attributions</td>
<td>Attributing challenges to symptoms of mental illness</td>
<td>Attributing challenges to positive symptoms of psychosis / mania</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attributing challenges to depression</td>
</tr>
<tr>
<td></td>
<td>Attributing challenges to past experiences</td>
<td>Attributing challenges to difficult childhood experiences</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attributing challenges to difficult adult experiences</td>
</tr>
<tr>
<td></td>
<td>Attributing challenges to service users’ personality</td>
<td>Attributing challenges as being ‘part of who they are’</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attributing challenges to service user’s bad temperament</td>
</tr>
<tr>
<td></td>
<td>Attributions of Controllability</td>
<td>Attributing challenges as being controllable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attributing challenges as having uncontrollable / degree of uncontrollable basis</td>
</tr>
</tbody>
</table>
### Table 7. Continued

<table>
<thead>
<tr>
<th>Focus of Analysis</th>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
</table>
| **Causal attributions** | Atributing challenges to recent / current environmental factors | Atributing challenges to approach by others  
                           |                                                                             | Atributing challenges to ward environment  
                           |                                                                             | Atributing challenges to biochemical factors  |
|                   | Atributing challenges to service users’ disagreement | Atributing challenges as being due to disagreement  
                           |                                                                             | with treatment  
                           |                                                                             | Atributing challenges as being due to disagreement  
                           |                                                                             | with restrictions  |
|                   | Atributing challenges to a coping strategy | Atributing challenges as being used as coping strategy  
                           |                                                                             | for escape / avoidance  
                           |                                                                             | Atributing the use of anger and aggression as a coping strategy  |
| **Thoughts & feelings about challenges** | Negative thoughts & feelings associated with challenges | Feelings of frustration and anger  
                           |                                                                             | Feelings of Sadness, sympathy, hopelessness & helplessness  
                           |                                                                             | Feeling de-motivated, deflated & disappointed  
                           |                                                                             | Doubts of competence & lack of confidence  
                           |                                                                             | Feeling uncomfortable, anxious & frightened  
                           |                                                                             | Feeling stressed – ‘burnt out’  |
|                   | Positive thoughts and feelings associated with challenges | Confidence in managing and overcoming challenges  
                           |                                                                             | Feelings of protectiveness  |
| **Coping** | Behavioural responses | Time away from service user  
                           |                                                                             | ‘Giving up’  
                           |                                                                             | Planning & preparation  
                           |                                                                             | Formal & informal support  
                           |                                                                             | Training  |
|                   | Cognitive responses | Reflection  
                           |                                                                             | Positive re-appraisal;  
                           |                                                                             | ‘Part of the job’  
                           |                                                                             | Understanding of service users’ difficulties  
                           |                                                                             | Focus on positive aspects  |

Themes will be presented below under each individual analysis, illustrated by interview extracts. However, due to the scope of these analyses and the subsequently large number of themes and sub-themes, it was not possible to provide detailed illustrations and multiple quotes for the production of each subtheme.
In this chapter, the use of ‘...’ within an extract indicates that an incomplete sentence has been quoted. Participants’ laughter and sighs are indicated in square brackets. Where quotations include the interviewer’s comments I denotes the interviewer, and R denotes the respondent.

3.8.3 Analysis

3.8.3.1 Question One: What do psychiatric staff perceive as the challenges service users present with?

3.8.3.1.1 Core theme: Mental & physical health problems

Positive symptoms of psychosis

All participants referred to mental health symptoms that service users present with as particularly challenging for them, with several describing some of the positive symptoms of psychosis, mainly delusional beliefs and disorganised thoughts.

For Mary, her lack of understanding about where Peter’s delusional system originated from made this challenging for her to work with.

*I’ve never quite got to the bottom of the beliefs about why these people are conspiring about him or against him... But as I say, I can’t quite get to the bottom of... there’s no... there’s no clear cut delusional system, if you see what I mean, like there is with some people... And I can never get to... that’s why I always find it quite hard, I think, to get to the purpose of why people are doing what they’re doing...*

Participant 1, Mary

Ivy found it challenging when reality and fiction were blended together in Greg’s delusional system. It was not only dangerous if she was a part of these delusions, but she felt that her input could potentially perpetuate or strengthen these beliefs, thus worsening his symptoms.

*... he had really quite violent beliefs about things, and he... he intended to do quite violent things to these fictional people. They weren’t real people, but fictional or fantasy people.*
But, sort of, reality kept intruding into his delusions, so that people around him and things around him were, sort of, thought to be part of this thing. So there was the concern that me seeing him might also become part of it... So it’s, sort of, trying to get the balance between not making it worse through exploring it, and trying to be empathic.

Participant 2, Ivy

Jane shared the experience of not fully understanding where certain delusional beliefs stemmed from and trying to strike the right balance in her response to these beliefs – she did not want to dismiss or collude with them.

... that can be very challenging, because we do have some very bizarre conversations going on [laughs] in a unit in relation to... not particularly to voices, but just to beliefs that... that they have in terms of things happening and... and that some staff, I think, find that difficult. And I do as well. You sit there thinking, ‘Well where did that one come from?’ [Laughs]. You know, and you don’t always know exactly how to respond. You don’t want to dismiss what someone’s just said, but at the same time you don’t want to get that wrapped up...

Participant 7, Jane

Mary also found Peter’s response to auditory hallucinations challenging to manage during sessions.

It’s quite hard. He responds quite openly to voices while we’re talking.

Participant 1, Mary

Low mood

In addition to positive symptoms, Kate, Mary and Ivy described symptoms such as low mood as problematic. The persistence of low mood was challenging for Kate.

His mood is hard to deal with...I mean [sigh] it’s not his depression...I mean, I’ve worked with that a lot. It’s just that...it’s constant...you know? All the time...it really takes out of you...I mean, where do you go from there, you know?

Participant 5, Kate
**Poor self-care / physical health**

Service users’ poor self-care and subsequent physical health problems were challenging for many participants. These problems were occasionally attributed to mental health problems (further outlined in Section 3.8.3.2.1). Poor sleep patterns or diet, lethargy, and lack of cleanliness were all indicated as factors that were challenging and impacted on the therapeutic relationship as it limited any time spent with the service user.

*He’s got bad sleep patterns so he’ll be awake all night and asleep during the day...I’m only there during the day.*

Participant 1, Mary

Jane also felt that issues of self-care and physical health restricted any time she had to focus on mental health issues:

*Healthy lifestyles and things, that’s a biggy. Diet and food and... and things like that is... is very difficult...it takes time away from actual therapeutic work.*

Participant 7, Jane

### 3.8.3.1.2 Core theme: Engagement

#### Lack of engagement

Poor engagement was a significant challenge for all participants. This involved engagement issues with the participant and / or other staff members and other service users. For Mary, she struggled with a complete lack of engagement. This was particularly challenging as she felt the preparation time had been wasted.

*I think just when he wouldn’t engage. You know, when I... I’d arrange things, I’d arrange to spend some time with him off the unit, and then he just wouldn’t leave the unit with me!.. Or I’ll set things up and people can’t follow through with it.*

Participant 1, Mary

Alan and Chris had a similar difficulty with service users not engaging at all.

*She, sort of... she isolated herself and wouldn’t come out of her room.*

Participant 3, Alan
You know, not engaging with the staff, not wanting to participate with things that are going on the ward. Those are the, kind of, typical things.

Participant 4, Chris

Unpredictable & changeable engagement

It was the unpredictable and changeable engagement that was challenging for Ivy.

At times he seemed as though he was well engaged with the therapy, but at other times he... I guess I felt that he hadn’t really engaged at all. So from week to week he could be quite different.

Participant 2, Ivy

Jane found that maintaining initial engagement was difficult.

Keeping him engaged. And motivated... I think that’s... To me, that’s... that’s the biggest challenge and to me that can be the most frustrating. You know, because you can get so far and then, you know, you seem to, kind of, right back again.

Participant 7, Jane

Apparent lack of motivation

Almost all participants referred to apparent lack of motivation as challenging, which was often associated with engagement. Although this could be considered as an attribution; participants had various attributions about what caused the apparent poor motivation (e.g. medication, depression, negative symptoms, laziness, and personality) and was thus deemed as an appropriate ‘Challenge’ theme.

R: Yeah, he’s never motivated to do anything
I: Motivated to do...?
R: Anything...it doesn’t matter what it is, even if I knew he was trying...it just that lack of motivation that I find...[sigh] I think is a real challenge.

Participant 5, Kate
3.8.3.1.3 Core theme: Boundaries

**Demanding & intrusive behaviour**

Many participants expressed their difficulty with maintaining therapeutic boundaries, and how service users were often intrusive and demanding.

*Yeah, I think that the most difficult aspect of her presentation was the... it’s the intrusiveness and the, kind of, demanding behaviour...*

Participant 4, Chris

*Mainly being quite... very intrusive. We generally like to keep the staffroom door open... And Simon would regularly... well, frequently walk into the office, which wasn’t always appropriate*

Participant 5, Kate

**‘Sexually inappropriate’ behaviour**

For some participants, it was difficult to know how to respond and manage behaviour that appeared to be too familiar and ‘sexually inappropriate’.

*... she was, kind of, over-familiar... a bit sexually inappropriate... with me, other staff, other patients... it was hard.*

Participant 4, Chris

3.8.3.1.4 Core theme: Therapeutic progress

**No / slow change**

All participants had significant challenges concerning the lack of therapeutic progress. This was particularly difficult over a long period, where therapeutic strategies had resulted in no change in presentation or very slow progress.

*... and as I say, we haven’t had an enormous amount of success with his illness.*

Participant 6, Eric
The progress he made was quite limited.

Participant 2, Ivy

I think it’s so difficult coming in day in and day out with nothing changing to the behaviour.

Participant 5, Kate

... in rehab, changes and improvements are so slow, it’s so easy to give up.

Participant 7, Jane

**Lack of (displayed) ‘insight’ /understanding**

For some, service users’ displayed lack of insight about their mental illness indicated a lack of therapeutic progress.

If her insight was better then you could work more easily with explaining stuff to her and reassuring her. But while she was, kind of, adamant that there was nothing wrong with her and she wasn’t ‘mental’ as she put it, then that becomes more tricky... we’re not really going to get anywhere.

Participant 3, Alan

I guess, the patients that are easier to work with are the ones that are maybe a bit more insightful and therefore a bit further on in terms of their recovery.

Participant 4, Chris

**Non-adherence to medication**

Some participants felt that non-adherence to medication disrupted progress.

She wouldn’t take medication, so she couldn’t get any better really.

Participant 3, Alan

But, I mean, his most recent exacerbation was again a bit tricky and he doesn’t always take his medication either, which complicates things, and hinders his progress.

Participant 6, Eric
In contrast, some felt that the medication itself could impede therapeutic progress. This is referred to below in Section 3.8.3.2.5 in relation to recent environmental attributions participants held.

3.8.3.1.5 Core theme: Risk issues

Violence & aggression

Throughout the interviews, issues that posed risk to the service user, participant or others were discussed. Due to the requirement for risk management, all types of risk were reported as taking time from other duties, including therapeutic work with other service users.

The main risk issue referred to was violence and aggression. Participants reported experiencing a great deal of hostility and angry outbursts resulting in verbal abuse, threatened and / or actual physical violence. This risk posed tended to result in service users requiring physical restraint or other forms of management. Incidents that were reported as predictable seemed to be less challenging for participants than those perceived as unpredictable.

... there were times that he’d, kind of, pretend to go hit me, but wouldn’t.

Participant 5, Kate

I mean, the behaviour itself, I mean, you know, the violence, yeah, I mean that is extremely difficult to accept and to manage.

Participant 5, Kate

Chris felt that it was more challenging when service users continually presented with violence and aggression, such instances that required service users to be restrained.

... but you can get people who are repeatedly difficult who, you know, might be restrained over several occasions or over long periods of time, kind of, periodically and it, you know... sometimes you feel it develops into a, kind of, 'us and them' situation.

Participant 4, Chris

However, although violence and aggression was commonly discussed throughout the interviews, many of the participants did not perceive it as a significant challenge for them.
Some believed that they had built a tolerance and perhaps became complacent about such behaviours. For some, it was considered normal behaviour for this setting.

*Do you know, in a way it was almost like... because when you work on wards you, kind of, see behaviour that you wouldn’t see anywhere else, and in some ways it, kind of, gets normalised as being okay, normal behaviour really.*

Participant 3, Alan

*Because there’s lots of violent incidents on these wards and, you know... and we almost expect it in some ways.*

Participant 5, Kate

**Self-harm**

One participant referred to self-harm of service users as a particular challenge for staff to manage. Chris felt that this risk issue also greatly impacted on the therapeutic relationship.

*But, I mean, there are other behaviours... like self-harm. That’s often a key thing for people working in inpatient settings to... a real challenge for people sometimes. And the relationships that go with people that self-harm over long periods in hospital. That can be very difficult for people... and the difficulties that can go along with that being seclusion and proper support in place.*

Participant 4, Chris

**Substance misuse**

The use of alcohol and illicit substances was also a risk issue for many participants.

*Well substance use has been a difficult thing.*

Participant 2, Ivy

*I think the most difficult thing to manage, really, in this setting is the dual diagnosis patients really, in an inpatients setting.*

Participant 4, Chris
Some participants felt that the use of substances had significant consequences on the service users themselves – exacerbating their symptoms – and to other service users and staff members.

*People that aren’t motivated to stop using and want to carry on and in spite of the effect it has on their behaviour or their mental state, and the impact that has on the rest of the clients in the ward.*

Participant 4, Chris

*I didn’t get to speak to all the people that I was supposed to because I was dealing with that single incident of trying to reduce the risk of needles. ‘Cause basically, needles had been lying around. It’s extremely unsafe. And that took up two qualified, really, shift for the whole time.*

Participant 5, Kate

**Absconding**

The final risk issue identified by participants was absconding. This behaviour posed more difficulty for Kate when the service user was involuntarily admitted under the Mental Health Act.

*...but it was just always, you know, being in that role of having to stop someone from leaving.*

Participant 3, Alan

*And he would also generally try and leave the ward. When he was sectioned, he’d try and leave the ward... and it would, kind of, be quite difficult really.*

Participant 5, Kate
3.8.3.2 Question Two: What attributions do staff members make about the cause of these challenges?

3.8.3.2.1 Core theme: Attributing challenges to symptoms of mental illness

Attributing challenges to positive symptoms of psychosis / mania

All participants reported causal attributions of a range of perceived challenges involving service users’ symptoms of mental illness. In particular, the positive symptoms of psychosis and the mania associated with bipolar disorder were perceived as causes for some of the challenges presented.

Well [laughs] a lot of his difficulties were to do with this huge delusional system he had, which was causing him a lot of distress.

Participant 2, Ivy

Fairly typical of what you’d expect of someone who’s manic, really, I think is that they can’t tolerate other people and they get really wound up easily.

Participant 4, Chris

Attributing challenges to depression

Some challenges, particularly apparent poor motivation, lethargy and lack of engagement were attributed to symptoms of depression.

And I felt like I wasn’t really getting anywhere and I knew that sometimes when people are very depressed, and they can’t even motivate themselves.

Participant 1, Mary

3.8.3.2.2 Core theme: Attributing challenges to past experiences

Attributing challenges to difficult childhood experiences

Many of the participants believed that some challenges were due to service users’ difficult upbringing involving difficult childhood experiences.
You know, with everything that she presumably had been through, you know, when she was younger etcetera, you just... it sort of made... to me it made sense why she got that way, why she was being like she was.

Participant 3, Alan

...but I can certainly see how his childhood and, kind of, onward, kind of, you know, growing up has... has had an influence on how he looks to seek attention and how he has his... how he interacts with staff. So I can... I can see that there’s been... you know, he’s had a lot of difficulties in his growing up, and I can see how as an adult he finds, you know... he finds relationships in particular and, kind of, social interactions quite difficult.

Participant 5, Kate

Attributing challenges to difficult adult experiences

Some participants referred to negative relationships and significant life events in adulthood as a cause for some of the challenges.

I know he’s had a lot of relationship break-downs which has had a massive impact on him... he’s really angry about it.

Participant 7, Jane

I think she started lashing out when her father died. I don’t think she’s been the same since...

Participant 3, Alan

3.8.3.2.3 Core theme: Attributing challenges to the service user’s personality

Attributing challenges as being ‘part of who they are’

Some participants referred to service users’ personalities in attributions of challenging presentations.

I guess his grandiose beliefs might have reflected some of his, you know, his personality and his deep seated desires and wishes of being an important and successful person.

Participant 2, Ivy
...my opinion really was that no amount of medication would actually possibly stop him behaving in the way that he does, ‘cause that’s part of him. As opposed to it being related to... well, illness.

Participant 5, Kate

Attributing challenges to service user’s bad temperament

Kate also suggested that Simon’s presenting challenges were a part of his temperament.

He’s demanding and angry when he doesn’t get his own way, but I think that’s down to him... his personality, he’s bad tempered.

Participant 5, Kate

3.8.3.2.4 Core theme: Attributions of controllability

Attributing challenges as being controllable

Whether or not participants believed service users had control over their presentation was a very significant factor throughout this analysis. The perceived control was mainly referred to as behaviours that they did not attribute to service users’ mental illness. This latter attribution was mainly discussed during Kate’s interview.

I, kind of, see it as a lot of how he presented was relating more to his behaviour as opposed... you know, I saw it as behaviour driven as opposed to illness driven.

Participant 5, Kate

Kate attributed her feelings of frustration (also discussed in Section 3.8.3.3.1) to Simon’s refusal to take responsibility for his challenging presentation, which she believed he was in control of.

So it was quite frustrating that ...he’s been very violent towards staff. Physically violent. And again there’s no responsibility there. It’s, ‘I was ill, and it’s not my fault. I can’t be held responsible for this because I’m unwell.’ That’s quite frustrating because, you know, from our objective opinion, and mine, and the team’s, it wasn’t illness driven. And he... it was almost like, ‘I’m ill, I can do what I want.

Participant 5, Kate
Kate and Mary also believed that some of the service users’ challenging presentations were deliberately aimed towards seeking attention and / or to provoke a negative reaction from staff.

*And I think it seemed that Simon... everything Simon did or said was in order to provoke some kind of reaction from staff.*

Participant 5, Kate

*Although sometimes I do feel that perhaps he’s... there’s some behavioural element to it. But I think sometimes he does say things to provoke a reaction.*

Participant 1, Mary

Many participants referred to their experience of working with other staff – and some of the staff attributions they have come across. Chris made a clear association between behaviours that staff associated as being unrelated to mental illness as being perceived as more challenging than those behaviours that staff found to be clearly symptom related.

*Because we... we’re tolerant of bad behaviour when we can see that it’s clearly related to symptoms of illness, and that’s... that’s understandable. It’s behaviours that are less clearly related to symptoms of illness that staff as a group will find difficult to... to manage.*

Participant 4, Chris

Mary and Alan referred to how other staff tended to attribute service users’ behaviour as deliberate as they were seeking to manipulate staff.

*You hear a lot of staff talking about, you know, people being manipulative. They could do more than they could actually do and things, they’re trying to get one over you.*

Participant 3, Alan

*You can have a laugh with him, you can have a joke with him, he can be quite warm. Some of the staff see that as manipulation, that he’s, kind of, wrapping you round... you know, wrapping you around his finger and getting you to do what he wants and stuff.*

Participant 1, Mary
Attributing challenges as having uncontrollable / degree of uncontrollable basis

In contrast to controllable attributions above, participants tended to share the view that service users had little to no control over presentations attributed to mental illness.

*I think she’s... she’s obviously quite acutely unwell, and as that resolves, then I think the degree of control that she has will increase. I think at the moment she’s not really fully responsible for herself or her behaviour.*

Participant 4, Chris

*I don’t think she has much control over it at all.*

Participant 3, Alan

Some staff believed that service users had a small degree of control over their behaviours and that it was a combination of controllable and uncontrollable behaviour:

*In what sense is it conscious and voluntary, and in what sense is it a product of, depending on your theory, unconscious motivations or assumptions and beliefs of which he would not consciously connect with his behaviour? I think it’s a combination of the two.*

Participant 6, Eric

*I don’t think he had a great deal of control over his beliefs and what was going on. I think, yeah, that was real and... to him, and it... it felt real. So I think probably he had a bit of day to day control of what was going on and what he did, but... Yeah, he wasn’t doing it deliberately.*

Participant 2, Ivy

3.8.3.2.5 Core theme: Attributing challenges to recent / current environmental factors

Attributing challenges to the approach by others

Many participants expressed causal attributions in relation to recent or current environmental factors. One environmental factor concerned how service users were approached by others. Both Mary and Jane felt that negative attitudes towards service users caused others to behave negatively towards them.
I think he does have a lot of negativity from a lot of staff and he does react to that. Staff are quite critical of him.

Participant 1, Mary

You know, and it just... sometimes it does very much feel like people are trying to sabotage or set Bob up to fail.

Participant 7, Jane

Attributing challenges to the ward environment

Confinement and lack of activities in the ward environment were attributed by participants to some perceived challenges.

I think that an environment like this escalates behaviour... But I think personally these types of environments I don’t think are helpful for a lot of patients.

Participant 5, Kate

I mean they’re so confined on the ward and there isn’t really any activities for them to do... so it’s no wonder really.

Participant 3, Alan

Attributing challenges to biochemical factors

Problems with biochemical factors including medication and substance misuse were also indicated as a cause of some of the challenges.

The main reason why he’s had recurrent episodes of psychosis is because he stops the Clozapine and uses cannabis.

Participant 6, Eric

Jane reported that Bob’s misuse of drugs and alcohol would exacerbate his symptoms and increase the presenting challenges.
And I would probably say that the drugs and alcohol probably did exacerbate some of those experiences considerably more as well.

Participant 7, Jane

Ivy expressed her belief that other staff members attributions, in relation medication and substance use, impacted negatively upon Greg.

I thought he was managed quite poorly by other staff. His psychiatrist and CPN were of the ilk that he just needed to take his medication and stop taking drugs and he’d be... he’d be okay. But he didn’t like his medication.

Participant 2, Ivy

3.8.3.2.6 Core theme: Attributing challenges to service users’ disagreement

Attributing challenges as being due to disagreement with treatment

Some participants believed that some presenting challenges were due to service users’ disagreement with treatment related factors, including; admission; diagnosis; medication; and staff approach. This differs from the ‘Attributing challenges to environmental factors’ theme above, where service users’ beliefs were not inherent in the attributions. The challenges associated with this attribution were mainly violence and aggression, including the projection of anger and hostility.

And he was really angry as well, because everybody kept telling him that it wasn’t real and that it was to do with schizophrenia. So what we... what I tried to do over time was to say, ‘Well, at the end of the day, that’s... whether it’s schizophrenia or whether it’s not is... is a disagreement between you.’

Participant 2, Ivy

Well, she was quite hostile, quite unhappy about being in hospital, quite angry about her situation, not really in agreement with or understanding the reasons for being in hospital, so tended to view the staff as, you know, as not being helpful to her. So therefore she was quite angry and at times would become quite abusive towards us.

Participant 4, Chris
Attributing challenges as being due to disagreement with restrictions

Some participants reported that challenges were attributed to service users’ disagreement with the ward rules and subsequent restrictions placed on them.

There’s so many rules placed on her, which she doesn’t exactly agree with. She’s not really allowed to do anything.

Participant 3, Alan

I think she’s... she in herself is restless and frustrated and can’t understand why people are, you know, kind of, restricting her movement and her freedom. You know, not letting her do what she wants to do, and she becomes very frustrated with that.

Participant 4, Chris

3.8.3.2.7 Core theme: Attributing challenges to a coping strategy

Attributing challenges to a coping strategy for escape / avoidance

Four of the participants expressed their perceived understanding of some challenges being due to a form of coping from negative feelings they had particularly with regards to their symptoms. The coping strategy was often perceived as a form of escape and / or avoidance.

I certainly understand why people use drugs and alcohol. You know, I think for a lot of our patients it... you know, if they’re... to cope with how they’re feeling. You know, being drunk or high is a damn sight better than what their usual state is.

Participant 5, Kate

...but he did develop eventually problems with alcohol, possibly as a way of coping with, kind of, residual symptoms.

Participant 1, Mary

Attributing the use of anger and aggression as a coping strategy

Two participants specifically referred to the service users’ use of anger and aggression towards others as unhelpful coping strategies, often resulting in a worsening of the feelings they are attempting to cope with. Alan felt that Anne’s strategy of being aggressive towards staff in order to deal with her fear actually resulted in an increase of fear.
She was doing what she was doing to protect herself. And I don’t think that... in terms of... I believe that she believed what she was thinking as well. You know, so pretty much all she was scared about, she was scared by, she felt threatened... even though it probably made her feel more scared in the long run.

Participant 3, Alan

3.8.3.3 Question Three: What are the emotional reactions / psychological difficulties associated with these challenges?

3.8.3.3.1 Core theme: Negative thoughts and feelings associated with challenges

Feelings of frustration and anger

There were a large number of negative thoughts and feelings experienced by participants in relation to a wide range of their perceived challenges. These were expressed towards the service user and / or towards themselves. The main feeling reported was frustration.

A lot of my difficult people is to do with engagement! I find that frustrating.

Participant 1, Mary

But at the same time it was frustrating that nothing was happening, no change in her.

Participant 3, Alan

The feeling of frustration was also described in accompaniment with other feelings related to challenges, including anger.

Quite angry, really. Yeah, I mean, it generally was quite frustrating because... especially if we’d given him the time that, you know, we’d planned, and... Because what was quite frustrating was that when we actually had the one-to-one time and it was his time to share, he never really had anything to say.

Participant 5, Kate
Participants tended to describe negative feelings towards the service user when they attributed their challenges as controllable. (See ‘Attributions of controllability’ theme above).

And I think the way that he... he, kind of, would display behaviours which were certainly within his control, but then say that he couldn’t help it because it was his illness, which was quite frustrating as well, because, you know, I personally do not believe that attempting to... to hit you or... or slowly walking to a door is... is in any way linked to mania or depression or any, kind of, you know, illness.

Participant 5, Kate

However, when participants described an understanding of the challenges, and did not perceive them as deliberate, they tended not to experience negative emotions.

But I think myself behind that I can see somebody who’s actually quite vulnerable, and I can see why it’s important to him and why he’s doing it. I know it’s not deliberate, so I don’t tend to get as annoyed by that.

Participant 1, Mary

... and that’s probably maybe why I and other staff don’t get quite as frustrated in the longer term about it, because we recognise that actually it’s not his fault. But staff that believe that he’s in control of those things, they’re more likely to get quite angry and frustrated with him.

Participant 7, Jane

Feelings of sadness, sympathy, hopelessness and helplessness

These feelings were described by Mary, Ivy and Alan in relation to beliefs about lack of therapeutic progress.

... it was quite sad really, and I felt, you know, I felt as though I was never going to get anywhere with him. I felt sorry for him really.

Participant 1, Mary
And I felt actually a bit hopeless, because it was very sad; he was only young. It seemed such, such a waste really, that he was in such a bad way. So I did feel quite sad for him. I thought it was... it was quite sad really, and I felt, you know, I felt as though I was never going to get anywhere with him.

Participant 2, Ivy

... it’s the sense that, well, we’re not, kind of, making any difference to her really. So that makes you... so the sense that has on you is, it’s kind of, I suppose it’s quite hopeless, and well, helpless.

Participant 3, Alan

Feeling de-motivated, deflated and disappointed

The lack of therapeutic progress seemed to result in de-motivation and deflation among some participants.

I suppose when people have been quite disturbed and they can’t remember who you are, never mind what you talked about when you last met them [laughs] can be challenging. ‘Cause it, sort of, makes you feel that... why... why bother, if... And that can be a difficulty sometimes.

Participant 2, Ivy

I think before I was more motivated and could see a... the prospect of change. But then obviously you get quite a lot of knock backs, and you go through the same cycles over and over again and...

Participant 1, Mary

...and this person comes back absolutely bladdered, then that can I suppose... can make you feel quite deflated and frustrated with that.

Participant 7, Jane

Whilst describing his slight reduction in motivation, Eric also described his feelings of disappointment towards some of the perceived challenges Paul presented with.
It’s somewhat disappointing that he won’t engage. It’s somewhat disappointing that he’s threatened some of the staff with violence.

Participant 6, Eric

Doubts of competence and lack of confidence

It was common for some of the participants to doubt their professional competence with service users who presented with these challenges. This sometimes led to a lack of confidence.

You know, it makes you question yourself and why, as I say, am I not selling the psychological model right? Is it my skills as a therapist that can’t motivate him?

Participant 1, Mary

It’s more like you just, kind of, question what it is that you’re doing yourself. That’s it. ‘Am I to be doing this? Should I be doing this kind of thing? This person does deserve better, really.’

Participant 3, Alan

Ivy also thought these feeling may trigger hostility.

So, not being confident in knowing whether something you say might trigger, sort of, hostility and aggression.

Participant 2, Ivy

Feeling uncomfortable, anxious and frightened

Ivy described feeling uncomfortable, anxious and frightened due to Greg’s unpredictable violence.

So I did feel very uncomfortable in the environment where I saw him.

Participant 2, Ivy
Well I used to be really anxious before I saw him, because I was... like, I used to find him quite frightening actually.

Participant 2, Ivy

Jane also referred to feeling scared in relation to the threat of aggression.

So it can be scary, particularly if you’re on your own in those situations.

Participant 7, Jane

**Feeling stressed – ‘burnt-out’**

Kate made statements about negative thoughts and feelings she had experienced, but also those she felt other staff in her team had. She reported high levels of stress and subsequent ‘burn out’ due to the challenges, and believed that staff members were unable to think about them objectively as a consequence.

... staff are becoming burnt out. And that we’re not able to look at things objectively anymore, because we’re burnt out from such challenging behaviour...

Participant 5 Kate

I think coming in day in and day out with nothing changing to the behaviour and nothing changing to the environment can rapidly burn you out, and you’re not working as good as you should be.

Participant 5, Kate

3.8.3.3.2 Core theme: Positive thoughts and feelings associated with challenges

**Confidence in managing and overcoming challenges**

There were varying degrees of confidence reported within and between participant interviews. In contrast to the ‘Doubts of competence and lack of confidence’ sub-theme above, some participants described feeling able to manage challenges and thinking they were able to overcome them. Jane described how she felt confident in managing the perceived challenges.
I feel very confident. You’re working with people, aren’t you, so in my experience, people can always throw something new at you, can’t you? [Laughs] But generally speaking I feel very confident in that.

Participant 7, Jane

Many participants referred to their confidence when presented with these perceived challenges having increased over time with experience.

I think that personally I’m, kind of, reasonably confident that those situations can usually be managed. And I do think that comes from just experience of having done it over the years.

Participant 4, Chris

It’s a learning curve. So yeah, I mean, quite high. I would probably say my confidence was up in the sevens. Sixes or sevens. But early on it was really quite low.

Participant 3, Alan

Feelings of protectiveness

Mary and Alan described how they felt protective over Greg and Anne respectively, in front of others, when they displayed challenging presentations.

I can become quite defensive in terms of protecting him in front of others, but I don’t think it’s... it’s not changed for the worse in terms of me and him. I think I’ve probably found myself being more supportive, if that makes sense [Laughs].

Participant 1, Mary

I felt like I needed to save her from the staff!

Participant 3, Alan
3.8.3.4 Question Four: What are the coping strategies used associated with the challenges and emotional reactions?

3.8.3.4.1 Core theme: Behavioural responses

There were various behavioural responses reported, aimed at reducing any negative emotional impact of the challenges experienced. Participants also referred to strategies they would use if the resources were available. Both types are illustrated below, as responses not used but *would* have been used were due to service constraints.

**Time away from service user**

Many participants chose to avoid or take a break from the service user when they presented with some of the challenges. For Jane, this was to avoid escalation.

*We know that if this person is upset the last thing you do is go into his room [laughs] amidst the chaos that’s probably going on in there. You keep a distance, so to not make it worse.*  

Participant 7, Jane

However, for Mary, time away from the service user was used to regulate her feelings.

*And I, kind of, toy between that and then I have a bit of a break from him and I’m feeling more motivated again!*  

Participant 1, Mary

Kate also referred to emotional regulation, as time would help her calm down before further interaction:

*Even if we have the time, to actually not maybe engage with the other patients because we’re still quite fired up really.*  

Participant 5, Kate

Chris described the impact of stress resulting from challenges on staff teams, resulting in time away from work.
They get burnt out, I think. That’s what happens. The stress overwhelms teams. The sickness levels get very high.

Participant 4, Chris

‘Giving up’

Participants reported that some challenges caused them to give up or not to try as hard therapeutically.

So I think sometimes it had the impact that I didn’t try, perhaps, as much as I might have done.

Participant 2, Ivy

And that’s not worked, so I guess I’ve given up really.

Participant 1, Mary

In contrast, Jane kept trying with the service user and did not give up.

I try it again. That’s part of the job, isn’t it? You don’t give up, you just continue...

Participant 7, Jane

Planning and preparation

Several participants planned and prepared beforehand to deal with challenges. This often led to thoughts that they were equipped to manage, thus minimising any actual or potential negative thoughts and feelings.

Generally speaking we know when he’s going to present in that way, so you can prepare yourself and you can have discussions about how you’re going to best manage that.

Participant 7, Jane

... what we try and do here, is we do practice how we react to those situations. So we anticipate what the difficult situations are, and we talk about it and we role play what we do say, what’s a good thing to say.

Participant 2, Ivy
Formal and informal support

The use of supervision to receive formal support and guidance for the challenges was referred to by several participants. This was often associated with increased confidence in ability.

*It’s something that I take to supervision quite a lot to discuss there... And in terms of helping me see that maybe, you know, I’ve done what I could have done.*

Participant 1, Mary

*...just having more... having supervision to know what it was that you were doing. Saying what’s helpful and what isn’t helpful. It might have made a difference to her, but I think it would have made a difference in terms of me feeling confident about things.*

Participant 3, Alan

Similarly, the use of informal support was a common method of seeking advice and regulating one’s emotions, often in the absence of formal supervision.

*I guess liaison with the other staff. Sort of, talking about it with other staff and...*

Participant 2, Ivy

*And I think often it's the informal support that goes on that gets people through the, kind of, stress and strains of it more than anything else.*

Participant 4, Chris

Informal support was vital to help Kate cope. She reported sometimes having negative thoughts and feelings if she did not talk things through with other staff. Kate stated that this led her to think about it at home and dread going back to work.

*And just, like, agitation as well really, kind of, leaving a shift. And feeling quite agitated. You know, if you hadn't, kind of, got chance to talk it through. Kind of, you know, you just left with a lot of quite negative thoughts and feeling quite agitated and, you know, it, kind of, leads to you not looking forw... to dread going into work.*

Participant 5, Kate
Training

Chris described the use of training as a useful method to help cope with challenges, particularly to cope with physical violence.

*I think the [sighs] training and the, you know, what you’re taught about managing those sort of situations is sufficient to, you know, to enable you to cope with the responsibility of it.*

Participant 4, Chris

However, Kate thought that she required further training to enable her not just to cope with the challenges but the emotional impact of them.

*I don’t think we’re trained enough. You know, and they don’t teach you as a student [laughs] and then you’re suddenly expected... and then there’s no ongoing training. We have C&R, you know, the restraint training with de-escalation, but that isn’t... that’s about how we can physically manage something. It’s not about how we emotionally deal with it. There isn’t anything that help... that we’re given or that we’re taught or that... not that you can teach things but, you know, we... it’s, kind of, left.*

Participant 5, Kate

3.8.3.4.2 Core theme: Cognitive responses

As well as behavioural responses there were various cognitive responses reported, aimed at reducing any negative emotional impact of the challenges experienced.

Reflection

Most participants referred to reflections on their responses towards challenges. However, these thoughts were sometimes self-critical and participants often considered whether they could have responded differently.

*So then I’m, kind of, you know... it makes me a bit... you know, when I look back I think, ‘Oh gosh, you know, I need to... I need to, like, learn not to do that, you know, and really... I go and reflect on it and think...*

Participant 5, Kate
Well, looking back I think that there was probably quite a lot more that could have been done.

Participant 3, Alan

Well [sighs, laughs] I don’t know really. I think probably with hindsight I might have got myself out of the situation rather than staying in it.

Participant 2, Ivy

Positive re-appraisal

Some participants described their interpretations of challenges and the use of positive re-appraisals to provide reassurance.

Jane used positive re-assuring thoughts to tell herself that it would get better over time and to keep trying with Bob.

... you know, he will grasp that and, you know, so I just, kind of, look at it as another day and let’s treat tomorrow as a new day and [laughs] see if we can improve things then!

Participant 7, Jane

Mary told herself that she had done all that she could with the service user thus re-assuring herself that the challenge was not due to her professional competence.

‘Look, I’ve done all I can... I don’t necessarily think it’s a reflection of my skills, but just the complexity of him, you know.

Participant 1, Mary

‘Part of the job’

Some participants reported that the challenges were part of the job and that they just had to get on with the job. This tended to minimise any negative thoughts and emotions. Eric reported that he did not dwell upon the challenges afterwards. Chris shared a similar experience, describing how he detached himself and does not think about the emotions
Yes, I mean, there are all sorts. But I don’t tend to view them negatively. I mean, it’s what we’re in the business of so I don’t dwelling on it.

Participant 6, Eric

I’ve found with stressful situations at work that I just have to deal with it, get on with it as best I can. And try and keep things in perspective, in that it’s... you know, it’s a shift. [Laughs]... I think a big part of working in this sort of setting is having... is being able to take a step back and, you know, be a bit detached from it and, you know, focus on the job and not think too much about the emotion of it all whilst you’re in those sort of situations.

Participant 4, Chris

Understanding of service users’ difficulties

Having an understanding of the service users’ difficulties and why they may have presented with the challenges often helped some of the service users to cope with the challenges and minimise any subsequent negative thoughts and feelings towards them.

if you can... I mean, having an understanding of where it might have come from and the meaning in relation to, it’s helpful to be able to think about what you could do to help

Participant 2, Ivy

... and I have to, kind of, take step back from that sometimes and try and look at it from the patient’s perspective, really. And I think that that’s something that’s always worth doing. I think you’ve got to check yourself and remind yourself of that, I think.

Participant 4, Chris

Focus on positive aspects of service user

Some participants also found it helpful to cope if they focused on the positive aspects of the service user and what they could or have achieved.

I’m not sure we really progressed much down that line, but he did start to think about it and think about possible changes. So I think it was in seeing that, actually, he did take that onboard and... and start to use it.

Participant 2, Ivy
Without, kind of, concentrating on hopeless causes and going further by what he's going to succeed in, you know, the positive aspects.

Participant 6, Eric

Like, we encourage, like, positive data logs, because it’s very easy, I think, for staff just to concentrate on the things that Bob isn’t doing. So by turning it on the head and getting staff to recognise things that Bob is doing, that can make you feel better.

Participant 7, Jane

3.9 DISCUSSION

In this section, the results of the analyses will be reviewed and considered in relation to the relevant literature. The strengths and limitations of this stage of the study will then be considered, along with clinical and theoretical implications. The themes and sub-themes from each of the four analyses can be referred to in Table 7.

3.9.1 Key findings in relation to the literature

Due to the interconnectedness of the themes, it was considered appropriate to examine the main findings of the analyses in relation to the literature, rather than on a theme-by-theme basis or indeed on a research question and results basis.

The studies exploring service user challenging presentations perceived by staff by Colson et al. (1985; 1986), Allen et al. (1986), Modestin et al. (1986) and Gallop and Wynn (1987) found that psychiatric inpatient staff had problems with presentations such as: lack of engagement and apparent poor motivation, positive and negative symptoms of psychosis, personality disorder, lack of therapeutic progress, and violence and aggression. These challenges were echoed by participants of this stage of the study, with the exception of personality disorders. This may be due to the fact that none of the ‘most challenging’ service users were diagnosed with personality disorder, or indeed because there is specific personality disorder services more recently set up in the UK often separate to the psychiatric inpatient services used in this study. All these studies found lack of therapeutic progress and engagement problems as the most challenging for staff, as well as ‘withdrawn psychoticism’ which was associated with slow therapeutic progress (Colson et al., 1985; Colson et al., 1986). These findings were also supported by this study’s participants. Colson et al. (1985; 1986) found that ‘violence-agitation’ and ‘suicidal behaviour’ was perceived by staff as the least challenging despite most of the subsequent literature on
psychiatric inpatient staff challenges, attributions, emotions and coping (identified in Chapter two) being centred around these themes. The present findings support these results, as five participants described feeling used to violence and aggression and at times, did not perceive it as challenging. This may be caused by ‘violence-habituation’ due to the sheer number of incidents in this setting, as suggested by Wykes and Whittington (1998). However, the authors also proposed a ‘violence-distressed’ group as some staff reported significantly higher distress following repeated assaults. In addition, staff members’ experience and or training may influence the perceived challenge. In this study, challenges associated with violence and aggression as well as substance misuse, self-harm, and absconding were mainly identified by participants due to the risk involved and the time required for risk management; in other words the inconvenience and lack of time for duties. Moreover, unpredictable and changeable behaviour was perceived as challenging to participants. Unpredictability was also found to be challenging in studies by Colson et al. (1985), Gallop and Wynn (1987) and Modestin et al. (1986).

In relation to causal attributions of challenging presentations, some were external to the service user, such as ward environment. However, more attributions appeared to be internal, such as symptoms of mental illness. This discrepancy is similar to the findings in the literature based on psychiatric inpatient staff attributions (Barrowclough et al. 2001; Gillig et al. 1998; Ilkiw-Lavalle & Greyner, 2003; Nolan et al. 2009; Sharrock et al. 1990). Despite the fact that low mood, withdrawal, lack of engagement, and apparent poor motivation could all be considered symptoms of depression (DSM-IV-TR), only two participants attributed these identified challenges in this way. This is also consistent with the literature where similar challenges have been identified and not attributed to depression (Colson et al. 1987; Ilkiw-Lavalle & Greyner, 2003; Modestin et al., 1986). In contrast, many participants attributed certain challenges to positive symptoms of psychosis / mania. This discrepancy may be due to the fact that positive symptoms (an excess or distortion) are more tangible than depressive symptoms (a decrease or loss of function).

As individual analyses took place, association between the domains, e.g. attributions and emotion, were not fully explored. However, there seemed to be more negative emotions experienced in reference to controllable presentations, and more understanding and empathic responses to those that were attributed to mental illness. This is consistent with the available literature (e.g. Apel & Bar-Tal, 1996; Dagnan et al., 1998; Barrowclough et al.; 2001; Sharrock et al., 1990; Stanley & Standen, 2000). Interestingly, when participants
described an understanding of the challenges and did not perceive them as deliberate they tended not to experience negative emotions in relation to those challenges. This highlights the importance of staff training around the formulation of service user difficulties as it could have a significant impact on the attributional and emotional response of staff (Berry et al., 2009).

In line with the theme of negative thoughts and feelings, anger was one of the most frequently reported emotions in the present study and in the review studies (e.g. Colson et al., 1987; Gillig et al., 1998; Sun et al., 2006). Thoughts of incompetence in this study also echoed staff members’ reports in the study by Gallop and Wynn (1987). Feelings of fear and anxiety were usually in relation to the perceived threat or the unpredictability of potential violence. One participant repeatedly reported feelings of stress that she and her colleagues had experienced. The impact of stress leading to being ‘burnt-out’ was also indicated. This highlights the importance of investigating staff experiences with these challenges in this setting, as support is evidently required – not just for the well-being of staff but due to the impact these emotions and possible emotional exhaustion of staff may have on service users (Jenkins & Allen, 1998; Rowe & Sherlock, 2005).

Interestingly, in the theme of positive thoughts and feelings, participants often referred to their experience increasing their confidence as well as feeling protective for the service user from other staff members. Curiously, the only emotional response to challenges that the Consultant Psychiatrist reported was disappointment. This could be due to the participant finding the challenges less severe, having received professional training on the understanding of challenges and emotional responses, or a number of other related factors. However, these associations are purely hypothetical and comparisons between professional and emotions could not be drawn due to the limited number of each (i.e. only one Consultant Psychiatrist).

Several coping strategies were placed under the themes of cognitive responses and behavioural responses. In cognitive responses, the use of positive re-appraisal as a coping strategy was used by three participants, similar to findings from Bowers et al. (2006). Reflection was considered by some as being a positive strategy, but for others it comprised self-criticism. One participant referred to the wish for allocated time to reflect, as she felt it would have been useful in her understanding of the challenging presentations and allowed time to process her emotions. In the theme of behavioural responses, participants
also referred to their actual responses and what they would find helpful if they had the resources. Consistent with the literature (e.g. Bonner et al., 2002; Bowers et al., 2006; Cutcliffe, 1999), formal and informal support was reported by all participants and was therefore very significant to this sample. This support, as well as training, was often indicated as being associated with an increase of confidence and competence in managing challenging presentations, further highlighting the importance of this support. Other strategies, including taking time away from the service user, were associated with a reduction in negative emotions experienced, similar to the sub-theme reflection. However, time away from or avoiding the service user could impact on the quality of client care (Hastings, 2002). It is therefore important for staff members to be supported in striking a balance between time to compose and reflect and having sufficient time with the client to enable an effective therapeutic relationship.

Therapeutic relationship was not a specific theme of the analyses, as it was threaded throughout the themes. All the challenges described seemed to have a direct impact on the therapeutic relationship between participants and the service users identified, as did the attributions held about these challenges, their emotional impact, and the coping responses. This supports studies which highlight the importance of the therapeutic relationship and its relationship with all of these factors individually (e.g. Apel & Bar-Tal, 1996; Berry et al., 2009; Hastings, 2002; Jenkins & Allen, 1998). Research on the therapeutic relationship also indicates the consequent impact it has on the clinical outcome of service users (e.g. Barrowclough et al., 2001). Considering this, further studies are required to increase our understanding of associations between staff attributions, emotions and coping, and ultimately the therapeutic relationship.

3.9.2 Methodological considerations

3.9.2.1 Analytic framework

The aim of this stage of the study was to produce a broad understanding of the four domains using a simple and flexible analysis that would inform the SEACCS development by attempting to capture key themes. Thematic analysis was therefore appropriate as one is able to produce rich meaningful data unconstrained by the limits of alternative qualitative methodologies. Moreover, Braun and Clarke (2006) proposed guidelines to maintain methodological rigour within this flexibility.
One example of an alternative approach was content analysis, which has been used to inform the development of questionnaires (Ryan & Bernard, 2000). However, this method focuses at a more micro level and often provides frequency counts (Wilkinson, 2000). In contrast, thematic analysis tends not to quantify themes and allows for data to be explored in richer detail allowing for simple (and indeed detailed) interpretations by the analyst, whereby reports of experiences and / or perceptions from one participant may well be vitally important in the development of themes. However, the level of importance may not have been matched using content analysis if there was a lower frequency of the content found.

A more detailed and interpretative analysis could have been carried out through approaches such as grounded theory or IPA, in order to try to understand in more depth the experiences of being a mental health professional working in a psychiatric inpatient setting. On a practical basis however, these methods were beyond the scope of the time-frame of this study and such detailed analyses were not required in order to meet the aims of the study. In addition, grounded theory requires the use of theoretical sampling. Thematic analysis however, allows a pre-defined sample, which was considered most suitable to meet the requirements of the research aims. Also, to avoid the influence of previous findings upon interpretative analysis, a review of the relevant literature should not be conducted prior to data collection (Charmaz, 2006). However, thematic analysis allows for this to take place (Tuckett, 2005) as it can sensitise the researcher to more subtle features of the data. Although a literature review was appropriate in conjunction with this method it was acknowledged that this may have led a focus on some aspects of the data at the expense of others (Charmaz, 2006). Also, the focus on the research questions meant that other potential themes were not considered, such as the impact of service constraints upon staff members. Although four separate analyses were carried out focusing on individual research questions it was difficult for the researcher to tease out certain aspects, e.g. challenges and attributions were often difficult to place in one analysis. As noted above, the researcher acknowledges that some challenges may have been reported as attributions e.g. apparent poor motivation and displayed lack of insight. However, the research team agreed that themes and sub-themes were aptly placed for the purpose of the research aims.
3.9.2.2 Reliability

Several steps were taken to ensure the processes of analyses were transparent, enabling the reader to judge whether or not the results are repeatable and thus reliable. The full process of analyses was described and examples of different stages of the analyses were provided in the appendices to enable the reader to understand each step. In addition, quotations from the transcripts were presented throughout the description of the themes to aid the reader’s understanding of how the themes were made. The use of quotations of what participants believed other staff thought, felt, attributed etc. was used in the analyses as it was believed by the research team that the time staff spent with one another on a challenging inpatient ward would have provided relevant insight into the perceptions and experience of the participants’ colleagues. Therefore these quotes were considered important and provided a wider scope for analysis, thus producing increased relevant data to inform the SEACCS. However, the accuracy of these reports is unknown, and verification would require cross-referencing with other staff members. This was beyond the scope of this present study.

3.9.2.3 Validity

Despite the aim to provide a descriptive semantic and deductive approach, the researcher acknowledges her belief that some interpretation is unavoidable and would most certainly be affected by her initial biases, outlined in Section 3.2.3.3. Thus, it was considered appropriate to employ a social constructivist stance, accepting the analyses and subsequent interpretations as being influenced by the researcher’s assumptions and biases. Hence, other researchers may have interpreted the data in different ways.

Due to time constraints, participants were not offered to conduct member checks in order to further validate the analysis (Mays & Pope, 1995). Consequently, it is unknown whether participants would fully agree with the interpretations of the researcher (although attempts were made to keep interpretations to a minimum and to produce themes semantically and deductively); therefore the results should be treated with more caution than if member checks had taken place.

In order to enhance validity, the researcher’s supervisors checked the analysis as recommended by Elliott et al. (1999), allowing discussion of the emerging themes by three team members until a general consensus was reached. The researcher considered the analyses alongside the pre-existing literature to increase validity. Lincoln & Guba (1985)
have described the balanced representation of a range of perceptions or constructions as representing ‘fairness’, offsetting researcher biases.

While elements of the process of transition from description to interpretation are subjective, extracts from the transcripts will enable readers to judge the validity of the findings.

3.9.2.4 Sample

The use of multi-disciplinary staff interviews in this study provided a holistic approach to staff-service user relationships (Soong & Soobratty, 2007). The interview allowed participants to describe issues important to them as openly as possible and enabled the SEACCS measure to be based on information gathered directly from the most important source of information – the staff themselves (Streiner & Norman, 2003).

However, six of the participants were recruited through links with the researcher’s supervisors, which may have incurred perceived obligation to participate in the study or may have impacted on the interview discussions. Thus, participants may have attempted to provide socially desirable responses and to be viewed as empathic health care professionals. The staff links with supervisors were often through training including psychological approaches. Hence, this sample may be more ‘psychologically minded’ than another more random sample may have been. It may have been useful to explore differences in level of training with responses (e.g. confidence, understanding of service users’ difficulties). The many interruptions throughout four of the interviews on participants’ thought processes may have impacted upon their ability to be open and honest in the interviews. It should be noted that there was a small sample, all of whom were white British and working in the North West of England. The researcher does not suggest that the results are generalisable across all psychiatric staff working in inpatient services. In particular, these views are likely to differ among other ethnic groups of staff or staff who have significantly more or significantly less experience. To account for the possible lack of generalisability, a detailed description of the sample was provided to assist the reader in deciding how relevant the findings might be to other participants.

3.9.3 Clinical and theoretical implications

This study contributes to the small body of data from studies that have been conducted with multi-disciplinary psychiatric inpatient staff members on staff challenges attributions,
emotional, and coping reactions. The lack of research in this area is reflected by the small number of studies in the systematic review (Chapter two), most of which focussed on only one or two aspects of the four areas. This study has demonstrated the sizeable number of challenges that staff perceive in relation to service users admitted to psychiatric wards, as well as the variety of attributions and vast number of emotions and coping strategies used by staff. It has described the specific perceived challenging presentations of service users, which often are merely referred to as ‘challenging behaviour’, a term which offers no explanation and could cover a magnitude of presentations which could individually be formulated in order to increase our understanding of them. In addition, this study has added to previous research that has shown significant links between all four areas above, links which have been shown in previous studies as well as the current study, highlighting a significant impact on the therapeutic relationship. The importance of this relationship has not only been associated with attributions, emotional, and coping responses of staff, but previous studies have shown the impact this has on the clinical outcome of the service user, as noted above. However, this study has not identified any causal associations between the four areas.

The difficulty in teasing apart the four domains reflects their inter-connectedness. This was also demonstrated by the review studies (Chapter two), whereby attributions have been described as challenges and so forth. This reflects the importance of this study to identify the specific perceived challenges, attributions, emotions, and coping strategies and their potential relationships. This stage made hypothesised associations, e.g. controllability and emotion, and it is important that future studies assess causal relationships in order to increase our understanding and develop measures, training programmes, and interventions accordingly. Future research should also investigate for any effect of discipline, level of experience, and type of training received in relation to attributions, emotions, and coping responses.
CHAPTER FOUR

Phase II - Further development of SEACCS

This chapter combines the results from the systematic review and the qualitative interviews. The aims, method, and results of this phase, followed by a brief discussion are outlined below.

4.1 Aims and objectives

Phase II aimed to further develop and construct the SEACCS, by undertaking the following objectives:

- Generate a pool of items by incorporating the results from both stages of Phase I;
- Reduce the items using expert panel;
- Construct the items within a questionnaire format; and
- Assess content and face validity of newly developed SEACCS.

4.2 Method

4.2.1 Item generation

Transcripts were examined alongside the themes and sub-themes in order to identify potential questionnaire items from the participants’ statements. If required, statements were re-phrased to aid clarification and converted to the present tense as a retrospective time-frame was anticipated. All statements contained the personal pronoun ‘I’ or ‘me’ where appropriate. The generated items were then reviewed alongside the results of the systematic review in order to verify them further and add any potential items that were not generated from the interviews. It was considered that poorer or inaccurate items would be detected and excluded from the measure at later stages of the study.

4.2.2 Item reduction

As outlined by Streiner and Norman (2003, pp.61-79), editing of the item pool was undertaken by the research team and a service user, Sally (see Section 3.5.3) to compile a reduced pool of items. Initially, items were removed which were deemed to be the following: repetitious, irrelevant, overly general, overly specific, or a reflection of an idiosyncratic experience. Further to this, items were removed or considered for amendment if their interpretability was deemed to be compromised (e.g. colloquial or
required a high reading ability) or if they contained double-barrelled words or ‘leading’ items. Although items were reviewed under the four domains, they were further reduced to sub-categories (themes and sub-themes) of items deemed to contain similar meaning.

In line with Streiner and Norman (2003, p.61), it was considered inappropriate to employ a formal measure of readability (e.g. Flesch Reading Ease, Flesch, 1948) as each item comprised an independent passage and it was anticipated that difficulties with readability would be overcome at the pre-testing stage of the study. This withstanding, Holden, Feckken and Jackson (1985) found an inverse relationship between the number of letters in an item and its validity. Resultantly, whilst retaining an items meaning, the number of letters were reduced where possible.

4.2.3 Questionnaire construction

Construction of the questionnaire was undertaken with the consideration of the following factors: instructions, order of items, item and response format, general versus individual service user challenges, and overall layout and length. Due to the limited time available to psychiatric inpatient staff to complete assessments (Whittington & McLaughlin, 2000), as reflected in the number of interruptions and cancellations of staff interviews (Section 3.5.3), it was necessary for the measure to be relatively brief and easy to administer.

4.2.4 Content and face validity (stage 1)

In line with Streiner and Norman (2003, pp. 19-22), informal assessment of content and face validity was conducted by means of an informal consultation group and individual interviews with psychiatric inpatient staff, rather than more statistically rigorous methods (e.g. Haynes, Richard & Kubany, 1995). The assessments anticipated content coverage via attempts to identify potential themes that were not generated already. Content relevance was ensured by attempts to identify existing themes that were considered irrelevant. In addition, participants’ views about the measure was sought in relation to the following: ease of use, 7-point Likert rating scale, clarity of item wording, and the existence of overlapping items. The suitability of the scale was also rated by participants. This ranged from ‘not at all suitable’ to ‘extremely suitable’. Subsequent modifications were applied after the pre-testing stage.
4.3 Results

4.3.1 Item generation

Items were generated and categorised using the themes, sub-themes and transcripts of staff interviews. Items were checked alongside the results of the systematic review results. Significant findings from the review felt to be missing from the item list were added at this point; for example staff feelings of ‘shock’, ‘disgust’, and ‘guilt’ (see Section 2.5.6.4). Statements referring to other staff members’ experience were altered to contain ‘I’ or ‘me’. Such statements may not have been entirely accurate. However, given the objective to generate a large pool of items for the draft questionnaire, these experiences were considered valuable. Otherwise, potential items were as close to verbatim as possible.

As many of the challenging presentations were reported as being more challenging when unpredictable – both during interviews and in systematic review studies – it was considered appropriate to include ‘unpredictable behaviour’ as an individual item.

This stage resulted in an initial pool of 424 items (Appendix 10).

4.3.2 Item reduction

The initial pool of possible items was edited by the research team and Sally in order to reduce the items prior to subsequent stages of the study.

Potential items were initially discarded if they were repetitious of the same issue. For example, item 215 (“I think they behave in this way because they are lazy”) was retained while items 216 (“I think they have poor self-care because they are lazy”) was discarded. Conversely, items which were deemed to reflect particularly idiosyncratic statements were removed, such as item 420 (“I consider fear of violence to be positive as you should never be over-confident when dealing with it”). Items that were deemed to be overly specific were also removed, e.g. item 11 (“I find them challenging when they seem to want to progress to independence but also want to be cared for”). On further inspection, some items were removed as they were not considered specific to challenges posed by the service user; including items regarding the service user’s family, e.g. item 127 (“I find the over-involving/demanding behaviour from their family challenging”).

Although some of the items may have used strong language (e.g. “lazy”) or may have seemed assuming (e.g. sexually inappropriate), it was deemed appropriate to retain the
integrity of the actual statements used by staff during the interviews and thus reflect staff members’ actual experiences. It was anticipated that any difficulties with these items would be identified during the subsequent development of the study.

The remaining items under each sub-category (see Section 4.3.1) were reduced to one or two items to represent and encapsulate the meaning of each sub-category. This resulted in 62 items in the SEACCS scale.

4.3.3 Questionnaire construction

Following item reduction, the main objective was to ensure all appropriate items were included within a self-report measure which was brief and simple to complete. Hence, the following factors were considered in the development of the subsequent draft version (Appendix 11).

4.3.3.1 Time-frame

It was decided that the draft measure would measure recent retrospective experiences. The time-frames of experience of ‘one week’, ‘two weeks’ or ‘recent’ were piloted. In order to correspond with the retrospective time-scale, items were re-worded to past tense.

4.3.3.2 General versus individual patient ratings

The interview schedule’s focus on an individual patient was employed to increase depth and fluidity in the discussion. Despite this, the researcher aimed to assess how psychiatric staff scored generally regarding the patients that they work with. It was considered that such general findings would further increase our knowledge of staff perspectives of the four dimensions, and provide focus on areas that require further assessment and staff training. Notwithstanding, the measure was designed in such a way that individual service users could be assessed by slightly changing the instruction wording and modifying plural references.

4.3.3.3 Measurement of experiences of general versus individual challenges

It was initially hoped that measurement of attributions, emotions, and coping strategies could be assessed for each identified challenge as it was hypothesised from previous stages that these may change according to different challenges. However, the large number of themes produced within each category made this unfeasible, resulting in a complex scale structure and reduced readability. Consequently, it was deemed appropriate to rate
experiences of general challenges across the four domains of the measure, the limitations of which would be acknowledged. This grouping together of each domain was considered most appropriate for ease of completion, enabling the rater to focus on one domain at a time (Bowling, 1997).

4.3.3.4 Rating scale

The decision was made to use Likert (1952) rather than dichotomous ratings, as continuous measures have been more frequently used when measuring individual constructs of this measure (e.g. HTRS, Colson et al., 1985; FWC-58, Rossberg, Hoffart & Friis, 2003; CHABA, Hastings, 1997). Streiner and Norman (2003) recommend a minimum of five response categories to maintain statistical reliability and reflect respondents’ preferences. The pilot work indicated that seven points was preferable. Resultantly, the measure asked participants to indicate the extent to which items described their experience on a scale ranging from 0 to 6. Polarised anchor points were used for each item, for challenges: ‘not at all challenging’ to ‘completely challenging’, for attributions: ‘not at all’ to ‘completely’, (with the exception of the final Control item: ‘none at all’ to ‘complete control’, for emotions and coping: ‘no, never’ to ‘yes, always’. The challenges subscale was scored by summing all the challenge item responses. However, total sub-scores were not appropriate for the remaining subscales as they measured different aspects within them. Therefore, meaningful total sub-scores were expected to follow the assessment of psychometric properties of the new measure, in particular, factor analysis.

4.3.3.5 Instructions and layout of questions

Following separation of the domains, specific instructions were provided for each section. In order to reduce the number of letters in each question, similar to a previous measure of staff experiences (CHABA; Hastings, 1997) the start of a question was placed at the top of each domain, with the remainder detailed in each item. For example; ‘HOW CHALLENGING DO YOU FIND IT WHEN SERVICE USERS PRESENT WITH...’

As indicated, it was presented in bold and italics in order for it to be clearly highlighted, and it was also placed at the top of each page to prevent the participant having to revert back. The format was double-sided to reduce the number of pages, thus increasing the likelihood of completion. Instructions to complete both sides were presented in bold and capitals at the bottom of each page.
The third section based on emotions was presented slightly differently. Each item was presented as a single word, i.e. a single emotion. This is similar to the Emotional Reactions to Challenging Behaviour Scale (Mitchell & Hastings, 1998) for intellectual disability care staff, which has displayed good reliability. As this layout has been tested before on a similar sample and as the section lent itself to single word items, it was considered appropriate in order to increase ease and speed of completion.

4.3.4 Content and face validity (stage 1)

The consultation group comprised: three psychiatric nurses, a nursing assistant, and a ward manager. The researcher guided an informal group discussion for 30 minutes. Six individual interviews of clinical psychologists, all of whom had experience in psychiatric inpatient wards, were also undertaken on an informal basis ranging between 15 and 30 minutes.

All informants from the consultation group and two interviewees reported that the structure and layout was clear, and the general consensus was that the seven-point scale was suitable. All participants rated the draft measure as ‘extremely suitable’ for its purpose. In terms of time-frame, the six individuals from the consultation group agreed upon ‘recent’ experience as the most appropriate term. Reasons provided included shift changes and absence for relatively long periods. That is, some staff may not be on the ward for over a week – ruling out the ‘one week’ option. Participants also stated that they may find it difficult to recall an exact two week time-frame, e.g. a challenging incident may have occurred 15 days previously or 13 days previously, and they would be reluctant to include either of those experiences. It was therefore felt that the term ‘recent’ would enable easier recall without restrictions. As the majority of the informants agreed upon ‘recent’, this term was employed.

There were no themes or specific items which participants felt were irrelevant. Although item 13 (‘Apparent poor motivation?’) in the challenges section could be considered an attribution, participants generally reported that it was appropriately placed, and the use of the preceding word ‘apparent’ increased its suitability for that section. However, three clinical psychologists reported and it was agreed upon by the consultation group that ‘lack of engagement’ should be clearly specified and included in this domain. In addition, ‘withdrawal and isolation’ was considered a separate challenge, and therefore should comprise a separate item. Further suggestions were discussed, such as expansion of items.
by adding examples, altering the wording to ‘strengthen’ items (e.g. adding the descriptor ‘persistent’).

Following results of this stage, two additional items were included in the challenges section (‘Withdrawal / isolative behaviour?’ and ‘Behaviour that does not adhere to ward rules?’) and five items were edited across the SEACCS (Table 8).

**Table 8: Amended items of the SEACCS following content validity**

<table>
<thead>
<tr>
<th>Original item</th>
<th>Amended item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low mood?</td>
<td>Persistent low mood?</td>
</tr>
<tr>
<td>Demanding behaviour?</td>
<td>Excessively demanding behaviour?</td>
</tr>
<tr>
<td>Apparent poor motivation?</td>
<td>Apparent poor motivation and / or lack of engagement e.g. in therapy, ward activities?</td>
</tr>
<tr>
<td>Poor social functioning?</td>
<td>Poor communication / social skills?</td>
</tr>
<tr>
<td>Service users’ refusal to take responsibility e.g. for their actions, therapeutic progress?</td>
<td>Service users’ unwillingness to take responsibility e.g. for their actions, therapeutic progress?</td>
</tr>
</tbody>
</table>

The amended SEACCS was re-examined by five of the clinical psychologists. Two separate examples were suggested for the additional item ‘Behaviour that does not adhere to ward rules?’. Hence, this was amended to: ‘Behaviour that does not adhere to ward rules e.g. absconding, entering staff office uninvited?’.

This resulted in the 64 item SEACCS, ready for distribution (Appendix 12).

**4.4 Discussion**

**4.4.1 Key outcomes**

This stage involved combining results from the systematic review and qualitative interviews in order to generate a meaningful SEACCS measure. The development involved a number of rigorous processes to ensure a clinically relevant tool which was likely to be fully completed in terms of readability and time. The postal survey and subsequent psychometric investigations are detailed in Chapter five.
4.4.2 Methodological considerations

Only one sub-scale total score, challenges, was obtained as the remaining domains comprised items which could not be summed meaningfully. Subsequently, no total measure score was obtained. As types rather than individual constructs were assessed, this poses difficulty for investigating the psychometric properties. However, the SEACCS was developed as an exploratory measure, and it was anticipated that exploratory factor analysis could generate factors (constructs or sub-scales) prior to adaptation / refinement of the final measure.

Due to the inclusive and exploratory nature of the newly developed SEACCS, it resulted in the experiences of attributions, emotions, and coping strategies having to be based on all of the challenges specified in that section. This was due to the unfeasibility of placing each item from the three domains under individual challenges. Although the staff experience of these areas would still be assessed and thus areas highlighted for support/training/formulation as well as relationships between items explored, the inability to investigate the impact of individual challenges should be considered.
CHAPTER FIVE

PHASE III – Postal Survey & Preliminary Psychometric Investigations

Following further development and construction of the SEACCS, this chapter comprised the third and final phase where the postal survey and the preliminary psychometric investigations of the SEACCS were undertaken. The aims, methods, results, and discussion are outlined below, followed by the overall conclusions of the study.

5.1 Aims

The general aims of this phase were to further develop the SEACCS following postal survey, by scrutinising the data and exploring relationships within the final measure. More specifically:

- Assess reliability by investigating item endorsements, internal consistency, inter-item relationships, and test re-test.
- Explore inter-relationships between the sub-scales and individual items.
- Explore relationships between the demographic information, sub-scales, and individual items.
- Generate and test hypotheses with the final version of the SEACCS (following item removal during screening and reliability tests) in order to assess the construct validity by exploring relationships with a common measure of psychiatric distress (GHQ-28).

5.2 Method

5.2.1 Participants

The goals for recruitment were to recruit:

- A sample that adequately represented the target population
- A sufficient number to meet the sample size and power requirements of the study.

5.2.1.1 Inclusion criteria

- Qualified and unqualified staff working with inpatients with SMI across the NHS Trusts used in the interview stage.
• Minimum of 10 hours contact with inpatients per week.
• Minimum of 3 months experience with service users on an inpatient ward.

5.2.1.2 Expected number of participants

There is no agreed standard for an acceptable minimum response rate. A previous postal survey across three NHS Trusts in England used a sample of multi-disciplinary psychiatric ward staff and achieved a response rate of 46 per cent (McNally et al., 2006). Hence, a similar response rate was expected, leading to a possible sample size of 116 participants based on 253 sent.

A ratio of four cases to one variable was suggested by Cattell in 1978, although more recent estimates range from 5 to 10 cases (Field, 2005, pp.638-640). As this would require a minimum of 256 participants to allow 64 variables to be entered into a factor analysis, using a case to variable ratio of 4:1, factor analysis was considered unfeasible. Instead, the basic psychometric properties assessing reliability of the SEACCS were undertaken.

A power calculation indicated that a minimum sample of 50 participants was required to ensure 80 per cent power, with correlations of 0.4 indicating statistical significance at the 0.05 probability level. A larger sample of 76 indicated that correlations of 0.32 would ensure 80 per cent power. For test retest, a minimum sample of 20 was recommended to ensure 80 per cent power to estimate Intra-class correlations with an accuracy of +/- 16 per cent.

5.2.1.3 Recruitment

Figure 2 below describes the sequential process of recruitment, in terms of service and ward level approval, provision of Participant Information Sheets-Questionnaires (PIS-Q; Appendix 13), questionnaire packs and their return, and finally the provision and return of retest packs.
Following individual meetings with ward managers, who agreed that appropriate multi-disciplinary staff could be invited to take part, the researcher identified relevant staff and obtained an appropriate number of packs. In relation to input from professions not based on the wards, the researcher arranged to meet with participants at a convenient location to discuss the study and provide the relevant information and documents. On three of the participating wards the ward managers requested that the researcher collected the completed packs from them directly as they felt this would increase response rates. The researcher was assured, however, that managers would collect sealed packs only, to ensure confidentiality. By collecting some of the completed packs in this manner it enabled the researcher to provide re-test questionnaires where indicated. The researcher was permitted to use a private room to open packs for this purpose and to code re-tests. The researcher collected one week after ward managers received their final pack to ensure the re-tests were completed following at least one week. Frequent contact was maintained with
participating ward managers via telephone calls and emails in order to identify any problems raised and to provide reminders

5.2.2 Measures

5.2.2.1 Demographic information

See Section 3.4.1 for details of the demographic information recorded.

5.2.2.2 General Health Questionnaire-28

The General Health Questionnaire (GHQ-28, Goldberg & Hillier, 1979) is the most widely applied self-completion measure of psychiatric disturbance in the UK and has worldwide application (Werneke, Goldberg, Yalcin & Ustun, 2000). It screens independently verifiable forms of psychiatric illness and is not diagnostic. The GHQ-28 is the most well-known and popular version of the GHQ to assess changes in individual’s daily functioning related to distress. Respondents base their responses on their health state over the past two weeks. The GHQ-28 yields four subscales: somatic, anxiety and insomnia, social dysfunction, and severe depression. High internal consistency and reliability has been reported (Goldberg & Williams, 1988).

Although the GHQ-28 is slightly less valid than the 60 item version, it is more suitable for samples who have limited time to complete a measure. It also permits analysis within sub-categories as it was developed for mainly research purposes (Goldberg & Williams, 1988). Validation of the subscales against a structured clinical interview revealed that the anxiety and insomnia (GHQ-B) and the severe depression (GHQ-D) subscales correlated equally with interview ratings of anxiety and depression. However, the somatisation subscale correlated less well than interview ratings of this domain (Goldberg & Williams, 1988).

There are four possible scoring methods, all comprising a 4 point scoring system for each item. The test authors, Goldberg and Hillier (1979), advocate the use of the GHQ scoring (0-0-1-1) method. However, the Likert scoring (0-1-2-3) enables the measurement of the frequency of distress and was therefore considered appropriate for this study. The measure yields four sub-scores and a total score calculated by summing item responses. Subscale scores range from 0 to 21, with higher scores indicating a greater probability of psychiatric distress. Total scores range from 0 to 84.
The tool, particularly the GHQ-B (anxiety and insomnia) and GHQ-D (severe depression) sub-scales, has been successfully used to assess distress in psychiatric staff in inpatient settings (Carson et al., 1999a; Fagin et al., 1995; Fagin et al., 1996) and to assess relationships of psychiatric staff distress with individual SEACCS domains, e.g. coping (Fagin et al., 1995) and negative emotions (Boey, 1999).

5.2.3 Procedure

5.2.3.1 Questionnaire distribution

In order to maximise the return of mailed questionnaires, a covering letter (Appendix 14) and pre-paid stamped addressed envelope was included with each pack, in addition to follow-up phone-calls as suggested by several authors (Bowling, 1997; Streiner & Norman, 2003).

Questionnaire packs were allocated an individual Participant Identification Number. The PIS-Q was placed first to explain the purpose and requirements of the study and participation. Following this was demographic information, SEACCS and GHQ-28. Given the lack of similar measures, order effects of the measures were unknown. Therefore, the SEACCS was presented first to initiate participants’ interest in the research and maximise response rates. Lastly, the Participant Details form (Appendix 15) was included, which was voluntary and solely used to identify participants for re-test by name and place of work details. This form stated that such information was purely for the purpose of sending re-test SEACCS, would only be seen by the researcher, and would be destroyed once re-test was coded to correspond with initial SEACCS. It was estimated that it would take approximately fifteen minutes to complete the pack.

5.2.3.1.1 Re-test

The re-test pack included a brief cover letter (Appendix 16), SEACCS and a stamped addressed envelope. The researcher either provided ward managers with re-tests or posted them at least one week after first administration. However, the precise period between initial completion and re-test was unknown as the completion date was not recorded. The period between first and second administration ranged between one and four weeks.
5.2.3.2 Content and face validity (stage two)

Following postal survey, an informal consultation group took place with participants from the content validity stage 1 (see Section 4.3.4) in order to divide the attributions, emotions, and coping domains into sub-categories for the psychometric investigations.

5.2.3.3 Data handling

The data set for analysis did not contain participant identifiable information, i.e. re-test participant details which were destroyed immediately after re-tests were coded. Each participant was allocated a unique identifier. Thus, anonymous data was entered onto a password protected computer. The procedure for handling, processing, storage, and destruction of the data was compliant with the Data Protection Act (1998).

5.2.3.4 Data screening

5.2.3.4.1 Data set accuracy

Individual files were examined to determine accuracy in comparison to the raw format, by employing descriptive statistics and frequency tables (Tabachnick & Fidell, 2001, p.57). Ten per cent of the questionnaire packs (identified by random selection) were also checked alongside the database.

5.2.3.4.2 Missing data

Strategies to manage missing data were employed in line with Tabachnick and Fidell (2001, pp.58-66):

1. If a single participant completed less than 80% of a single measure, that ‘case’ was considered for removal prior to analysis.

2. As there was no missing GHQ-28 data, the published guidelines for missing data were unnecessary.

3. When single SEACCS items or the challenging subscale scores could not be calculated, the following methods were employed:
   a. If missing data was less than five per cent, and appeared to be randomly distributed, the variable was replaced with the median average of that item prior to analysis.
   b. If missing data was more than five per cent, removal and the imputation method described were considered, the latter allowing analysis of all cases and variables.
5.2.3.4.3 Normality of the data

All continuous data were examined to check normality using a combination of three strategies. Initially, histograms were eye-balled to establish the distribution curve. Tests of skewness and kurtosis data were applied, where z scores above 2.58 were considered to indicate significant skewness or kurtosis at p<0.01 (Field, 2005, p.72).

In relation to normally distributed data, means and standard deviations (SD) were employed followed by parametric tests. In relation to non-normally distributed data, medians and interquartile ranges (IQR) were used prior to non-parametric tests. Where both normal and non-normal data was compared, respective descriptive statistics were followed by non-parametric inferential statistics.

5.2.3.5 Statistical analysis

Data was analysed using the Statistical Package for the Social Sciences for Windows, Release 16.0 (SPSS Inc, 2010). When continuous data were normally distributed, Pearson’s Product Moment correlations were computed, and Spearman’s rho correlations for non-normally distributed data. Categorical data were examined using independent samples t tests, and one-way analysis of variances (ANOVAs) for normally distributed data, and Mann-Whitney U tests and Kruskal-Wallis tests for not normally distributed data. All tests were two tailed and the accepted level of significance was p ≤ 0.05. Percentage figures were presented to one decimal place. All other calculated statistics were presented to two decimal places. Only statistically significant results are quoted in the text.

5.2.3.6 Reliability

The reliability of a test is the extent to which the measurements are consistent, stable and repeatable. When developing a scale, there are specific methods commonly used to determine levels of reliability, often involving statistical analyses. One of these tests includes examining the internal consistency of the scale. Essentially, this method compares test items that measure the same construct. Cronbach’s alpha is typically used during scale development with items that have several response options (e.g. 7-point Likert scale). To indicate acceptable - good internal consistency, Cronbach’s alpha should be between 0.7 - 0.9, the higher alpha, the increased level of reliability demonstrated (Streiner & Norman, 2003). However, alpha much above 0.9 may indicate that items are measuring the same concept. Stability and repeatability is assessed through a test-retest procedure that involves administering the measure to the same individuals under the same conditions.
after some period of time. Test-retest reliability is estimated with correlations between the scores at Time 1 and those at Time 2 (to Time \( x \)). Two assumptions underlie the use of the test-retest procedure. The first required assumption is that the characteristic that is measured does not change over the time period. The second assumption is that the time period is long enough that the respondents’ memories of taking the test at Time 1 does not influence their scores at the second and subsequent test administrations. This form of reliability is often tested by examining Intraclass correlations (ICCs). The higher the degree of correlation between the two forms, the more stable they are. Conventionally, the following co-efficients indicate the corresponding levels of reliability: 0.7 – 0.8 is acceptable; 0.8 – 0.9 is good; 0.9 – 1.0 is excellent reliability (Streiner & Norman, 2003).

5.2.3.6.1 Reliability and item scrutiny

A number of stages of analysis were undertaken in the item selection and preliminary description of the final SEACCS psychometric properties:

1. Examination of endorsement frequency, discrimination of items, and response categories were examined. Items with very low endorsements (less than 20 per cent of the sample) were considered for removal. A proposed ideal response rate on any single response category is between 0.2 and 0.8 (Streiner & Norman, 2003). However, due to the large range of this scale (7-point scale), the removal of items displaying below 20% endorsement was considered unfeasible.

2. Where appropriate, investigations of redundancy were conducted by examining inter-item relationships and internal consistency of sub-scales. High inter-item relationships (\( r > 0.9 \)) within sub-scales would indicate poor discriminatory power and therefore the items would be considered for deletion. Low inter-item correlations (e.g. below 0.2) were not considered for removal as the subscales assessed different types of each domain rather than individual constructs.

3. Cronbach’s alpha was computed to measure internal consistency within available sub-scales. An alpha above 0.7 was considered acceptable (Streiner & Norman, 2003). Where alpha was below 0.7, items were investigated to identify whether alpha significantly increased upon deletion, and thus considered for removal. However, as the sub-scales assessed types of each domain and they were hypothetical, rather than generated from psychometric investigations (e.g. factor analysis), the Cronbach’s alpha and inter-item correlations were exploratory and their use may be questionable.

4. Due to the number of items, the restricted range of the items’ values, and the lack of three sub-scale total scores, descriptive statistics were considered appropriate to
compare the test-retest responses. Items with more than an acceptable level of 20% discrepancy between tests were considered for removal (Bland & Altman, 1995). Where appropriate, exploratory ICCs were assessed for total sub-scale scores. However, points of caution noted above in relation to ICC were applicable here.

5.2.3.7 Relationships between SEACCS and demographic information

The demographic characteristics of participants were examined using the statistical analyses outlined in Section 5.2.3.5. Relationships were explored between demographic information and SEACCS sub-scales, and individual items excluded from sub-scales.

5.2.3.8 Relationships between SEACCS and GHQ-28

In order to assess the construct validity of the SEACCS, hypotheses of associations between SEACCS sub-scales, individual items with sub-scales and total GHQ-28 scores were generated and tested using statistical analysis outlined in Section 5.2.3.5. Construct validity entails demonstrating the ability of a construct to explain a network of research findings and to predict further relationships. The predictions made are the result of theoretical associations about the proposed psychological construct (Streiner & Norman, 2003). Where statistically significant predicted associations are found, construct validity is demonstrated. Similar to tests of reliability (see Section 5.3.6.1), a higher correlation coefficient is suggestive of better validity.

5.3 Results

5.3.1 Questionnaire completion

5.3.1.1 Questionnaire packs

A total of 253 packs were distributed across 12 psychiatric inpatient wards, consisting of six acute wards, three Psychiatric Intensive Care Unit (PICU) wards, and three rehabilitation wards, within two NHS Trusts. Seventy seven completed measures were returned, resulting in a 30.4% response rate.

5.3.1.2 Demographic information

Of the 77 participants, four did not report any demographic data, four more chose not to divulge their age, a further three did not report ethnicity, and one did not identify professional status. The available data indicated there were 49 female and 24 male
participants aged between 21 and 63 years (\( \bar{M} = 37 \) years). A large majority of the participants (53) were white British. Black Africans (9) comprised the second largest ethnic group, followed by black Caribbean (4), white Irish (3), Asian (3) and mixed ethnic background (1).

The majority of participants were nurses (47). The second largest profession comprised support workers (11), followed by ward managers (5), psychologists (4), medics (3), occupational therapists (2) and assistant practitioners (1). Forty two participants held a professional qualification, while a large minority of 29 did not. The duration of work experience in mental health ranged from three to 408 months (\( \bar{M} = 98 \) months), while time spent working at the respective wards ranged from three to 190 months (\( \bar{M} = 34 \) months).

The majority of staff (52) worked in an acute ward. Fifteen worked in psychiatric intensive care (PICU), while the remaining six worked in a rehabilitation ward. A minority of staff worked in single sex (six female only and five male only) rather than mixed sex wards.

5.3.1.3 Re-test

Of the 77 participants, 47(61.0%) completed the Patient Details form, thus agreeing to re-test. From these, 15 measures were completed and returned, resulting in 31.9 \% response rate.

5.3.2 Content and face validity (stage 2)

The informal consultation group divided the scales into sub-groups to be psychometrically investigated. Following consensus, sub-groups were formed as displayed in Table 9 below. Eight attribution items were considered ‘internal’ and four were considered ‘external’. The remaining item (controllability) was considered to be exclusive to the sub-groups. Seventeen emotions were considered ‘negative’. Three emotions were considered ‘positive’. The remaining emotion (‘sympathy’) was considered to be arbitrary and therefore exclusive. Consensus was not reached for a coping subscale. Participants generally reported that coping could not be divided into sub-groups as too many appeared arbitrary. Therefore, items deemed unsuitable for sub-groups were considered individually during psychometric investigations.
### Table 9: Sub-groups within the attribution and emotion items

<table>
<thead>
<tr>
<th>Attribution items</th>
<th>Emotion items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internal</strong></td>
<td></td>
</tr>
<tr>
<td>Service users using them as a coping strategy?</td>
<td>Frustration</td>
</tr>
<tr>
<td>Service users’ laziness?</td>
<td>Confusion</td>
</tr>
<tr>
<td>Service users trying to be manipulative?</td>
<td>Shock</td>
</tr>
<tr>
<td>Symptoms of mental illness?</td>
<td>Anger</td>
</tr>
<tr>
<td>Service users’ personalities?</td>
<td>Disappointment</td>
</tr>
<tr>
<td>Service users seeking attention?</td>
<td>Incompetent</td>
</tr>
<tr>
<td>Service users’ wish to walk over staff e.g. attempt to get one over on staff,</td>
<td>Sadness</td>
</tr>
<tr>
<td>humiliate staff?</td>
<td>Stress</td>
</tr>
<tr>
<td></td>
<td>Frightened</td>
</tr>
<tr>
<td><strong>External</strong></td>
<td></td>
</tr>
<tr>
<td>Service users’ past experiences e.g. childhood trauma, difficult</td>
<td>Confident</td>
</tr>
<tr>
<td>experiences, previous relationships?</td>
<td>Protective</td>
</tr>
<tr>
<td>Environmental factors e.g. reaction</td>
<td>Calm</td>
</tr>
<tr>
<td>to how they have been approached by staff / other service users / visitors,</td>
<td></td>
</tr>
<tr>
<td>ward environment?</td>
<td></td>
</tr>
<tr>
<td>Service users’ medication?</td>
<td></td>
</tr>
<tr>
<td>Service users’ disagreement with staff e.g. disagree with treatment,</td>
<td></td>
</tr>
<tr>
<td>advice, ward rules?</td>
<td></td>
</tr>
<tr>
<td><strong>Arbitrary</strong></td>
<td></td>
</tr>
<tr>
<td>How much control do you think service users have over these challenges?</td>
<td>Arbitrary</td>
</tr>
<tr>
<td></td>
<td>Sympathy</td>
</tr>
</tbody>
</table>

### 5.3.3 Data screening

#### 5.3.3.1 Accuracy of the data set

Data set accuracy was investigated as suggested by Tabachnick and Fidell (2001). No errors were identified.

#### 5.3.3.2 Missing data

One case had a large amount of missing data throughout the data set, including 64 per cent of the SEACCS. As more data was missing than present, this case was removed prior to analysis, leaving a sample of 76.

The SEACCS had less than five per cent missing data on 17 items. As the data appeared to be missing randomly, median values based on the available data for the item were inputted.
Only one case had not fully completed the GHQ-28. This case remained in the sample as there was no missing data from the SEACCS.

5.3.3.3 Normality of the data

For demographic data, only age was found to be normally distributed. Duration in mental health and duration on the ward were both positively skewed and were successfully transformed using logarithmic transformations.

All 64 SEACCS items were normally distributed, in addition to the following subscales: total challenges (severity), internal and external attributions, positive emotions, total number of coping, and total number of negative emotions. However, the negative emotions sub-scale was positively skewed and the total number of challenges was negatively skewed. Transformations were applied to both variables. However, only the total number of challenges subscale was successfully transformed, with logarithmic transformations.

The total GHQ score and two subscales: somatic (GHQ-A); and anxiety and insomnia (GHQ-B) were normally distributed. In contrast, data from the social dysfunction subscale (GHQ-C) was positively skewed and remained so following transformations. The severe depression subscale (GHQ-D) was negatively skewed and also remained so following transformation, using reverse scores (Field, 2005).

5.3.4 Tests of reliability and item scrutiny

5.3.4.1 Frequency of endorsements

Response distribution was examined for each item and the percentage of participants responding to each response category was calculated for all items (Appendix 17). None of the items were endorsed by less than 20% of the sample. In fact, all of the 16 items in the challenges subscale were endorsed by 90% or over of participants (i.e. 10% or under responded ‘not at all’) with the exception of one item (8), endorsed by 88.8%. None of the response rates for any individual response category was over 80%. Therefore, no items were considered for removal at this stage.
**5.3.4.2 Inter-item correlations**

An inter-item correlation matrix was explored for every sub-scale of the SEACCS, including the whole coping domain. As can be seen from Table 10, none of the inter-item correlations were above 0.9, therefore no items were considered for removal due to redundancy.

**Table 10: Range of inter-item correlations within each sub-scale**

<table>
<thead>
<tr>
<th>Subscale/section</th>
<th>Range of inter-item correlations (r)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenges</td>
<td>0.08-0.75</td>
</tr>
<tr>
<td>Internal Attributions</td>
<td>0.04-0.71</td>
</tr>
<tr>
<td>External Attributions</td>
<td>0.06-0.61</td>
</tr>
<tr>
<td>Negative Emotions</td>
<td>0.01-0.70</td>
</tr>
<tr>
<td>Positive Emotions</td>
<td>0.37-0.58</td>
</tr>
<tr>
<td>Coping (un-categorised)</td>
<td>0.01-0.75</td>
</tr>
</tbody>
</table>

**5.3.4.3 Internal consistency**

Internal consistency was measured by computing Cronbach’s alpha for the SEACCS subscales. Internal consistency was excellent for total challenges (α = 0.91) and negative emotions (α = 0.92). It was acceptable for positive emotions (α = 0.72), and internal attributions (α = 0.77). However, external attributions displayed a lower consistency (α = 0.61) due to item 12, ‘Service user’s disagreement with staff...’. As can be seen in Table 11, if the item was deleted, alpha did not significantly increase (0.64).

**Table 11: Item-total correlation for external attributions sub-scale**

<table>
<thead>
<tr>
<th>External attribution item number</th>
<th>Corrected Item-Total Correlation</th>
<th>Cronbach's Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>0.48</td>
<td>0.47</td>
</tr>
<tr>
<td>4</td>
<td>0.46</td>
<td>0.48</td>
</tr>
<tr>
<td>9</td>
<td>0.39</td>
<td>0.54</td>
</tr>
<tr>
<td>12</td>
<td>0.25</td>
<td>0.64</td>
</tr>
</tbody>
</table>

The item was subsequently examined in relation to the frequency of endorsements (Appendix 17). Participants consistently endorsed this item (i.e. no-one responded ‘not at
all’ to this item) and the remaining response categories were well represented. Given this, it was considered appropriate to retain the item at this stage.

Although the coping items were not categorised into sub-scales in the content and face validity stage of the study (Section 5.3.2), Cronbach’s alpha was applied to this group of items and found to be within the acceptable range of internal consistency ($\alpha = 0.74$).

### 5.3.4.4 Test re-test: Descriptive statistics and ICCs

Descriptive statistics were calculated for each item and the total challenges subscale of the SEACCS. ICCs were explored for the total challenges subscale and all hypothetical sub-scales.

The acceptable threshold of the difference in item responses between administrations was below 20% (1.2). Similarly, 20% (3) or below of participants scoring above the item response threshold was considered acceptable agreement. The level of agreement is outlined below for each domain of the SEACCS, as well as the ICC for each subscale.

**Challenges**

No participants scored outside the acceptable threshold on two Challenges items (12 and 13) between initial and follow-up administrations. On all remaining items, the number of participants who scored more than 20% differently between administrations was within the acceptable range.

In relation to the total score for the challenges domain, only two participants displayed a discrepant score higher than the 20% threshold between administrations. This subgroup did not exceed the 20% threshold of the participant sample. The ICC for total challenges also suggested good test-retest reliability ($0.81, p < 0.01$).

**Attributions**

Participants responded within the item response threshold for two items within the attributions scale (1 and 6) between administrations. On the remaining eleven items, 20% or less of participants responded with a discrepant score higher than 20% between
administrations, thus within the acceptable range. The ICC was 0.79 (p<0.01) for internal and 0.34 (p > 0.05) for external attribution total scores.

**Emotions**

Participants did not respond within the acceptable response threshold to any of the 21 items between administrations (more than 20% differently). On three items (8, ‘Sadness’, 16, ‘Helpless’, and 21, ‘Sympathy’), more than 20% of participants (six, four and four respectively) responded with a discrepant score higher than 20% between administrations. On all remaining items, the number of participants with a discrepant score higher than 20% between administrations was within the acceptable range. The ICC was 0.75 (p < 0.01) for negative, and 0.67 (p < 0.01) for positive emotions.

**Coping**

Participants responded within the item response threshold for two of the coping items (9 and 11) between administrations. Of the remaining items, only one item (7, ‘I tell myself that I will get better at dealing with it over time’) resulted in more than 20% of participants (four) responding with a discrepant score higher than 20% between administrations.

5.3.4.4.1 Items above the acceptable threshold

Four items out of 64 were found to be outside the acceptable threshold using descriptive statistics: emotion items 8, 16, and 21; and coping item 7. Due to the small sample of re-tests, the possibility that completion of re-tests varied from one week to one month, and there being strong theoretical grounds for retaining these items as, specifically, the concepts of the items were found both in the relevant literature (Chapter two) and in the qualitative interviews (Chapter three), none of the items were removed. However, these items should be considered with caution.

Due to the small sample size and the large number of items that remained in the final version of the SEACCS, exploratory factor analysis could not be conducted; therefore, exploratory relationships between hypothetical sub-scales and individual items were carried out.
5.3.5 Exploration of relationships within the SEACCS

Pearson’s correlations (Appendix 19) and Spearman’s rho correlations (Appendix 20) were carried out, where appropriate, in order to explore the relationships between the sub-scales and individual items. Along with the total (severity) challenges, internal and external attributions, negative and positive emotions sub-scales, the total number of challenges, negative emotions, and coping strategies reported by participants were also included in the exploratory correlations. The individual items explored are those that were not included in the sub-scales: attribution item 13 ‘How much control do you think the service user has over these challenges?'; emotion item 21, ‘Sympathy'; and all 14 coping items (Appendix 18). Exceptionally, the total challenges (severity) sub-scale below was also correlated with individual items across the emotions domains.

The results of these tests for each of the domains of the SEACCS are outlined below.

5.3.5.1 Relationships of variables with total challenges (severity) sub-scale

Spearman’s rho indicated no significant correlation between the sub-scale total challenges (severity) and the negative emotions sub-scale total score.

Pearson’ correlations were computed to assess total challenges (severity) with the normally distributed variables (sub-scales and individual items). Significant positive relationships were found with internal attributions ($r = 0.52$, $p < 0.01$) and external attributions ($r = 0.43$, $p < 0.01$). No significant relationship was found with attribution item 13 (controllability), positive emotions, the total number of negative emotions, or emotions item 21 (‘Sympathy’). In relation to individual items, positive significant relationships were found with the negative emotion items: 2, ‘Confusion’ ($r = 0.33; p < 0.01$); 6, ‘Disappointment’ ($r = 0.32; p < 0.01$); 11, ‘Frightened’, ($r= 0.36, p < 0.01$); and 13, ‘Uncomfortable’ ($r = 0.31; p < 0.01$). A significant positive relationship was also found with the positive emotion item 10, ‘Protective’ ($r = 0.27; p < 0.05$). No significant relationships were found with the total number of coping strategies or any of the individual coping items, with the exception of a significant negative relationship with coping item 3, ‘I just react without really thinking about it or dwelling on it’ ($r = -0.27, p < 0.05$).

5.3.5.2 Relationships of variables with total number of challenges

Spearman’s rho correlations indicated significant positive correlations between total number of challenges and both internal attributions ($rho = 0.26, p < 0.05$) and negative
emotions (rho = 0.26, p < 0.05). A significant negative relationship was found with coping item 12, ‘I think of it as part of my job so I just have to get on with things’ (rho = -0.30, p<0.01). The remaining sub-scale and item scores were non-significant with this variable.

5.3.5.3 Relationships of variables with internal attributions sub-scale

Pearson’s correlations indicated significant positive correlations between internal attributions and total number of negative emotions (r = 0.24, p < 0.05), attribution item 13, ‘How much control do you think the service user has over these challenges?’ (r = 0.46, p < 0.01); coping item 2 (r = 0.32, p < 0.01); and coping item 13, ‘I think about it for a long time afterwards, over and over again’ (r = 0.35, p < 0.01). There was no significant correlations between this subscale and the remaining coping items, total number of coping strategies, positive emotions, emotion item 21 (‘Sympathy’), or attribution item 13.

Spearman’s rho correlations found a significant positive relationship between internal attributions and negative emotions (rho = 0.24, p < 0.05, Appendix 20).

5.3.5.4 Relationships of variables with external attributions sub-scale

Pearson’s correlations indicated significant positive relationships between external attributions and emotion item 21, ‘Sympathy’ (r = 0.31, p < 0.01), in addition to several coping items: 5, ‘I talk it over with other staff’ (r = 0.24, p < 0.05); item 8, ‘I try and understand the service user’s difficulties and why they present in this way’ (r = 0.37, p < 0.01); 9, ‘I try to focus on the positive aspects of the service user’ (r = 0.35, p < 0.01); item 10, ‘I reflect on it afterwards and think about what I could have done differently’ (r = 0.29, p < 0.05); 11, ‘I use supervision and / or training to learn more about it’ (r = 0.23, p < 0.05); and 13, ‘I think about it for a long time afterwards, over and over again’ (r = 0.25, p < 0.05). There were no significant correlations found between external attributions and the remaining individual items or with positive emotions, total number of negative emotions, or total number of coping subscales (Appendix 19).

Spearman’s rho indicated no significant correlation between external attributions and negative emotions.

5.3.5.5 Relationships of variables with negative emotions sub-scale

Spearman’s rho correlations were computed to assess any relationships between negative emotions and the remaining variables of interest (Appendix 20). This subscale was
significantly positively associated with number of coping strategies used (rho = 0.40, p < 0.01) and significantly negatively correlated with three coping items: 1, ‘I keep trying with the service user’ (rho = -0.28, p < 0.05); 10, ‘I reflect on it afterwards and think about what I could have done differently’ (rho = -0.24, p < 0.05); and 13, ‘I think about it for a long time afterwards, over and over again’ (rho = -0.39, p < 0.01).

5.3.5.6 Relationships of variables with positive emotions sub-scale and ‘sympathy’

Pearson’s correlations were computed to assess further relationships between positive emotions and ‘sympathy’ with the remaining variables of interest. This subscale was significantly positively associated with emotion item 21, ‘Sympathy’ (r = 0.54, p < 0.01) and three coping items: 8, ‘I try and understand the service user’s difficulties and why they present in this way’ (r = 0.26, p < 0.05); 9, ‘I try to focus on the positive aspects of the service user’ (r = 0.30, p < 0.01); and 14, ‘I tell myself that I am doing as much as I can for the service user’ (r = 0.23, p < 0.05). The remainder of variables (not referred to in above sections) were found to be non-significant with positive emotions and ‘sympathy’.

5.3.6 SEACCS and demographic information

Similarly to explorations of relationships between the SEACCS sub-scales and the excluded individual items, demographic data was explored with the same variables. No significant differences or relationships were found in terms of age, ethnicity, or type of profession. Significant findings across the remaining demographic variables are outlined below.

Professionally qualified and unqualified groups

Independent samples t-tests indicated that non-professionally qualified staff reported significantly higher positive emotions score (M = 11.14; SD = 3.72) than professionally qualified staff (M = 8.95, SD = 3.15) (t(69) = 2.67, p < 0.01). No significant differences were found between professionally qualified and the remaining SEACCS variables of interest (Appendix 21).

Duration working on the ward

Pearson’s correlations indicated significant negative relationships between the transformed duration working on the ward variable and two coping items; 7, ‘I tell myself that I will get
better at dealing with it over time’ (r = -0.33, p < 0.01) and 10, ‘I reflect on it afterwards and think about what I could have done differently’ (r = -0.24, p < 0.05). One significant positive correlation was found with coping item 13, ‘I think about it for a long time afterwards, over and over again’ (r = 0.26, p < 0.05). No further significant relationships were found (Appendix 22).

**Duration working in mental health**

Pearson’s correlations were computed to explore the relationships of the transformed duration on working in mental health variable across the SEACCS variables. Spearman’s rho correlations were used to explore for any relationships with the total negative emotion sub-scale scores. Overall, two significant negative relationships were found: coping item 7, ‘I tell myself that I will get better at dealing with it over time’ (r = -0.25, p < 0.05); and 13, ‘I think about it for a long time afterwards, over and over again’ (r = -0.25, p < 0.05). The remainder were non-significant (Appendix 22).

**5.3.7 Generating hypotheses between SEACCS and GHQ-28**

As noted in Section 5.2.2.2, the GHQ total score, GHQ-B (anxiety and insomnia) and GHQ-D (severe depression) were found to be related to similar aspects of the SEACCS, as well as correlating equally well with interview ratings of these emotions (Goldberg & Williams, 1988). Therefore, these scales were considered suitable and their scores were anticipated to have significant relationships with the SEACCS.

Further to the item selection (reliability) stage outlined in Section 5.3.4 above resulting in the final number of SEACCS items, the following hypotheses, primarily based on the findings in the literature in Chapter two, were generated - with the SEACCS and the GHQ-28:

1. SEACCS total challenges severity scores would be positively associated with the GHQ total score.
2. SEACCS negative emotions would be positively associated with GHQ total score, GHQ-B and GHQ-D subscales.
3. SEACCS total number of negative emotions would be positively associated with GHQ total score, GHQ-B and GHQ-D.
4. SEACCS positive emotions would be negatively associated with GHQ total score, GHQ-B and GHQ-D subscales.
5. SEACCS total number of coping strategies would be positively associated with GHQ total score.

The individual coping items were not categorised during the content validity stage. In addition, no clear relationship was reported between staff attributions and distress in the systematic review (as not assessed). Given this, a priori hypotheses were not made and exploratory relationships were assessed between GHQ total score, GHQ-B and GHQ-D, with both the individual coping items and with the internal and external attributions sub-scales.

5.3.8 Testing hypotheses between SEACCS and GHQ-28

Pearson’s correlation (Appendix 23) and Spearman’s rho correlations (Appendix 24) were computed to test hypothesis one. No significant relationship was found between total challenges severity score and GHQ total score. Therefore this hypothesis was not supported.

Spearman’s rho correlation co-efficient indicated that negative emotions total score was significantly positively associated with GHQ total score, GHQ-B and GHQ-D sub-scale. Spearman’s rho also indicated that negative emotion total score was positively associated with the GHQ-D subscale. Therefore, hypothesis two was supported. This was also true of hypothesis three, using Pearson’s and Spearman’s correlations where appropriate (Table 12).

<table>
<thead>
<tr>
<th>SEACCS variable</th>
<th>GHQ Total</th>
<th>GHQ-B</th>
<th>GHQ-D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Emotions Total</td>
<td>Rho 0.35**</td>
<td>0.29*</td>
<td>rho 0.35**</td>
</tr>
<tr>
<td></td>
<td>P 0.00</td>
<td>0.01</td>
<td>p 0.00</td>
</tr>
<tr>
<td>Total number of negative emotions</td>
<td>R 0.31*</td>
<td>0.27*</td>
<td>rho 0.27*</td>
</tr>
<tr>
<td></td>
<td>P 0.01</td>
<td>0.03</td>
<td>p 0.02</td>
</tr>
</tbody>
</table>

**Significant at <0.01; *Significant at <0.05
A significant negative correlation was found between positive emotions and GHQ total score (Appendix 23). However, no significant relationship was found with GHQ-B and GHQ-D, providing partial support for hypothesis four (Table 13).

Table 13: Pearson’s and Spearman’s rho correlations between positive emotions with GHQ total, GHQ-B and GHQ-D.

<table>
<thead>
<tr>
<th>SEACCS variable</th>
<th>GHQ Total</th>
<th>GHQ-B</th>
<th>GHQ-D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive emotions Total</td>
<td>R -0.27*</td>
<td>-0.21</td>
<td>rho -0.12</td>
</tr>
<tr>
<td></td>
<td>P 0.02</td>
<td>0.07</td>
<td>p 0.31</td>
</tr>
</tbody>
</table>

*Correlation significant <0.05

A significant positive relationship was found between number of coping strategies total score and GHQ total score ($r = 0.25$, $p < 0.05$), thus supporting hypothesis six.

5.3.8.1 Exploratory relationships between SEACCS coping items and GHQ-28

Pearson’s and Spearman’s rho correlations were computed, where appropriate, to explore relationships between GHQ total score, GHQ-B, and GHQ-D with individual coping items. Only coping item 13 (‘I think about it for a long time afterwards, over and over’) was found to have significant relationships with GHQ variables. It was positively associated with GHQ-B ($r = 0.38$, $p < 0.01$) and GHQ total score ($r = 0.35$, $p < 0.01$).

5.3.8.2 Exploratory relationships between SEACCS attribution sub-scales and GHQ-28

No significant relationship was found between internal attributions and the GHQ variables. However, external attributions was significantly positively associated with GHQ-B ($r = 0.24$, $p < 0.05$).

5.4 Discussion

This section begins by presenting a summary and interpretation of the results of Phase III. This is followed by a discussion of methodological considerations and future directions. Clinical implications of the results are then presented prior to the overall conclusions of the study.
5.4.1 Summary and interpretations of key findings

5.4.1.1 Content and face validity

Content and face validity was carried out in two stages of the study as outlined at Section 4.3.4 and Section 5.3.2.

The results of the consultation group and informal staff interviews indicated that the content coverage of the draft version of the SEACCS was considered ‘extremely suitable’ and relevant. This indicated that the item generation and item reduction stages had been successful. Following suggested improvements to add two items, re-wording five items, and, as identified by the follow-up staff group, a further alteration of one item, the SEACCS contained 64 items.

Prior to psychometric investigations, another consultation group was formed (using same participants as first stage) in order to divide the attributions, emotions, and coping scales into sub-categories. Agreement was achieved about items being divided into sub-groups of ‘internal’ and ‘external’ attributions, and ‘negative’ and ‘positive’ emotions. However, the attribution based on service user control and the emotion item ‘sympathy’ were not considered suitable for these sub-groups, and were therefore deemed as arbitrary items. This was also true for all of the coping items, whereby consensus could not be reached about the grouping of types of coping items. This reflects the difficulty of measuring coping and the complexity and variety of types of strategies which can and have been grouped together (e.g. Carver et al., 1989; Folkman et al., 1986).

5.4.1.2 Data screening

All 64 SEACCS were found to be normally distributed, thus highlighting the appropriateness of the rating scale. Also, the lack of missing values indicated the ease of the scale’s readability.

5.4.1.3 Reliability and item scrutiny

As noted above the items were normally distributed, which was reflected in the percentage of responses across the items (Appendix 17). Interestingly, every item within the challenges subscale was endorsed by over 90% of participants, with the exception of item 8 (‘withdrawal / isolative behaviour?’), which was endorsed by only 88.8%. Although, this item still had a high endorsement rate, the fact that more participants scored 0 (‘not at
all’) than any other item may be due to this presentation being less tangible than others (e.g. verbal abuse or demanding behaviour), and may not require spontaneous management, and therefore may be perceived as less challenging. The high endorsement rates reflect the relevance of this measure in highlighting the considerable range of perceived challenges, rather than just violence and aggression as the literature would suggest. Also the high endorsement rate for each challenge provides evidence that support is required to help manage and minimise these perceived challenges.

None of the inter-item relationships across the four domains were above 0.9, indicating that all items were measuring distinct variables. Investigations of low commonality was considered inappropriate, as the items were assessing different types within each domain e.g. if a participant scored highly on the challenge ‘verbal abuse’ and lowly on the challenge ‘persistent low mood’. If items displayed low commonality, there would be no grounds for removal of these items as they would be considered different types of challenges rather than a construct of challenges, and therefore would not necessarily be expected to correlate well with one another. With this in mind, exploratory investigations of internal consistency within sub-scales and the coping domain were conducted, though their outcomes were and should be considered cautiously. Cronbach’s alpha was above 0.7 (the acceptable value) for each subscale as well as the coping items, except for the external attributions sub-scale. However, given that alpha did not significantly increase upon an item removal and the item was consistently endorsed, the item was retained.

Descriptive statistics were considered most appropriate for test re-tests due to the small sample size (15) and possible responses (7). Only four of the 64 items were not within the acceptable threshold of reliability, indicating that generally the SEACCS has good test re-test reliability. These items were retained on the basis of their theoretical relevance. Although the ICC tests were carried out, there were discrepancies between them and the descriptive statistics. For example, the low ICC within the external attributions scale was not complimented by the descriptive statistics, whereby all attributions were within the acceptable range. This may be due to the different types of attributions as opposed to a construct of external attributions, thus questioning the meaningfulness of ICC on SEACCS total sub-scale scores.

Following exploratory tests of reliability and item scrutiny, no items were removed. Subsequently, factor analysis could not be carried out on the SEACCS due to the number
of items (64) and the small number of participants (Cattell, 1978; Field, 2005). Consequently, exploratory investigations of the hypothetical sub-scale total scores and individual items (where appropriate) were carried out as discussed in Section 5.4.1.4 below.

5.4.1.4 Exploratory relationships within the SEACCS

Strong positive correlations were found between total challenges severity scores and both internal and external attributions, indicating associations between type of attributions staff made and severity of challenges reported. However, perceived service user control was not associated with challenge severity and controllability was not associated with ‘sympathy’. This is inconsistent with Weiner’s (1980) theory, whereby if a presentation is perceived as uncontrollable it is more likely to elicit a sympathetic response; although Weiner’s later theory (1985) highlighted the importance of stable attributions on an individual’s response. However, stable attributions, similar to those assessed by Weiner (1980; 1986), Sharrock et al. (1990), and Barrowclough et al. (2001) could not be assessed with challenges, as the sub-scales of attributions were hypothetically placed into ‘internal’ and ‘external’ only.

No association was found between total challenges, total coping, or positive and negative emotion subscales. It is theoretically possible that there is no relationship between these variables. Another possibility could be that the sub-scales are not sensitive enough to detect relationships.

Increased challenge severity was associated with increased reporting of the negative emotions: ‘Uncomfortable’, ‘Frightened’, ‘Confusion’, and ‘Disappointment’. These results indicate that perceived challenges are indeed associated with types of negative emotional responses for staff members and are consistent with some of the emotional responses found in previous studies (e.g. Colson et al, 1986; Kindy et al, 2005; Rossberg & Friis, 2003). These findings also support the proposal by Wanless and Jahoda (2002) that staff experience multiple attributions and emotions in relation to challenges, as opposed to staff members holding just one perspective as suggested by Weiner’s (1980) attributional model. Moreover, the findings suggest that explorations of challenge severity should perhaps be assessed across types of emotion, as opposed to simply ‘positive’ and ‘negative’ or simply ‘anger’ and ‘sympathy’ (e.g. Sharrock et al., 1990). Challenge severity was also associated with increased reporting of one positive emotion, ‘Protective’.
However, emotions directed toward service user and directed toward self (staff member) were not differentiated in this emotion domain. Hence, protectiveness may have related to the participant themselves and/or the service user. It could be argued that the emotions significantly correlated with challenge severity are more socially desirable emotional responses, as opposed to ‘anger’ or ‘frustration’ for example, which were the most commonly reported emotions associated with challenges in the relevant literature (e.g. Colson et al., 1986; Gillig et al., 1998; Sun et al., 2006) as well as in the staff interviews during Phase I of the current study. The possibility of socially desirable responses is further outlined in Section 5.4.2.1.

Only one coping item was associated with challenge severity. That is, higher scores on the item ‘I just react without really thinking about it or dwelling on it’ were associated with lower challenge severity scores. Similarly, the total number of challenges was negatively associated with one coping response ‘I think of it as part of my job so I just have to get on with things’. These results indicate that participants who do not engage with thoughts about the challenges or dwell on their thoughts, report fewer challenges and are less likely to report challenges as severe. These items are similar to one of the coping strategies, ‘Just get on with the job’, used by staff in the study by Wykes and Whittington (1991), ‘detachment’ found by Hastings (1995), and the strategy of ‘distancing’ proposed by Folkman (1986) which was the most commonly reported strategy in Whittington and Wykes’ (1994) study. Distancing was found to be associated with less anxiety reported two weeks following the challenge (assault). Their findings coupled with the results of the current study suggest that these coping responses may be useful in the perception of challenges, thus reflecting the importance of the assessment of coping in response to challenges.

Unlike challenge severity, total number of challenges was positively associated with the negative emotion subscale. This provides further evidence of the association of perceived challenges and staff emotional response, but also suggests that the number of challenges is an important factor to assess. It can be assumed that providing support and training to staff in order to minimise the perceived challenges may also minimise the severity of negative emotion experienced. This has not been demonstrated in the psychiatric inpatient staff literature where this relationship has not been explored and most of the studies have assessed only one or two pre-determined challenges.
The importance of the assessment of emotional responses was demonstrated further by the finding that negative emotion severity and total number of emotions was positively associated with internal attributions. No association was found between negative emotion and external attributions. Thus, the findings support the relevance of the division of the attribution subscales. Internal attributions scores were also positively associated with the level of perceived service user control. These findings are consistent with those of Sharrock et al. (1990), Moore et al. (1992) and Barrowclough et al. (2001) and the findings from staff interviews in Phase I of the current study. Internal attribution scores were also associated with a coping item which could be considered as unhelpful (‘I think about it for a long time afterwards, over and over again’). Although this item was also associated with external attributions, this sub-scale appeared to be associated with more ‘helpful’ coping strategies e.g. ‘I try to focus on the positive aspects of the service user’ and possibly more ‘problem-focused’ (Lazarus & Folkman, 1984) coping strategies e.g. ‘I use supervision and/or training to learn more about it’ and ‘I try and understand the service user’s difficulties and why they present in this way’. However, the helpfulness of strategies is tentatively suggested as agreement about concrete interpretations of coping items were not achieved during the consultation group.

Although no significant relationship was found between positive emotions and external attributions, positive emotions total scores were associated with similar variables to those associated with external attributions e.g. ‘sympathy’ and coping variables, thus supporting the notion that those coping items may be considered as ‘helpful’. The emotion item ‘Sympathy’ was very strongly associated with positive emotions, and sympathy has been associated with more helpful and therapeutic responses in previous studies (e.g. Apel & Bar-Tal, 1996; Sharrock et al., 1990; Weiner, 1980). Given this, it was likely that positive emotions would be associated with increased helpful behaviour as reported by Stanley and Standen (2000), although this relationship was not possible to determine in this study.

Many of the coping items were related to lower negative emotions total scores (e.g. ‘I reflect on it afterwards and think about what I could have done differently’). This is consistent with the findings from staff interviews during Phase I and highlights the importance of effective coping strategies to minimise or prevent staff experiences of negative emotions. Moreover, this finding indicates the need for support and training to develop staff members’ repertoire of useful coping strategies in response to challenging presentations. Importantly, this study highlights exactly which coping strategies are useful
in the reduction of negative emotions as well as those associated with increased positive emotions (e.g. ‘I try and understand the service user’s difficulties and why they present in this way’), thus reflecting the importance of the assessment between these domains. The total number of coping strategies used was positively associated with negative emotion total score. This provides further evidence that assessment of helpful strategies is required prior to provision of training as too many strategies may be counter-productive. Development of a discrete set of specific strategies for staff in this setting may be more useful. These findings support Wykes and Whittington (1991) who found that the higher the number of coping strategies used, the higher the psychological difficulties experienced, and that different coping strategies resulted in different levels of staff psychological difficulties at different times. However, similar to the findings of this study, the causal direction of these relationships cannot be determined; therefore it may be that due to the experience of negative emotions that staff members increase the number of strategies employed.

5.4.1.5 Exploratory relationships with SEACCS and demographic information

Unqualified staff reported significantly higher rates of positive emotions than professionally qualified staff. This may appear surprising, as one could naturally assume that professionally qualified staff would be more ‘Confident’, ‘Calm’, and ‘Protective’ due to their training. However, this finding provides evidence that it is the type of training staff members receive that is important in increasing desirable responses from staff in relation to challenging presentations. Training is required to aid understanding and management of staff responses in addition to the presenting challenges. This result is inconsistent with Berkowitz and Heimer (1989), who suggest that negative affect is ameliorated by professional experience, resulting in a more positive response.

There were no significant differences between the types of staff discipline across the SEACCS variables. This is inconsistent with the findings by Colson et al. (1986) who found that different types of professions reported different emotional responses to particular challenges. However, it could again suggest that the type of training staff members receive is most significant to the staff responses measured by the SEACCS.

The longer staff members had worked in mental health and on the ward, the less likely they were to use the coping strategy; ‘I tell myself that I will get better at dealing with it over time’. This would seem intuitive, given the reference to time. Such participants were also
less likely to use the strategy, ‘I think about it for a long time afterwards, over and over again’. However, participants who had worked longer on the current ward were significantly more likely to use this strategy. This reflects the difference of experience in mental health and duration on the same ward. As this item was found to be associated with higher GHQ scores (see Section 5.3.8.1), the result is somewhat concerning. It may be that staff members who have spent longer on an unsupportive ward, or have been working with service users with no / slow therapeutic progress for a longer time (as found in staff interviews of current study; Colson et al., 1985; Gallop & Wynn, 1987; Modestin et al., 1986) respond in this way. Another concerning finding was that staff who had worked longer on the ward were less likely to use the strategy; ‘I reflect on it afterwards and think about what I could have done differently’. This may indicate that staff members more experienced on the ward have less time to reflect than their inexperienced counterparts, as indicated during the staff interviews of this study. Alternatively, the longer participants have worked on the ward, they may not feel they need to reflect, as they may believe there is no need to respond differently, or they may have habituated (Wykes & Whittington, 1998).

5.4.1.6 Relationships between SEACCS and GHQ-28

The GHQ-28 was employed to assess construct validity of the SEACCS. As the specific content and final number of items of the SEACCS were unknown prior to item scrutiny and reliability tests, the hypotheses between the SEACCS and GHQ-28 were not generated until after these stages. The results for each hypothesis are interpreted below:

Hypothesis 1: SEACCS total challenges severity scores would be positively associated with the GHQ total score

This hypothesis was not supported by the results. Although this hypothesis was assumed, it was not, however based on any previous findings in the literature as challenge severity has not been assessed with psychiatric distress. This result is consistent with the results above in Section 5.4.1.4, whereby challenge severity was not associated with negative emotions total score or the individual emotions ‘Anxious’ or ‘Sadness’ (i.e. similar to anxiety and depression GHQ sub-scales). It is possible that these GHQ scores were associated with specific types of challenges, for example, Wildgoose et al. (2003) and Wykes and Whittington (1998) found associations between staff distress (as measured by GHQ) and service user violence (only challenge measured). It may be that total challenge
severity is too broad and the individual challenges too variable in order to detect a relationship with the GHQ score.

Hypothesis 2: SEACCS negative emotions total score will be positively associated with GHQ total score, GHQ-B (anxiety and insomnia) and GHQ-D (severe depression) subscales.

This hypothesis was fully supported by the results, providing construct validity of the emotions domain of the SEACCS and evidence of the sensitivity of the negative emotions sub-scale. These findings are consistent with those of Hastings (2002), who found that intellectual disability staff negative emotions were associated with staff distress.

Hypothesis 3: SEACCS total number of negative emotions score will be positively associated with GHQ total score, GHQ-B and GHQ-D.

This hypothesis was also supported and adds to the construct validity of the negative emotions sub-scale. Due to the apparent relationship with staff distress, this reflects the importance of assessment of the number of negative emotions experienced by staff.

Hypothesis 4: SEACCS positive emotions total score will be negatively associated with GHQ total score, GHQ-B and GHQ-D subscales.

This hypothesis was partially supported as a significant negative relationship was found with GHQ total score. It may be considered surprising that total positive emotions was not associated with the emotion subscales of the GHQ (anxiety and insomnia and severe depression). This may be due to the difference of the positive and negative emotions and that the three positive emotions are not the opposite of the seventeen negative emotions, e.g. ‘Confidence’ is not the opposite of sadness or indeed depression (GHQ-D), as indicated by the lack of relationship between the SEACCS emotion sub-scales. Therefore, the lack of relationship does not negate the construct validity of the positive emotions, though they may not be sensitive enough to detect potential relationships. Nonetheless, the significant relationship of the total score provides partial construct validity of the positive emotion sub-scale.
Hypothesis 5: \textit{SEACCS total number of coping strategies will be positively associated with GHQ total score.}

This hypothesis was also supported. This suggests that the number of coping responses is important to assess not only due to its relationship with negative emotion severity but due to its association with staff distress, as indicated by the findings of this study which are consistent with findings by Wykes and Whittington (1991).

Exploratory correlations with individual items found that coping item 13, ‘\textit{I think about it for a long time afterwards, over and over}’ was found to have a significant relationship with GHQ total score and GHQ-B, providing further evidence that this item assesses an ‘unhelpful’ form of coping. GHQ-B was also associated with external attributions. One possibility could be that instead of attributing challenges to factors internal to the service user, participants tended to attribute them to themselves (external to the service user), resulting in increased levels of anxiety or staff psychiatric distress that could result in more self-blaming external factors. However, these factors are purely hypothetical as no causal relationship can be determined.

\textbf{5.4.2 Methodological considerations and future directions}

\textbf{5.4.2.1 Recruitment and sample characteristics}

The aim of this study was to assess the SEACCS across multi-disciplinary staff. However, the majority of participants were nurses. Although this is somewhat unsurprising given the distribution of the disciplines in this setting, the bias may have affected the results.

Although various techniques were used to maximise the return rate (Bowling, 1997), there was approximately 30% response rate for initial questionnaire packs and re-tests. However, it could be suggested that the high response quality, indicated by the small amount of missing data, has equal importance to the response rate. Nonetheless, the study produced a small sample size; therefore the results should be considered with caution. A re-submission could not be made to recruit from the third NHS Trust R & D department due to the time-frame of the study. Participants who agreed to a re-test could not be contacted individually in accordance with the protocol which stated all identifiable information would be destroyed following the sending of the re-test packs. However, all ward managers were contacted weekly via telephone in order to maximise the likelihood of completion. As it was a self-report measure and participants who agreed to re-test had to
complete the Participant details form, they may have been more inclined to produce more socially desirable responses particularly as all recruitment took place through the ward managers. Although the researcher clearly stated in the pack and in person that the identifiable information would be destroyed and not shared with ward managers, it is possible this recruitment process impacted on response rates. One alternative may have been to provide everyone with a re-test at the same time of initial testing, thus avoiding identifiable information. However, this could have resulted in even less overall response rates as two tests may have been off-putting or confusing, and there would be no way of knowing if the re-tests were actually completed at the same time. Although the method used for re-test ensured there was at least one week between testing, there could have been up to one month between testing. This possible disparity should be considered when reviewing the re-test results.

Although this scale was developed using the relevant literature and based on actual psychiatric inpatient staff experiences, it should be noted that participants were all NHS staff across the North West of England. In addition to the impact of the small sample size, generalisation of results is limited.

5.4.2.2 Item wording

Staff members’ own terms were employed in the wording of the items. Despite this, staff may have been more inclined to use such terms during an interview where they could speak freely and have time to reflect on their experiences, in comparison to completion of the SEACCS where staff could have been more reluctant or indeed unaware of some of their responses. However, the time required for staff interviews would not be feasible in this setting on a regular basis. Also, future investigations could involve ‘diluting’ the items in order to explore any significant difference in variance across the items and possibly to obtain increased sensitivity among the subscales. For example, challenges such as ‘Persistent low mood’ and ‘Excessive demanding behaviour’ could be altered to ‘low mood’ and ‘demanding behaviour’; emotions like ‘anger’ could be altered to ‘irritable’ etc. This may also reduce the likelihood of socially desirable responses.

5.4.2.3 Item selection and exploratory analysis

Due to the large number of SEACCS items and small sample size, exploratory factor analysis was not appropriate. This led to the use of participants to develop further subscales within the SEACCS domains. Although the content and face validity was a strength
of the study, the sub-scales were not based on psychometric properties, therefore the results of investigations with these sub-scales should be considered with caution. Content of the SEACCS items pertain to one of four domains. However, exploratory analysis with a large sample is necessary to determine the exact type of factor structure. If different subscales are found during future investigations, the subscales might provide specific areas of focus for staff training; and the SEACCS might prove useful in order to further assist with evaluating staff training programmes.

The inability to categorise the coping items may suggest the scale was too diverse. A strength of the scale was the fact that it is relatively brief and would instantly highlight many areas of clinical interest (which would not normally be considered or measured) to ward managers and areas which require potential training for staff. However, its current diversity and lack of actual constructs indicates that the scale requires further psychometric investigations prior to being used as a research tool, and to determine the appropriateness of retaining the four domains in one scale. This does however reflect the exploratory nature of the study and the number of stages required in the development of a meaningful, reliable, and valid measure. Nonetheless, significant relationships were found across the four domains, thus supporting the rationale of the study.

It is important to consider that most of the psychometric investigations in this study were of an exploratory and preliminary nature. Due to the limited research across these areas, particularly with this staff group, and the unknown content of the SEACCS prior to the study, no a priori hypotheses were made within SEACCS items. As the number of items within the SEACCS was so high, inter-item relationships across the whole scale were not considered feasible for the scope of this study. However, due to the lack of constructs within the current SEACCS, these correlations would be appropriate during future investigations particularly to assess any differences in staff responses with individual challenges. The lack of constructs also questions the conceptual meaningfulness of Cronbach’s alpha and ICC within the sub-scales. Although the results of these tests were generally within the acceptable range, their results should be considered with caution. However, a strength of this study was the combination of exploration of psychometric properties alongside clinical judgement applied in the SEACCS development. For example, Cronbach’s alpha was low for the ‘external’ attributions sub-scale due to item 12, but clinical judgement from the research team meant that the item was retained following consideration of its theoretical and clinical relevance.
Although hypotheses have been proposed about the results of investigations, the correlation analyses make it impossible to draw conclusions about causality. Also, the complexity of teasing apart the four domains has been reflected at every stage of this study (including previous literature referred to in the systematic review). Future research should aim toward refining these separations and investigating the causal relationships in order to expand on the limited theoretical knowledge of these areas and to use this knowledge in order to develop and refine staff training and support.

5.4.2.4 Selection of additional measures

The results between the SEACCS and GHQ-28 indicated reasonable construct validity. However, due to the number of domains within the SEACCS, as well as sub-scales within these domains, it would not be expected that good construct validity would be achieved from one single measure. As it was unknown what the SEACCS was going to specifically contain prior to the study, the GHQ-28 seemed an appropriate choice of measure given its robustness, its obvious relationship with negative emotions (i.e. anxiety and depression) and coping, and due to it having been successfully used with this staff group in previous studies (e.g. Fagin et al., 1996; Wykes & Whittington, 1998). Further possible assessments to examine construct validity could involve a measure of staff willingness to help similar to that used by Sharrock et al. (1990) and Stanley and Standen (2000), as much of the literature has highlighted the relationship of helping with each of the three responses related to challenges. Concurrent validity for individual domains of the SEACCS could also be assessed using tools such as the Attributional Style Questionnaire (Peterson et al., 1982), an adapted Emotional Responses to Challenging Behaviour Scale (Mitchell & Hastings, 1998), the FWC-58 (Rossberg et al., 2003), or the DCL (Carson et al., 1996a).

5.4.3 Clinical implications

Due to the impact of staff attributional, emotional, and coping responses based on perceived challenging presentations on both the staff member and the service user, it is imperative that these domains are further assessed and managed. The literature reviewed in Chapters one and two suggests that violence and aggression are the most challenging, if not the only challenges, psychiatric staff are presented with.
This discrepancy was also found in the analysis of the interviews, supporting previous findings indicating that there are many more challenges perceived by staff (Colson et al., 1985; 1986; Gallop & Wynn, 1987; Modestin et al., 1987) and suggesting that further studies should be carried out to explore the challenges staff perceive in this setting – given the magnitude of the challenges faced, which have not been fully assessed in previous studies. It was clear from this stage of the study that staff not only have a variety of causal attributions, but experience many different emotions, often negative and use various strategies to enable them to cope. Such strategies may indeed have been helpful, but there also appeared to be unhelpful responses, or indeed staff felt that they did not have the opportunity to help them cope with the challenges, e.g. time to reflect, formal support, and training. Hypothetical associations across the domains were also discussed during this stage (see Section 3.9.1). For example, attributions of controllability appeared to produce more negative emotions from staff. Therefore, this stage of the study has explored and identified numerous challenges and responses that staff experience which not only expands on our limited theoretical knowledge of staff experience within this setting, but imperatively highlights the need to further assess these experiences and the relationships across the four domains in order to tailor the support and training provided.

Crucially, the development stages and subsequent results of this study have indicated several more challenges staff experience, which may have ordinarily been overlooked. Comprehensive assessment can now be carried out using the SEACCS where ward managers and relevant staff can quickly explore staff experiences and develop training and interventions accordingly. The SEACCS could also be easily adapted in order to assess staff members’ experiences and attributions of individual clients. This could aid formulation meetings about staff understanding of the client’s presentations, similar to the staff training programme piloted by Berry et al. (2009) and Bonner et al. (2002), and indicate if different experiences among staff working with the same service user occur.

Staff emotional and coping responses would also be quickly identified using the SEACCS, immediately indicating where support was required, but also which helpful strategies staff have already employed. These findings can be utilised and incorporated into training and support programmes for staff members in this setting. Therefore, the findings from the SEACCS would add to the theoretical knowledge of the relationships between the domains and also the subsequent clinical support for staff. Tailored training may also decrease staff psychiatric distress, which is clearly related to some of the aspects assessed by the
SEACCS, and vitally, may improve the therapeutic relationship and the clinical outcome of the service user.

Following training programmes, the SEACCS could also be used to detect change of staff perceptions and responses, and inform subsequent adaptations to the training.

Due to the busy environment and current lack of staff, the short time required for completion, and the incorporation of all four domains in one measure, the SEACCS may be a desirable choice for ward managers to use with their staff. The consistent use of one measure would also make it possible for direct comparisons of results to take place, a process which this study has highlighted as evidently lacking in the psychiatric inpatient literature.

5.4.3.1 Examples of SEACCS application

In order to further demonstrate the usefulness and the clinical applicability of the SEACCS, some examples of two of the participants’ responses are provided below:

Participant 10 (P10): A female Nursing Assistant who worked on a mixed gender acute psychiatric ward and had worked in both a mental health setting and on the ward for three months in total.

P10’s responses indicated that she found all 16 of the presentations extremely challenging (mainly scored ‘6’), and had a total challenge score of 95 out of a possible score of 96. P10 also scored much higher on internal attributions than external attributions (e.g. scored ‘6’ for ‘Service users’ ‘laziness’ and scored ‘2’ for ‘environmental factors’ e.g. how they have been approached by staff...’) and responded that she believed service users had complete control over these challenges. P10 scored ‘6’ for many negative emotions, indicating that she always felt emotions such as ‘Frustration’, ‘Confusion’, ‘Incompetent’, ‘Frightened’ and ‘Demotivated’. Interestingly, P10 also responded that she never felt calm or confident when these challenges occur. P10 scored ‘0’ for the coping strategies ‘I keep trying with the service user’, ‘I just react without really thinking about it’, and ‘I take a break/time away from the service user’ and indicated that she always thinks about the challenge for a long time afterwards, over and over and talks it over with other staff.
Participant 69 (P69): A female Clinical Psychologist who worked in a mixed gender PICU ward and had experience in mental health for 6 years and 4 months and had worked on the ward for one year.

P69 indicated that she found 15 out of the 16 presentations challenging, scoring ‘0’ for ‘Positive symptoms of psychosis...’ and had a total challenge score of 34 out of 96. P69 scored 3 or below for most challenges, including; ‘Excessively demanding behaviour’, ‘Behaviour that does not adhere to treatment...’, and ‘Poor communication/social skills’. However P69 did score ‘5’ out of ‘6’ for the challenge, ‘Threatened or actual physical violence’. Contrary to P10, P69 scored much higher on external causal attributions than internal attributions (e.g. scored ‘5’ for ‘Service users’ past experiences...’, and ‘Environmental factors e.g. reaction to how they have been approached...’ and scored ‘0 – Not at all’ for ‘Service users’ laziness’ and ‘Service users’ wish to walk over staff...’). P69 responded that she perceived service users to have some control over these challenges by scoring ‘3’ out ‘6’. P69 did indicate that she experienced many of the negative emotions; however, most of these were scored in the middle of the scale with a score of ‘3’ or below. Slightly higher scores were provided for responses of ‘Calm’ and ‘Confident’.

Alternatively from P10, P69 reported high coping scores on items such as; ‘I keep trying with the service user’, ‘I take a break/time away for the service user’, ‘I try and understand the service user’s difficulties...’ and ‘I reflect on it afterwards...’ and a lower score for the item, ‘I think about it for a long time afterwards...’.

From the participants’ responses above, clear associations suggested during the interview stage and found during the exploratory psychometric investigations above can be very quickly obtained by relevant staff and utilised for the provision of staff support and training. For example, the coping strategies P69 used appear to be more helpful (given the lower total challenges scores and negative emotions scores, and higher positive emotion scores) than those used by P10. P69’s high challenge score of violence may suggest that she requires further training and support in the management of this. It may be possible that staff who spend less time with service users and who are not based on the ward receive insufficient training in this area. The participants above worked in different ward types, had different levels of experience and training which is bound to have impacted on the responses they provided. It is therefore important to also assess the relevant demographic information and the effect on staff experience across the four domains.
5.4.4 Overall Conclusions

The aim of this study was to develop a tool to assess the perceptions of multi-disciplinary psychiatric staff members’ in relation to challenging presentations of service users, their causal attributions, and their emotional and coping responses to these challenges (SEACCS), as well as the relationships across responses. It was anticipated that the SEACCS would be a clinically relevant measure and a tool to build on the limited theoretical knowledge of the relationships within and across these domains. In order to develop this measure, rigorous methods were used across three phases of the study. The use of both qualitative and quantitative methods in the development of this tool based on psychiatric inpatient staff members’ actual experiences has ensured the production of a meaningful and clinically relevant tool for this staff group.

While the limitations have been acknowledged throughout the study, most of the findings from the exploratory psychometric investigations of the SEACCS were consistent with findings from staff interviews in the first phase of the study. These findings were also consistent with many of the relevant studies that were systematically reviewed; therefore the relevance of this tool has been reflected in the results and in the value of these combined methods.

In conclusion, this study provides the first step in the careful construction of a clinically relevant and useful tool to assess psychiatric inpatient staff experiences of challenging presentations and associations across the domains. It also presents a preliminary analysis of reliability, content and face validity, and construct validity as assessed with the GHQ-28. However, future research is required in order to further explore the psychometric properties of the SEACCS, including factor analysis to assess the exact type of factor structure.

One of the most important objectives for the development of this particular scale was to identify the challenging presentations staff members experience and the associated attributions, emotions, and coping responses, in order to identify specific areas where staff training and staff support is required. This objective has been achieved and areas for staff training and support have been identified and discussed throughout each phase of the study.
Complete References


Systematic review references


APPENDIX 1 - Verification of Quantitative Study Eligibility

Author(s)__________________________________________________________________________________________________________________________
                                                                                      _________________________________________________________________________________
Publication Title_____________________________________________________________________________________________________________________
                                                                                      _________________________________________________________________________________
Journal_______________________________________________________________________________________________________________________________
Year of Publication____________________

Type of participants
Adult psychiatric inpatients (18-65) diagnosed with a severe and enduring mental illness and/or staff (18-65) who work in a psychiatric inpatient setting with individuals who have severe and enduring mental illness

Types of outcome measures
The assessment of:
Difficult patients/challenging behaviour characteristics
Staff attributions/views/attitudes of difficult patients/challenging behaviour
Staff emotional response/impact of challenges/attributions
Staff coping strategies/intervention to manage emotions / difficult patients/challenging behaviour

Types of studies
Randomised controlled trial
Experimental study
Quasi-experimental design
Observational study
Case study
Case series

Do not continue with study if one box from each section has not been ticked
APPENDIX 2 - Verification of Qualitative Study Eligibility

Author(s)_________________________________________________________________
________________________________________________________________________
Publication Title__________________________________________________________
________________________________________________________________________
Journal____________________________________________________________________
Year of Publication___________________________

1. Type of participants
Adult psychiatric inpatients (18-65) diagnosed with a severe and enduring mental illness
and/or staff (18-65) who work in a psychiatric inpatient setting with individuals who have
severe and enduring mental illness □

2. Types of areas explored
The exploration of:
Difficult patients/challenging behaviour characteristics □
Staff attributions/views/attitudes of difficult patients/challenging behaviour □
Staff coping strategies/intervention to manage difficult patients/challenging
Behaviour □

3. Data collection
Is it clear how the data were collected? □
Is it clear how the data were recorded? □
Is it clear who collected the data? □

4. Data analysis
Is it clear how the analysis was done? □
Is it clear how the categories/themes were derived from the data? □
Is there adequate description? □
Was the analysis repeated by more than one researcher to ensure reliability? □

Do not continue with study if one box from section 1 and 2 has not been ticked and
more than one box from section 3 and 4 have not been ticked
## APPENDIX 3 - Summary of Studies included in systematic review

<table>
<thead>
<tr>
<th>Author(s), Country</th>
<th>Sample</th>
<th>Challenging pt characteristic</th>
<th>Measures</th>
<th>Analysis</th>
<th>Key findings</th>
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<tbody>
<tr>
<td>Colson, et al (1985), USA</td>
<td>127 inpatients in 5 long term psychiatric hospitals; Psychiatrist, Social worker, Nurse and Activity therapist from 11 teams</td>
<td>Multiple</td>
<td>HTRS; global ratings of overall treatment difficulty; progress; prognosis</td>
<td>Factor analysis; Pearson’s correlations</td>
<td>4 factors found: character pathology; withdrawn psychoticism; violence-agitation; &amp; suicidal behaviour. Each 4 factors significantly related to perception of overall treatment difficulty. Only withdrawn psychoticism was related prognoses to perceptions of progress &amp; higher withdrawn psychoticism was seen to make less progress and poorer prognoses. Higher overall treatment difficulty related to less progress and poorer prognoses.</td>
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<td>Modestin et al (1986), Switzerland</td>
<td>8 nurses and 10 physicians on psychiatric intensive Treatment unit</td>
<td>Multiple</td>
<td>Questionnaires (developed by authors) assessing: who difficult patients are &amp; their characteristics; follow-up to assess re-hospitalisation, suicide frequency &amp; psychosocial adaptation; clinical records</td>
<td>Rank correlations; 2 tailed t-tests; Chi-square</td>
<td>26 problem patients and 26 non problem patients (controls) identified. 12 classes formed to classify staff statements of difficult patients. Difficult patients were more likely to suffer from psychoses or PD, present with more behavioural pathology, prescribed more medication, &amp; longer hospitalisations than controls. Suicide proneness of difficult patients was high. Follow-up indicated that majority of difficult patients did not earn their own living. No other difference of social adaptation was found between controls.</td>
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<tr>
<td>Study</td>
<td>Sample Size</td>
<td>Measures</td>
<td>Methods</td>
<td>Findings</td>
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<tr>
<td>Colson et al (1986), USA</td>
<td>127 inpatients in 5 long term psychiatric hospitals; Psychiatrist, Social worker, Nurse and Activity therapist from 11 teams</td>
<td>Multiple HTRS; global ratings of overall treatment difficulty; progress; prognosis; Clinical records (levels of treatment)</td>
<td>Hierarchical grouping analysis; Multivariate ANOVA; Mann-Whitney U-test</td>
<td>Profile groups A-J were devised (‘A’ most difficult to treat). These differed in pattern of mean scores across on HTRS, each profile presented a distinct form of difficulty. Group A was significant in requiring the most special controls. This group tended to be too slow to change &amp; most restrictive level of responsibility.</td>
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<tr>
<td>Allen et al (1986), USA</td>
<td>127 inpatients in 5 long term psychiatric hospitals; Psychiatrist, Social worker, Nurse and Activity therapist from 11 teams</td>
<td>Multiple HTRS; global ratings of overall treatment difficulty; progress; prognosis; Clinical records (levels of treatment); consultation with staff</td>
<td>Factor analysis; Pearson’s correlations</td>
<td>Patient difficulty ratings significantly related to treatment variables. High overall treatment difficulty related to greater degree of supportive-restrictive interventions. Higher level of treatment difficulty associated with greater overall dissatisfaction. Withdrawn psychoticism associated with greater use of each form of supportive-restrictive intervention.</td>
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<td>Study</td>
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<td>Data Collection Methods</td>
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<tr>
<td>Colson et al. (1986), USA</td>
<td>127 inpatients in 5 long term psychiatric hospitals; Psychiatrist, Social worker, Nurse and Activity therapist from 11 teams</td>
<td>Multiple</td>
<td>HTRS; Rating scales (treatment difficulty &amp; affective responses)</td>
<td>Factor analysis; Pearson’s correlations</td>
<td>Some dimensions of psychopathology, particularly suicidal-depressed behaviour and violence-agitation, elicited different emotional reactions among different disciplines. The more difficult the process of hospital treatment, the more likely staff experienced a variety of emotions.</td>
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<tr>
<td>Allen et al. (1987), USA</td>
<td>57 inpatients (unclear if taken from same sample as Colson et al²,³)</td>
<td>Multiple</td>
<td>GAS completed by authors using clinical records for admission and discharge; ratings of treatment difficulty (unclear if taken from Colson et al.²)</td>
<td>Unclear</td>
<td>Two of four treatment difficulty dimensions were negatively related to improvement, withdrawn psychoticism and violence agitation. Character pathology was not related to degree of improvement. Modest negative relationship between violence-agitation and improvement. Suicide-depressed behaviour was not related to improvement.</td>
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<tr>
<td>Gallop &amp; Wynn (1987), Canada</td>
<td>25 nurses; 12 inpatients (majority have diagnosis of schizophrenia or PD)</td>
<td>Multiple</td>
<td>Interviews; Feelings Checklist (staff &amp; patients)</td>
<td>Content analysis, unclear how scale was analysed</td>
<td>Many difficult patients identified had PD. What constitutes a difficult patient was expressed differently by staff &amp; patients. Unclear themes identified. 24 of the 25 patients identified by the nurses were remembered as presenting with many of same difficulties. These behaviours were frequent, unpredictable and unremitting. Unresponsiveness was equated with no motivation.</td>
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<tr>
<td>Study</td>
<td>Participants</td>
<td>Methodology</td>
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<td>Sharrock et al. (1990)</td>
<td>34 staff members, majority nurses</td>
<td>Difficult behaviour (unspecified)</td>
<td>Staff Optimism Scale (modified version); ASQ (modified); Scales developed by authors to Measure helping behaviour &amp; emotion; Pearson’s correlations; Multiple regression</td>
<td>Staff explanations were related to staff optimism to anticipated helping behaviour. Generally, staff made internal, controllable stable &amp; global attributions about the ‘target’ difficult patient. Helping behaviour was most strongly related to staff optimism &amp; stable &amp; controllable attributions were both negatively and independently related to levels of optimism.</td>
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<td>Wykes &amp; Whittington (1991)</td>
<td>24 staff, mainly nurses (various grades)</td>
<td>Physical violence</td>
<td>Spielberger State Anxiety Questionnaire; Maudsley Strain Questionnaire; Interview (based on coping) at 3 time points; Kappa; Multiple regression; content analysis</td>
<td>Ignoring the incident by avoiding thinking about it and taking time away from work or colleagues was associated with decreases in psychological difficulties over time. The higher the level of psychological difficulties experienced, the more coping strategies were reported. Decreases in psychological difficulties were significantly related to the adoption of denial as a coping strategy, irrespective of level of strain.</td>
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<td>Whittington &amp; Wykes (1994)</td>
<td>24 staff, mainly nurses (same sample as Wykes &amp; Whittington)</td>
<td>Physical violence</td>
<td>Spielberger State Anxiety Questionnaire; Maudsley Strain Questionnaire; Interview (based on coping) at 2 time points; Further analysis of Wykes &amp; Whittington data, analysis unclear</td>
<td>Average levels of anxiety following assault were unremarkable; however, a small group of assaulted staff experienced severe anxiety in the absence of serious physical injury. Some had PTSD-like symptoms and others reported higher levels of anxiety compared to norms reported from male inpatients hospitalised with anxiety disorders. Anxiety was significantly higher at 72 hours than at the subsequent interview.</td>
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<td>Authors</td>
<td>Sample Size</td>
<td>Type of Violence</td>
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<tr>
<td>Apel &amp; Bar-Tal²⁰⁻¹⁹ (1996), Israel</td>
<td>133 nurses in 20 closed wards across 10 Psychiatric Hospitals</td>
<td>Violence (unspecified type)</td>
<td>2 vignettes (arbitrary, non-arbitrary); Reaction scales (3 possibilities; Violent, therapeutic or vigilant)</td>
<td>Content analysis; t-tests</td>
<td>Staff scored the arbitrary scenario as less predictable &amp; less controllable by the nurse because the incident was not triggered by something the nurse did. When patient behaviour was perceived as arbitrary, staff were believed to respond with a therapeutic reaction more frequently than to non-arbitrary scenario.</td>
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<td>Cutcliffe⁸ (1997), UK</td>
<td>6 nurses, psychiatric inpatient unit</td>
<td>Violence (type unspecified)</td>
<td>Semi-structured interviews</td>
<td>hermeneutic phenomenological thematic analysis</td>
<td>3 key themes identified; personal construct of violence, feeling equipped and feeling supported. The more equipped nurses felt, the more likely they were to view violence as an entirely negative, destructive, and ruinous activity.</td>
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<tr>
<td>Gillig et al.¹⁵ (1998), USA</td>
<td>54 psychiatric inpatients, mainly with Schizophrenia; 32 nurses; Acute psychiatric Inpatient ward</td>
<td>Physical aggression</td>
<td>Scales developed by authors measuring degree to which item contributed to physical aggression, causes, emotional impact; Checklists of tactics supported &amp; actual behaviour; Overt Aggression Scale</td>
<td>Chi-squares</td>
<td>The majority of both staff and patients agreed that patients who were psychotic were more likely to be involved in physically aggressive incidents. More staff and fewer patients attributed incidents to patient intoxication. 85% of staff attributed physical aggression to learned behaviour. Staff reported having trouble-sleeping, change in appetite, increased depression &amp; sadness, rage &amp; anger</td>
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<td>Study</td>
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<td>Wykes &amp; Whittington (1998), UK</td>
<td>Nurses across 6 acute psychiatric wards. 3 groups, baseline, assault group and control group. Unclear how many of the baseline used in other 2 groups</td>
<td>Physical violence</td>
<td>IES; PTSD-SS; STAI; STAXI; GHQ-28; BDI; DHQ; Hospital violent incident register (Assaulted group completed all measures, baseline and controls did not complete IES or PTSD-SS)</td>
<td>ANOVAs; Multiple regression</td>
<td>Most assaults were physically minor but 5% of assault group met criteria for PTSD. Assaulted staff reported worse mental health than controls and poorer anger control than at baseline. Psychological distress was higher following assaults resulting in physical injury and staff who were repeatedly assaulted reported either significantly higher or significantly lower than those assaulted once.</td>
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<td>Barrowclough et al. (2001), UK</td>
<td>20 key workers (nurses) paired with 20 patients majority with Schizophrenia, low secure unit</td>
<td>Positive &amp; negative symptoms; level of social functioning; social behaviour; incidents involving ‘challenging behaviour’</td>
<td>PANSS; Social Functioning Scale; Social Behaviour Scale; Clinical records frequency of challenging behaviour incidents; Staff EE assessed Using CFI; All Completed expressed feelings &amp; perceived feelings scales</td>
<td>Spearman’s Rank correlations</td>
<td>No high EE interview was found. Critical comments were associated with more stable &amp; controllable attributions for patient problems. Social functioning was associated with staff perceived &amp; expressed negative feelings. Patients’ perceived negativity was related to criticism &amp; warmth &amp; staff reports of negativity</td>
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<td>Study</td>
<td>Participants</td>
<td>Violence Type</td>
<td>Methodology</td>
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<td>Wildgoose et al. (2001), UK</td>
<td>127 staff, mainly nurses</td>
<td>Threats of violence; actual violence</td>
<td>GHQ-12; IES; Rating scale (experience of threat or actual violence)</td>
<td>Odds ratios; t-tests</td>
<td>72% experienced one or more incidents of threatened or actual violence that they found distressing. 32% found it ‘very stressful’, 37% moderately stressful and 31% found it ‘mildly stressful’. 9% of these took time off work following most distressing incident. Nurses were much more likely than other professions to experience such incidents. Those who experienced incidents were significantly more likely to score above the threshold on GHQ-12. Those who experienced several or more incidents had significantly higher mean GHQ-12 and IES scores than those who only experienced one or two.</td>
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<td>Bonner et al. (2002), UK</td>
<td>6 inpatients; 12 staff members; all involved in incident of physical restraint</td>
<td>Violence leading to physical restraint</td>
<td>Semi-structured interview</td>
<td>Qualitative technique of Miles &amp; Huberman (1984) unnamed</td>
<td>12 themes found. Staff and patients felt that post-incident debriefing was useful. Staff reported that this occurred occasionally. Several staff members reported that the incident had re-awakened distressing memories of previous traumatic events.</td>
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<tr>
<td>Study</td>
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<td>Participants</td>
<td>Methods</td>
<td>Findings</td>
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<td>Ilkiw-Lavalle &amp; Grenyer (2003), Australia</td>
<td>29 staff, majority Nurses; 29 patients, majority with bipolar disorder or schizophrenia, across 4 psychiatric inpatient units</td>
<td>Verbal &amp; physical aggression</td>
<td>Aggressive/Assaultive Incident Form; semi structured interviews</td>
<td>Many staff members perceived the patients’ illness as the cause of aggression and believed that to manage aggression, changes in medication were highly indicated. No association was found between the type of aggression displayed and whether staff experienced a negative emotion following the incident.</td>
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<tr>
<td>Rossberg &amp; Friis (2003), Norway</td>
<td>253 staff, mainly nurses, across 17 psychiatric wards</td>
<td>Aggression; suicidal behaviour</td>
<td>FWC-58; SDAS; Checklists (medications)</td>
<td>Blockwise multiple hierarchical regression</td>
<td>Staff reported positive feelings about patients much more frequently than negative feelings. Patient characteristics revealed much more of the variance in negative feelings than in positive feelings. Aggressive behaviour was more strongly associated with negative feelings than suicidal behaviour. Illness severity did not explain a significant amount of the variance in any dimension.</td>
</tr>
<tr>
<td>Kindy et al.\textsuperscript{17} (2005), USA</td>
<td>10 nurses</td>
<td>Physical violence</td>
<td>Semi-structured interviews; 2 questionnaires (experience of working with violence, thoughts &amp; feelings &amp; description of an actual assault, thoughts and feelings during it)</td>
<td>Interpretative phenomenological analysis</td>
<td>4 key categories were generated: ‘safety fortifications’; ‘catalysts for violence’; ‘perplexing aftermath’; and ‘pervasive invasive sequelae’. Perplexing aftermath – participants reported being hypervigilant, distrustful, and fearful following an assault, which resulted in poor morale. Following an assault, they were burdened by fear of future injuries, affecting their ability to earn a living, a desire to leave after weighing the risks and benefits and perceiving minimal hope for change. Pervasive invasive sequelae – staff described a need to withdraw or shut down out of concern that clients would sense fear and take advantage of it or simply burning out from the overwhelming feelings of stress.</td>
</tr>
<tr>
<td>Sun et al.\textsuperscript{23} (2006), Taiwan</td>
<td>15 nurses; 15 patients who had either suicidal ideation or attempted suicide, across 3 psychiatric hospitals</td>
<td>Suicidal ideation; attempted suicide</td>
<td>Semi-structured interviews</td>
<td>Grounded theory</td>
<td>A substantive theory of suicide-nursing care was developed. 2 categories in context element of paradigm explored (team working and psychiatric ward environment) 4 categories emerged from ‘intervening conditions’ (nurses attitudes and beliefs have an effect on caring; barriers to caring; negative and thoughts and feelings about care provided and support systems.</td>
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<tr>
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<td>Participants</td>
<td>Event</td>
<td>Measure</td>
<td>Analysis</td>
<td>Findings</td>
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<tr>
<td>Bowers et al.(^7) (2006), UK</td>
<td>56 staff, 16 ward managers, 17 nurses, 14 OTs and 9 consultant psychiatrists, across 14 acute psychiatric wards and 3 PICUs</td>
<td>Suicidal ideation; suicide attempt, serious assault, &amp; absconding of high risk patients</td>
<td>Operant Philosophy and Policy Interview (developed for this study)</td>
<td>Unclear (analysed by 3 researchers)</td>
<td>Staff reported feelings of shock, depression, demoralisation, upset, loss and grief, followed by ruminations, guilt and anxiety. Processing of the emotional impact was hindered by the pace of the ward life, a lack of external support, and management investigations. Patient responses were largely ignored.</td>
</tr>
<tr>
<td>Nolan et al.(^6) (2009), USA</td>
<td>42 inpatients with diagnosis of schizophrenia; Staff (unclear number or profession)</td>
<td>Aggression (unspecified type)</td>
<td>Overt Aggression Scale</td>
<td>Kappa; ANOVA; unclear</td>
<td>Staff attributed aggression to more internal factors (e.g. psychotic symptoms, tension) than patients did. Responses to aggressive incidents did not take staff and patient causes of aggression into account, they related to the type and severity of aggression.</td>
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Invitation to take part in a research study

Participant Information Sheet

Study Title: What challenges do staff in psychiatric inpatient settings face?

You are being invited to take part in a research study. Before you decide whether to take part it is important you understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with other people if you wish. Ask us if there is anything that is not clear or you would like more information. Take time to decide whether or not you wish to take part.

Why is the study being done?

This study aims to look at the challenges staff face with service users in an inpatient setting and the things that are most likely to help overcome these challenges. We will meet with staff to explore their views and experiences of working with service users who have severe and enduring mental illness. Information from these interviews will be used as the first stage of developing a staff questionnaire.

Who will be taking part?

We are hoping that 6-8 qualified staff members will take part. Participants will have a minimum of 10 hours contact with service users on an inpatient ward per week.

Why have I been asked to take part?

We are asking you because you are currently working within an inpatient setting that provides care and treatment to individuals who have a severe and enduring mental illness.

Do I have to take part?

No. It is up to you whether or not you decide to take part. Taking part in the study will not affect your employment in any way. If you decide to take part you can leave the study at any time without giving a reason.

What will it involve for me?

You will be seen by a researcher for an interview which will last approximately 30 – 45 minutes. This will involve talking about your experiences of working with this client group, any challenges you face and your feelings towards these challenges.
We will try and make appointments for interviews at times which suit you. The interviews will take place during work time with the permission of your manager(s). You can of course have any breaks you need and the tape can be stopped and edited at any time during the interview at your request.

**What are the advantages and disadvantages of taking part?**

You will be able to inform and reflect upon your professional experiences. This may help you later in your day-to-day work with service users and may increase work satisfaction and well being.

People often welcome the opportunity to discuss and reflect upon their job roles. However it is possible that talking about difficult work issues may result in some distress. If you wish, we can give you details of people that might be able to help you if this occurs.

**What if something goes wrong?**

If you are unhappy about any aspect of this research you can contact the lead researcher (Nadia McColgan, Division of Clinical Psychology, University of Manchester, Tel. XXXX. Email: XXXX or the academic supervisor for this project (Professor Gillian Haddock, Tel. XXXX).

If you wish to make a complaint, you can contact a University Research Practice and Governance Coordinator, Tel: 0161 2757583 or 0161 2758093

Email: research-governance@manchester.ac.uk

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Manchester, but you may have to pay for your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

**Will my taking part be confidential?**

If you agree to take part in the study, any information you give the researcher will be kept strictly confidential and will conform to the Data Protection Act of 1998 with respect to data collection, storage and destruction. Your name will not appear on any of the forms, we will give you a study number instead. Any information you give to the researcher will not be shared with anyone outside the research team without your consent, unless the researcher feels that either yourself or others are likely to be harmed or that unsafe practice is revealed. In this unlikely event, the researcher would be required to contact the necessary persons (for example, a member of senior management within the department). The researcher would inform you of this before this happened.

We will ask for your consent to audio record the interview. These recordings are made so that interviews can be transcribed (typed) which will help us to look at your responses in more detail. The audio recording and the written transcription of
the interview will be stored securely at University of Manchester premises. Your name will not appear on any audio recordings or written transcriptions of the interview, we will use a study number instead.

If you agree to take part, the researcher will keep a copy of your consent form for the research records. This copy may be reviewed by the Trust R&D Department to confirm that you have given written informed consent. Responsible individuals from the University of Manchester may also look at the research records to audit the conduct of the research.

**What will happen to the results of the study?**

The results of the study will be used to develop a questionnaire of staff challenges. They will be published in a doctoral thesis archived in the University of Manchester Library, and it is also intended that the results will be published in a peer-reviewed journal. You will not be identified in any publication. If you would like a summary of the overall results, please let the researcher know. Where there are high numbers of participants from a single site, it will be possible to arrange a presentation of findings following completion of the study.

We will ask your permission to publish quotations from the interview. It will not be possible to identify you from your quotations. Your name will not be used alongside any quotations.

*You may decline permission for us to publish direct quotations from the interview at any time prior to publication and still take part in the study*

**Who is organising and funding the research?**

The research is organised and funded by the University of Manchester.

**Further Information**

Please contact Nadia McColgan by sending an email to XXXX or by leaving a message on XXXX, if you would like more information about the study, or if you have any concerns during the study.

*Thank you for taking time to read this sheet and considering whether to take part in this study*
APPENDIX 5 – Staff Demographic Questionnaire

**Staff Demographic Questionnaire**

ID number: __________

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**Ethnicity**

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<td>☐ British</td>
<td>____________________</td>
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<tr>
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<td>☐ Irish</td>
<td></td>
</tr>
<tr>
<td>☐ Any other Black background</td>
<td>☐ Any other White background</td>
<td>Specify __________</td>
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**Place of work:** ___________________________________________

**Name of ward:** ___________________________________________

**Job title:** _______________________________________________

**Professionally Qualified:** Yes ☐ No ☐

**Date awarded professional qualification?** ___ / ___ / ___

(If applicable)

**Name of Qualification:** _____________________________________

(If applicable)

**Other professional qualifications:** __________________________

**Highest level of education completed**

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</table>

Other (please state): _______________________________________

**Duration working in the Mental Health sector?** ___ year(s) ___ month(s)

**Duration working on this ward?** ___ year(s) ___ month(s)
APPENDIX 6 – Interview Schedule

Interview schedule

Tell me about the sorts of patients you work with

Can you think of one patient (past/present) you find/found particularly difficult to manage?

Relationships

Can you describe your relationship with (insert name)? Start from the beginning of your relationship

Has this changed over time? If so, how?

What sense do you make of your relationship with that person now?

How do/did they make you feel (e.g. can you remember feeling fear or anger towards them) and behave?

How comfortable are you around them?

Presenting problems

Background

Diagnosis

If they were here now, what would they be like?

What was it about them that was/is difficult to manage? Why do you think these features in particular present as challenges?

Has this person ever....

- Been overtly hostile/aggressive?
- Self-harmed?
- Had psychotic symptoms such as delusions, behavioural disorganisation?
- Exhibited behaviour that appear demanding, attention seeking, manipulative, unco-operative, self-destructive?
- Isolated themselves, appear low in mood, don't engage
- Tell me about medication for this person

How easy do you find their difficulties to understand (very clear or very ambiguous)? If not clear, how do you deal with that?

What would you rate as being most difficult to manage?

From what you know of this person, what do you think caused them to experience mental health problems?
How much control do you think they have over their own behaviour/illness?

Ways of working with client

What kind of work did/do you undertake with them?

Tell me how you try and overcome these difficulties

What do you think would make them less challenging?

How confident do you feel in dealing with this person (where does that confidence/lack of confidence come from)? Has your confidence changed over time? How?

How are these ‘difficult’ patients different to patients who are much easier to work with?

Were there any pressured moments where this person was exhibiting difficult behaviours (e.g. violence or distress) and you had to think and act quickly?

What sense can you make of those moments now?

Do you think other staff use similar methods to overcome that person’s difficulties in the same way? If not, what’s different?

How is/was this person managed by the service (e.g. their care plan)?

How do you feel about the decisions made surrounding their care?

What support do you get with this?

What (if anything) do you feel could be improved/changed on a service level to make it less challenging?

Any more challenges you can think of?

Ending

Is there anything that I have not raised that you think I should know about?

Can you tell me a bit about what it has been like to be interviewed today?

Has there been anything particularly difficult or distressing that we’ve discussed that you feel you would benefit from additional support from?
APPENDIX 7 – Reflective diary

Following Pilot Interview 1

The interview went very well and seemed to flow. The questions seemed to facilitate a lot of reflective responses. I did need to elaborate on the word “difficult”, with the use of the word “challenging”, which seemed to make more sense to the participant. The participant seemed very interested and surprised even about her own reflections. I was rather surprised by this, because of the participant being a clinical psychologist; one may think that reflection is ingrained in the nature of the job. However, it made me realise that one does not often get the opportunity to reflect on solely one client – even through supervision, particularly post qualification – for that length of time, particularly with the focus being on the staff member’s thoughts, feelings and experiences, as opposed to that of mainly the service user. The interview did get interrupted, whereby the recording was stopped. It did not seem to effect the participant’s concentration too much, although it did take a couple of minutes to get back into the flow if the interview. This interruption should be considered, however, when analysing the data. The participant stated at the end that she thought the interview was a good chance to stop and reflect on many aspects of her work and the service user discussed. I felt happy and somewhat relieved that the interview seemed to go well, and the interview schedule seemed appropriate.

Following Pilot Interview 2

Again, the interview flowed well. It took slightly longer for the participant to focus on one service user. However, once this occurred, the interview went smoothly. This participant could think of a lot of other examples of difficulties, both at the start and at the end of the interview. It appears that focusing on one service user seems to work well, encouraging more in depth reflection on all of the areas, and does not seem to be detrimental to the expense of recalling other difficulties with other service users. Due to the success of both pilot interviews, my supervisors and I have agreed that they can be included in the main study. However, on the basis of both pilot interviews, it’s clear that questions should refer to ‘challenging patients’ as opposed to ‘difficult patients’ or patients that are ‘difficult to manage’. Both participants seemed to struggle with the term ‘difficult’, requiring further clarification. I did want to avoid the term ‘challenging’ as I think it is too closely related to the term ‘challenging behaviours’ (which is very common terminology on wards without specificities) and I wanted to explore all difficulties including external factors related to the patient, not necessarily attributed to their behaviour, however, ‘challenging’ was a more acceptable and appropriate term to the participants. This should be noted when developing the SEACCS measure also. Both terms should perhaps be piloted when it’s developed.

Following Interview 3

This interview seemed to flow well, and the reference to “challenges” seemed to be understood well by the participant. The participant seemed to be very psychologically minded in his responses, reporting very empathic attributions about the challenging service user. I was unsure how much of his responses may have been what he thought I wanted to hear (especially as he had worked alongside one of my supervisors), and he did seem slightly nervous at first, but this seemed to sub-side once the interview began to flow, and he appeared more comfortable, which I think helped him to be honest and reflect on his experience, as opposed to being too concerned about his responses and the interview itself. This was the first time the service user discussed was female. It made me wonder whether female staff may find male service users more challenging, and male staff with female service users.
Following Interview 4

This time, the interview took place on the ward as opposed to the university. For some reason, it seemed to make the content of the interview more real to me, even although I have worked on a few inpatient wards. The participant had been trained as a nurse and was now in a more senior role. I did think that his professional seniority showed. The participant seemed very confident in his responses, and also seemed very insightful and reflective in his work and his attitudes. I wondered whether the level of training, particularly the psychological training had had this impact on him, as well as experience of working on the same ward for so long. I did wonder again, however, if any of his responses were what the participant thought I wanted to hear – the socially desirable response. Although we were in an office, signposted with a ‘private, meeting in progress’, there were several interruptions throughout the interview from other staff members, often requiring the help of the participant. This did seem to hinder the flow of the interview and may have affected the participant’s responses.

Following Interview 5

This interview had to be cancelled twice on short-notice due to incidents on the ward, as did an interview with another potential participant. It highlighted the difficulty in having meetings or anything scheduled on the ward as it can often have to be cancelled due to unforeseen incidents, which in itself is a significant challenge for staff working in this setting. The interview seemed to flow well, although, I did think that the participant often corrected herself, stating that what she had just said sounded terrible, or “not empathic as a nurse should be”. I did think I was able to encourage the participant to carry on as honestly as possible, without bias or the use of leading questions. For the first time, the participant seemed to express a lot of anger regarding the service user. I was struck, however, by how the participant seemed to alter some of her views on the service user, by having the time to focus and reflect on his difficulties. The participant did state how nurses on the ward do not get the opportunity to discuss service users and reflect, this too seemed to make her quite angry, and therefore, she believed that the interview was a positive experience that enabled her to do so. As I have experience working on the ward, I felt I could empathise with some of the experiences reported. However, I must note that some of the anger expressed and apparent dislike for the service user did make me feel slightly uneasy. Although, I think this was contained, it is important to consider the impact this had on me and the potential subsequent impact on the service user. It is important to reflect and discuss my emotional experience throughout the interviews during supervision.

Following Interview 6

This interview flowed very well and the participant seemed to be very enthusiastic in taking part, and again pleased that someone was taking an interest on staff experiences. This participant was a ward manager and reported having had a lot of training, including psychological training. This seemed apparent throughout the interview, as the responses did seem very psychologically minded. Most of the challenges were with the staff, and their attributions and approach towards service users. The participant seemed to offer a lot of valuable insight into other staff members’ experiences. I think these would be pretty accurate, given how closely she works with them, and encourages them to be honest about their feelings about the service users. I did notice that a lot of positives were reported regarding the service user, an approach that the participant reported that she tries to encourage to her team. The participant noted that she found the interview helpful and thought of some more ideas to take back to her team. This was quite a pleasurable experience and I was happy to be a part of the insight into positive changes, although the suggestions were solely thought up by the participant through reflection – which again highlighted to me, just how powerful reflection can be.
Following Interview 7

This was my first interview with a Consultant Psychiatrist. From the start, I sensed that the interview had a very different feel to it compared to the others. The participant constantly tried to look for ‘hidden’ questions, and telling me “I think you want me to say...” often pre-empting my questions before they were finished. I found this quite difficult to manage, though I think I managed to contain the interview, and gradually reduce the responses starting with what I apparently wanted to hear, followed by his actual thoughts. I also found the use of a lot of medical jargon quite difficult to understand and follow. However, where relevant, I asked for clarification on their meanings. I did notice that the participant did not seem to report any negative emotions in relation to the service user’s challenging presentations. Although, he could not think of many challenges related to service users at all. Most of the challenges referred to were about the service. I did wonder about the factors possibly contributing to the lack of challenges: considerable understanding of the service user’s difficulties; rigidly basing difficulties on medical model; level of experience; less time spent actually with the service users; or being able to notably make a change at a service level as well as service user level, as well as personality and style of coping. I suspect it may have been a combination of several of these factors. I think it would be helpful to discuss these factors during supervision, and possibly to explore them further through analyses.

During Analysis

I did find the level of detail of the interviews overwhelming. After discussion with my supervisors, it was agreed that I was focusing on too many aspects of the data e.g. service issues, which although interesting and important, was not related to my aims. One of my supervisors reminded me that when carrying out quantitative analysis, you should not trawl through the data; instead you should statistically test data relevant to the aims of the study, as should be done with qualitative data. This was a very helpful point. It was suggested later that I should perhaps carry out four separate analyses – in order to help me focus on the research questions and not get ‘lost in the data’. This seemed to be helpful, although I did find it difficult to tease apart many of the aspects into separate analyses e.g. some of the challenges and attributions, and some of the emotions and coping. This seemed to be the most challenging aspect of the analyses.
CONSENT FORM

Client Identification Number for this study: ……..

Title of Project: *What challenges do staff in psychiatric inpatient settings face?*

Name of Researcher:

Name of Participant:

1. I confirm that I have read and understand the information sheet dated 06.04.2010 version 2 for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

3. I give my consent for interview and assessment sessions to be audio-recorded.

4. I agree to direct quotations from the interview to be published and understand that my name will not be used alongside quotations.

5. I understand that relevant sections of my data collected during the study may be looked upon by individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission to these individuals to have access to my records.

6. I agree to take part in the study.

Name of Participant _______________ Date _______________ Signature _______________

Name of Person taking consent (if different from researcher) _______________ Date _______________ Signature _______________

Name of Researcher _______________ Date _______________ Signature _______________
APPENDIX 10 – Initial pool of SEACCS items

CHALLENGES

*Mental illness*
1. I think they are challenging when they suffer with a psychotic disorder
2. I think they are challenging when they have a personality disorder
3. I think they are challenging when they lack insight into their mental illness
4. I think they are more challenging when they have had several admissions into psychiatric inpatients wards
5. I think they are challenging when they disagree/argue with staff about their mental illness/symptoms
6. I think they are challenging when their symptoms have been present for a long time
7. I think they are challenging when their current admission has been for a long time (also progress)
8. I find them challenging when they are ambivalent about their treatment (progress)
9. I find them challenging when they are ambivalent about their illness (also progress)

*Engagement & motivation*
10. I find them challenging when they are ambivalent about engaging with me
11. I find them challenging when they seem to want to progress to independence but also want to be cared for
12. I find their lack of engagement challenging
13. I find it challenging when they disengage with their treatment
14. I find it challenging when their engagement is unpredictable
15. I find it challenging when their behaviour is unpredictable (elsewhere)
16. It is challenging to structure therapeutic work/time to see them when their engagement is so unpredictable
17. It is challenging when they have an irregular sleep pattern
18. It is challenging when they sleep through the day and are awake during the night
19. It is challenging when they stay in bed most of the time
20. I find their lack of motivation challenging to manage
21. I find their avoidance challenging to manage
22. I find it challenging when they are withdrawn
23. I find it challenging when they isolate themself
24. I find it challenging when they do not comply with the ward rules
25. I find it challenging when they do not engage with ward activities

*Positive symptoms (if patient suffers from psychotic disorder)*
26. I find it challenging when I do not understand where their delusional beliefs come from
27. I find it challenging when they do not have a clear delusional system (like other patients)
28. I find it challenging when I am a part of their delusional beliefs
29. I find it challenging when they are paranoid / suspicious of me
30. I find it challenging when they respond to hallucinations when I am with them
31. I find it challenging when they want me to collude / agree with their delusional beliefs
32. I find it challenging when they distrust me
33. I find it challenging when they have had several psychiatric admissions and they distrust the service
34. I find it challenging when they have had several psychiatric admissions
Medication
35. I find it challenging when they are non-compliant with their medication
36. I find it challenging when they stop and start their medication
37. I find the side-effects of their medication challenging to manage e.g. lethargy, irritability
38. I find it challenging when they are prescribed numerous medications

Therapeutic progress
39. I find their changeable presentation challenging
40. I find their contrasting presentation challenging
41. I find it challenging when their behaviour changes from one extreme to another
42. I find it challenging when their mood changes from one extreme to another e.g. one minute happy, the next sad
43. I find it challenging to structure therapeutic work/sessions with them
44. I find it challenging when I have used many different therapeutic strategies with them and nothing has worked
45. I find it challenging when my therapeutic strategies are unsuccessful with them
46. I find their limited therapeutic progress challenging
47. I find it challenging when there is no change to their presentation
48. I find it challenging when they are very slow to change
49. I find it challenging when they do not make the right decisions about their mental health care
50. I find it challenging when they do not seem to make the right decisions on what could help them
51. I find it challenging when they do not try to help themselves
52. I find it challenging when they do not take your therapeutic advice
53. I find it challenging when they lack responsibility
54. I find it challenging when they do not accept any responsibility for themselves
55. I find it challenging when they want to progress but also want to be cared for
56. I find it challenging when they are ambivalent about their illness
57. I find it challenging when they are ambivalent about their treatment
58. I find it challenging when their current admission has been for a long time

Violence & aggression
59. I find it challenging when they are physically violent towards me
60. I find it challenging when they have been physically violent towards me on several occasions
61. I find it challenging when they have been physically violent towards me on more than one occasion
62. I find it challenging when they are physically violent towards other patients
63. I find it challenging when they are physically violent towards another member of staff
64. I find it challenging when they have been physically violent towards other members of staff on several occasions
65. I find it challenging when they are physically violent towards furniture/inanimate objects
66. I find it challenging when they threaten me with physical violence
67. I find it challenging when they have threatened me with physical violence on more than one occasion
68. I find it challenging when they are verbally aggressive towards me
69. I find it challenging when they have been verbally aggressive towards me on several occasions
70. I find it challenging when they are verbally aggressive towards other patients
71. I find it challenging when they are verbally aggressive towards other members of staff
72. I find it challenging when they have a hostile manner (without actual or threat of physical violence)
73. I find it challenging when they are angry
74. I find it challenging when their physical violence is unpredictable
75. I find it challenging when there does not seem to be any trigger to their physical violence
76. I find it challenging when there does not seem to be any trigger to their verbal aggression
77. I find it challenging when their does not seem to be any trigger to their anger
78. I find it challenging when they require restraint
79. I find it challenging when they require continual restraint

Dual diagnosis
80. I find it challenging when they misuse alcohol and / or illicit substances
81. I find it challenging when they bring alcohol and / or substances onto the ward
82. I find it challenging managing the risk/security issues associated with them bringing alcohol and / or substances on to the ward

Self-harm
83. I find it challenging when they deliberately self harm
84. I find it challenging when they have self-harmed on more than one occasion
85. I find it challenging when they threaten self-harm
86. I find it challenging when they have threatened to self harm on more than one occasion
87. I find it challenging when they present with suicidal ideation
88. I find it challenging when they have attempted suicide
89. I find it challenging when they threaten suicide
90. I find it challenging when they have threatened suicide on more than one occasion

Other risk issues
91. I find it challenging when they attempt to abscond from the ward
92. I find it challenging when they do abscond
93. I find it challenging when they have attempted to abscond on more than one occasion
94. I find it challenging convincing them not to leave the ward

Boundaries
95. I find it challenging when they overstep the boundaries
96. I find it challenging maintaining boundaries with them
97. I find it challenging when they are over-familiar with me
98. I find it challenging when they seem to be exhibiting sexually inappropriate with me
99. I find it challenging when they seem to be exhibiting sexually inappropriate behaviour with other patients
100. I find it challenging when they seem to be exhibiting sexually inappropriate behaviour with other members of staff
101. I find it challenging when they display sexually disinhibited behaviour
102. I find it challenging when they are intrusive
103. I find it challenging when they are demanding of your time and / or assistance
104. I find it challenging when they are constantly of demanding of your time and/ or assistance
105. I find it challenging when they are non-compliant with ward rules (2)

Social competence
106. I find it challenging when they have poor social functioning
107. I find it challenging when their behaviour disrupts other patients
108. I find it challenging when they do not engage with ward activities (2)
109. I find it challenging when they have a lack of social interest
110. I find it challenging when they are disrespectful to me
111. I find it challenging when they are disrespectful to other members of staff
112. I find it challenging when they are disrespectful to other patients
113. I find it challenging when they isolate themselves (2)

**Personal hygiene**
114. I find it challenging when they lack cleanliness
115. I find their smell due to lack of cleanliness challenging
116. I find their body odour due to lack of cleanliness challenging
117. I find their poor hygiene challenging
118. I find their inappropriate toileting challenging (e.g. urinate or faecal smears inappropriate places)
119. I find their unhealthy lifestyle challenging
120. I find their poor diet challenging
121. I find their lack of exercise challenging

**Mood**
122. I find it challenging when they are angry / hostile
123. I find it challenging when they are irritable
124. I find it challenging when they are depressed
125. I find it challenging when they are low in mood

**Patient family**
126. I find the lack of involvement from their family challenging
127. I find the over-involving / demanding behaviour from their family challenging
128. I find the lack of insight about their mental illness from their family challenging

**ATTRIBUTIONS**

129. Their challenging behaviour is due to their personality
130. They chose to behave in this way
131. They are socially skilled so they are capable of engaging
132. I think mainly their past experience has resulted in them behaving in this way
133. I think their past experience has a lot to do with why they have behaved in this way
134. I think they are trying to manipulate me / others to get what they want
135. They do not want to engage mainly due to the symptoms they experience
136. They disengage mainly due to the symptoms they experience
137. It cannot be due to their mental illness because they can switch it on and off
138. Their challenging behaviour is mainly due to their mental illness
139. Their challenging behaviour is not due to their mental illness
140. Their challenging behaviour is a coping strategy for them
141. They think they are not in control of their challenging behaviour but I disagree
142. I think some of their symptoms may affect their engagement
143. I think they are withdrawn due to their illness
144. I think their unpredictable behaviour shows that it cannot be due to their illness as it is inconsistent
145. I think their unpredictable behaviour shows that they are in control of it as it is inconsistent
146. They self harm due to their illness (e.g. depression, delusions, command hallucinations)
147. They self harm as a cry for help
148. They self harm for attention
149. They threaten self harm to receive attention
150. They threaten self harm but have no intention of doing it – they just want a reaction from you
151. Their medication causes them to be lethargic and sleepy through the day
152. Their medication causes them to be irritable
153. Their irregular sleep pattern has nothing to do with their illness/medication
154. They are in control of their sleep pattern
155. Their poor self-care is due to their lack of motivation
156. Their poor self care is due to their mental illness
157. Their lack of motivation is not due to their mental illness
158. They could motivate themself if they wanted to
159. They are in control over their motivation
160. They could engage if they wanted to
161. They have control over whether they engage or not
162. They choose not to progress therapeutically
163. They choose not to help themself
164. They choose not to get better
165. They choose not take any therapeutic advice from staff
166. They want to be cared for
167. They react to negativity from other staff
168. They react from negativity from other patients
169. I think they are capable of doing more to help themself
170. I understand that their past experiences influences their current behaviour
171. I think sometimes they make up their delusions to provoke a reaction from staff
172. I think they threaten violence to receive attention from staff
173. I think they are violent to receive attention from staff
174. I think they threaten/actual violence to make me/other scared
175. I think their sexually inappropriate is mainly due to their mental illness
176. I think they are in control of their sexually inappropriate behaviour
177. I think their delusional beliefs causes these challenging behaviours
178. I think these challenging behaviours are due to a mixture of their mental illness and their personality
179. I do not think the patient does these challenging behaviours deliberately
180. I think the patient disengages deliberately
181. I think this challenging behaviour is influenced by how staff approach them
182. I think they choose to isolate themself
183. I think they isolate themself mainly due to their mental illness
184. I think the way in which staff behave towards them may feed into their delusional beliefs
185. I think they behave in this way to protect themself
186. I think they behave in this way because they are scared
187. I think they behave in this way because they feel vulnerable
188. I think they behave in this way because they are bored on the ward
189. I think this behaviour is typical of someone with this mental illness
190. I think their behaviour will improve as they get better
191. It is challenging for them to engage due to their mental illness
192. I think they choose to misuse substances/alcohol
193. I think they are in control of misusing substances/alcohol
194. I think they threaten staff with violence to receive attention
195. I think they choose to behave in this way because they want more time from staff
196. I do not think any amount of medication is going to change them as it is due to them, not their illness
197. I think they make out that their mental illness is worse than it actually is so that they can stay for longer
198. I think they behave in this way because they are on the wrong medication
199. I think they behave in this way because they know their rights and staff are duty bound
200. I think they think they can do what they want
201. I think they behave in this way because they think they can walk all over staff
202. I think they understand their illness but choose not to comply with treatment
203. I think the ward environment may escalate this challenging behaviour
204. I think the environment may cause these behaviour to increase
205. I think this behaviour is due to their poor social functioning
206. I think their violence is mainly due to their mental illness
207. I think their family are demanding because they struggle with the patient’s mental illness
208. I think they enjoy the freedom without the responsibility
209. I think their lack of responsibility is mainly due to their mental illness
210. I think they choose not to accept any responsibility for themself
211. I think they do not comply with medication because they do not agree with staff about their mental illness
212. I think they are angry because they do not agree with staff about their mental illness
213. I think they are violent because they do not agree with staff about their mental illness
214. I think substance/alcohol misuse exacerbates their symptoms
215. I think they behave in this way because they are lazy
216. I think they have poor self care because they are lazy
217. I think they do not engage because they are lazy
218. I think they are more suspicious/paranoid following several psychiatric admissions
219. I think they lack motivation due to several psychiatric admissions
220. I think they do not engage because they feel hopeless about improving
221. I think they behave in this way because they are trying to sabotage their treatment
222. I think they behave in this way because they are overwhelmed by services
223. I think they behave in this way because they lack control
224. I think they will always behave in this way because they have always been like that
225. I cannot see this behaviour ever changing because they have always been like that

**EMOTIONS**

*Emotions & physical impact toward patient*

226. I feel frustrated towards them
227. I feel frustrated with them when they do not engage with me
228. I feel frustrated with them when they constantly demand my attention / time
229. I feel frustrated when I set aside time for them and they don’t use it
230. I feel frustrated when they disagree with staff about their mental illness/symptoms
231. I feel frustrated when they cannot understand how to help themself
232. I feel frustrated about their lack of progress
233. I feel frustrated about there being no change to their presentation
234. I feel frustrated about the slow progress
235. I feel frustrated because it feels like we are going round in circles
236. I feel frustrated when they misuse alcohol and/or substances
237. I feel annoyed with them
238. I feel anger towards them
239. I feel angry with them when they constantly demand my attention / time
240. I feel angry when they refuse to accept any responsibility for themselves
241. I feel angry when they misuse alcohol and/ or substances
242. I feel disgusted with them
243. I feel disappointed with them
244. I feel disappointed with them when they do not try to help themself
245. I feel sad
246. I feel sad about them being so ill
247. I feel sad about their mental illness
248. I feel sad when they self harm
249. This makes me feel disheartened
250. I feel disheartened about how bad their symptoms are
251. I feel disheartened by their illness
252. I feel disheartened by their lack of progress
253. This makes me feel shocked/ surprised
254. I feel shocked when they self harm
255. I feel upset when they self harm
256. This makes me disappointed with them
257. I feel disappointed with them when they do not try to help themself
258. I feel disappointed about their lack of progress
259. I feel disappointed about there being no change in their presentation
260. This makes me feel frightened of them / what might happen when they are threatening me with physical violence
261. This makes me feel scared of them / what might happen
262. This makes me feel frightened of them / what might happen
263. I felt scared at first but then this reduced the more it occurred
264. I feel intimidated by them when they are threatening me with physical violence
265. I feel nervous around them
266. I feel nervous around them when their physical/verbal violence is unpredictable
267. I feel unsafe around them
268. I feel threatened by them
269. I feel threatened by them when their physical/verbal violence is unpredictable
270. I feel uncomfortable around them when they are over-familiar with me
271. I feel uncomfortable around them when they are sexually inappropriate towards me
272. I feel uncomfortable towards them when they threaten violence towards me
273. I feel uncomfortable when they respond to hallucinations when I am with them
274. I feel uncomfortable when they distrust me
275. I feel uncomfortable when they want me to collude / agree with their delusional beliefs
276. I feel overwhelmed
277. I feel overwhelmed by their symptoms
278. I feel hopeless about their future
279. I feel helpless
280. I feel incompetent
281. I feel incompetent because I do not seem to be helping them
282. I feel worried
283. I feel worried about their violent behaviour
284. I feel worried when they threaten violence
285. I feel anxious
286. I feel anxious about their violent behaviour
287. I feel anxious when they threaten violence
288. I feel anxious when they threaten self harm
289. I feel anxious when they present with suicidal ideation
290. I feel stressed
291. I feel stressed about their violent behaviour
292. I feel stressed when they threaten violence
293. I feel stressed about restraining them
294. I feel stressed when they threaten self harm
295. I feel stressed when they present with suicidal ideation
296. I feel sympathetic towards them
297. I feel sympathetic towards them due to the symptoms they experience
298. I feel sympathetic towards them due to their lack of change
299. I feel de-motivated with them
300. I feel de-motivated to work with them
301. I feel de-motivated towards them when they misuse substances and or alcohol
302. I feel less motivated with them as it continues
303. I feel like giving up with them
304. I feel confused
305. I feel confused about how to help them
306. I do not feel confident in managing this difficulty
307. I feel positive towards them
308. I feel protective towards them
309. I feel protective towards them when they self harm
310. I am understanding/empathic towards them
311. I feel safe around them
312. I feel optimistic about their future
313. I feel confident in managing this challenging

Emotion toward self
314. I feel guilty about not being able to help them
315. I feel guilty about feeling negative towards them
316. I feel guilty about restraining them
317. I feel helpless
318. I feel hopeless about their therapeutic progress
319. I feel confused
320. I feel confused about how to manage this
321. I feel worried about how to behave around them in case they react angrily
322. I feel worried how to behave around them in case they react violently
323. I feel frustrated with myself
324. I feel frustrated with myself because I can’t seem to help them
325. I feel exhausted
326. I feel deflated
327. I feel drained
328. I feel burnt-out
329. I feel like I’m not doing a proper job with them
330. I feel satisfied with my input with them
331. I do not feel confident in my abilities to manage this difficulty

COPING
332. I have realised that they have to change themself, I’m not going to change much for them otherwise
333. I spend time away from them
334. I spend time away from them until I feel motivated to try and engage with them again
335. I disengage with them for a while
336. I avoid them
337. I avoid them until I feel like trying again
338. I avoid them until I calm down
339. I lack motivation to work with them
340. I am not scared because experience prepares you to get to know what they are capable of
341. I downplay these challenges
342. I downplay the risk they pose
343. I feel like giving up
344. I pass the responsibility back to them as it is ultimately down to them to help themself
345. I question my professional abilities
346. I question whether I am doing the right thing
347. I use supervision for support
348. Supervision provides reassurance that I’m doing my job properly, I can’t do anymore
349. I know I cannot do anymore to help them
350. I use supervision as it provides me with further strategies to try
351. I think of other strategies to try with them
352. I have formulation meetings to try and understand their difficulties
353. I formulate their difficulties so that I can understand them better
354. I believe I have improved in managing this difficulty with experience
355. I think experience helps to manage this difficulty
356. I think experience helps to understand this difficulty
357. I think stress in managing this difficulty decreases with experience
358. I think confidence in managing this difficulty increases with experience
359. I don’t try as much with them therapeutically
360. I change the structure of therapy to fit with their difficulties
361. I do a risk assessment before entering the room with them
362. I try and plan ahead
363. I make sure I am prepared for them
364. I am prepared for this difficulty
365. I talk it through with other staff
366. I seek informal support from other staff
367. Having a greater understanding of these difficulties help to reduce any negativity towards them
368. I try to focus on the positive aspects
369. I take time to reflect on what happened and what I could do differently
370. I feel deflated
371. I feel burnt-out
372. I take time off work
373. I dread going into work
374. I dread seeing the client
375. I think about it at home
376. I feel stressed outside of work
377. I practice how to respond to certain difficulties
378. I try to learn more about them as I’m going along
379. I don’t feel qualified enough to manage it
380. I don’t feel experienced enough to manage it
381. I know that it is a learning curve in terms of managing this difficulty
382. I try and talk to them about the reasons for this
383. I let them know exactly how I feel about it
384. I confront them straight away
385. I don’t want to intervene purely on instinct – want to know there is some evidence for what doing
386. I am uncertain of what to do
387. I learn more about how to deal with it through training
388. It is part of the job to manage these difficulties
389. I have a thick skin
390. I feel more confident about restraint with experience
391. I just react without thinking about it
392. I just deal with it there and then without thinking about it
393. It helps when all staff are on the same page
394. I set clear boundaries with them
395. I detach myself from the difficulty
396. I don’t dwell on it too much
397. It helps to look at it from the patient’s perspective
398. Good teamwork helps to manage this difficulty
399. I need a break from managing this difficulty
400. I feel pressure to manage this difficulty
401. I keep perspective
402. I just get on with it
403. I just have to live with the unpleasantness
404. I discuss these difficulties with other staff
405. I feel very tired when dealing with this continually
406. I stick with what I am doing
407. I am unable to look at difficulties objectively due to burn-out
408. I am abrupt with them
409. These things happen, I just have to get on with it
410. I lower my expectations for helping them
411. I try to improve my therapeutic relationship with them
412. I don’t experience any negative emotion because it is part of my job to deal with this
413. I keep trying with them
414. I learn what works and what doesn’t work in managing this
415. I try and prevent these difficulties from re-occurring
416. I feel more supportive towards them over time
417. Focusing on the positives helps alleviate any frustration/anger/negative emotion
418. I talk to others about how these difficulties make me feel
419. I keep my distance when they are aggressive to ensure my safety
420. I consider fear of violence to be positive as you should never be over-confident when dealing with it
421. I put on a front
422. I confront feelings about difficulties and what has been learned from it and how to change things
423. I fill in an incident form
424. I tend to think about the incident for a long time afterwards
Below is a list of challenges that staff working on psychiatric wards have said that they experience in relation to service users with severe and enduring mental illness. We want to know what YOU find challenging in these settings. Think about YOUR OWN RECENT EXPERIENCE of inpatient work. Please read each question, and place a circle around the number on the scale that best reflects your own views and experience.

**HOW CHALLENGING DO YOU FIND IT WHEN SERVICE USERS PRESENT WITH...**

<table>
<thead>
<tr>
<th></th>
<th>Not at all challenging</th>
<th>Extremely challenging</th>
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<tbody>
<tr>
<td>1. Verbal abuse?</td>
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<td>2. Unpredictable / changeable behaviour?</td>
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<td>3. Low mood?</td>
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<td>4. Demanding behaviour?</td>
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<td>5. Threatened or actual physical violence?</td>
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<td>6. Behaviour that does not adhere to treatment e.g. medication, professional advice, views of their illness?</td>
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<td>7. Positive symptoms of psychosis e.g. hallucinations, delusions, thought disorder?</td>
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**PLEASE COMPLETE BOTH SIDES OF PAGE**
<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all challenging</th>
<th>Extremely challenging</th>
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<tbody>
<tr>
<td>8. No therapeutic progress or very slow change in their presentation?</td>
<td>0 1 2 3 4 5 6</td>
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<td>9. Sexually inappropriate behaviour?</td>
<td>0 1 2 3 4 5 6</td>
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<td>10. Self-harm, suicidal ideation, threatened or attempted suicide?</td>
<td>0 1 2 3 4 5 6</td>
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<td>11. Poor social functioning?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>12. Alcohol and / or substance misuse?</td>
<td>0 1 2 3 4 5 6</td>
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<td>13. Apparent poor motivation?</td>
<td>0 1 2 3 4 5 6</td>
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<tr>
<td>14. Poor self care e.g. hygiene, sleep, diet, exercise?</td>
<td>0 1 2 3 4 5 6</td>
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</table>
Below is a list of reasons that psychiatric staff have said typically cause service users with severe and enduring mental illness to display challenging presentations. We are now interested in YOUR own personal view of WHY service users may present with these challenges. Please read each question, and circle the number on the scale that best reflects your thoughts and views.

**THESE CHALLENGING PRESENTATIONS ARE DUE TO....**

1. Service users using them as a coping strategy?  
   Not at all  Completely  
   0  1  2  3  4  5  6

2. Service users’ laziness?  
   Not at all  Completely  
   0  1  2  3  4  5  6

3. Service users’ past experiences e.g. childhood trauma, difficult experiences, previous relationships?  
   Not at all  Completely  
   0  1  2  3  4  5  6

4. Environmental factors e.g. reaction to how they have been approached by staff/other service users/visitors, ward environment?  
   Not at all  Completely  
   0  1  2  3  4  5  6

5. Service users trying to be manipulative?  
   Not at all  Completely  
   0  1  2  3  4  5  6

6. Symptoms of mental illness?  
   Not at all  Completely  
   0  1  2  3  4  5  6

7. Service users’ personalities?  
   Not at all  Completely  
   0  1  2  3  4  5  6

**PLEASE COMPLETE BOTH SIDES OF PAGE**
**THESE CHALLENGING PRESENTATIONS ARE DUE TO....**

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<tr>
<td>8.</td>
<td>Service users’ seeking attention?</td>
<td>Not at all</td>
<td>Completely</td>
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<td>9.</td>
<td>Service users’ medication?</td>
<td>Not at all</td>
<td>Completely</td>
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<td>10.</td>
<td>Service users’ wish to ‘walk over’ staff e.g. attempt to ‘get one over’ on staff, humiliate staff?</td>
<td>Not at all</td>
<td>Completely</td>
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<td>11.</td>
<td>Service users’ refusal to take responsibility e.g. for their actions, therapeutic progress?</td>
<td>Not at all</td>
<td>Completely</td>
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<td>12.</td>
<td>Service users’ disagreement with staff e.g. disagree with treatment, advice, ward rules?</td>
<td>Not at all</td>
<td>Completely</td>
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<tbody>
<tr>
<td>13.</td>
<td>How much control do you think service users have over these challenges?</td>
<td>Not at all</td>
<td>Complete Control</td>
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Below is a list of emotions that psychiatric staff have said that they experience when they have to work with challenging presentations. We want to know how YOU typically feel in this situation. Think about YOUR OWN RECENT EXPERIENCE of these challenges displayed by service users. Please consider each of the emotional reactions, and circle the number on the scale that best describes how you feel when you are presented with these challenges.

**PLEASE COMPLETE BOTH SIDES OF PAGE**

WHEN THESE CHALLENGING PRESENTATIONS OCCUR, I FEEL...

<table>
<thead>
<tr>
<th>Emotion</th>
<th>No, never</th>
<th>Yes, always</th>
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</thead>
<tbody>
<tr>
<td>1. Frustration</td>
<td>0 1 2 3 4 5 6</td>
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<tr>
<td>2. Confusion</td>
<td>0 1 2 3 4 5 6</td>
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<tr>
<td>3. Shock</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>4. Anger</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>5. Confident</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>6. Disappointment</td>
<td>0 1 2 3 4 5 6</td>
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<tr>
<td>7. Incompetent</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>8. Sadness</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>9. Stress</td>
<td>0 1 2 3 4 5 6</td>
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<tr>
<td>10. Protective</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>11. Frightened</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>12. Deflated</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>13. Uncomfortable</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>14. Guilty</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>15. Calm</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>16. Helpless</td>
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<td></td>
</tr>
<tr>
<td>17. De-motivated</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>18. Anxious</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>19. Hopeless</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>20. Disgusted</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>21. Sympathetic</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
</tbody>
</table>
Below is a list of strategies that psychiatric staff have said that they use to cope with challenging presentations and the emotions they experience as a result of them. We want to know how YOU typically deal with these challenges. Think about YOUR OWN RECENT EXPERIENCE of these challenges displayed by service users. Please consider each of the coping strategies, and circle the number on the scale that best describes how you deal with these challenges and how they make you feel.

**IN ORDER TO COPE WITH THESE CHALLENGES AND HOW THEY MAKE ME FEEL....**

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>No, never</th>
<th>Yes, always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I keep trying with the service user</td>
<td>0</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>2</td>
<td>I confront the service user and tell them how I feel</td>
<td>0</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>3</td>
<td>I just react without really thinking about it or dwelling on it</td>
<td>0</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>4</td>
<td>I take a break/time away from the service user</td>
<td>0</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>5</td>
<td>I talk it over with other staff</td>
<td>0</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>6</td>
<td>I plan and prepare for the next time I see the service user</td>
<td>0</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td>7</td>
<td>I tell myself that I will get better at dealing with it over time</td>
<td>0</td>
<td>1 2 3 4 5 6</td>
</tr>
</tbody>
</table>
IN ORDER TO COPE WITH THESE CHALLENGES AND HOW THEY MAKE ME FEEL....

8. I try and understand the service user’s difficulties and why they present in this way
   
   No, never  
   Yes, always  
   0 1 2 3 4 5 6

9. I try to focus on the positive aspects of the service user
   
   No, never  
   Yes, always  
   0 1 2 3 4 5 6

10. I reflect on it afterwards and think about what I could have done differently
    
    No, never  
    Yes, always  
    0 1 2 3 4 5 6

11. I use supervision and / or training to learn more about it
    
    No, never  
    Yes, always  
    0 1 2 3 4 5 6

12. I think of it as part of my job so I just have to get on with things
    
    No, never  
    Yes, always  
    0 1 2 3 4 5 6

13. I think about it for a long time afterwards, over and over again
    
    No, never  
    Yes, always  
    0 1 2 3 4 5 6

14. I tell myself that I am doing as much as I can for the service user
    
    No, never  
    Yes, always  
    0 1 2 3 4 5 6

**THANK YOU FOR COMPLETING QUESTIONNAIRE**
APPENDIX 12 - Staff Emotions, Attributions, Challenges & Coping Scale SEACCS

Below is a list of challenges that staff working on psychiatric wards have said that they experience in relation to service users with severe and enduring mental illness. We want to know what YOU find challenging in these settings. Think about YOUR OWN RECENT EXPERIENCE of inpatient work. Please read each question, and place a circle around the number on the scale that best reflects your own views and experience.

**HOW CHALLENGING DO YOU FIND IT WHEN SERVICE USERS PRESENT WITH...**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not at all challenging</th>
<th>Extremely challenging</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Verbal abuse?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. Unpredictable / changeable behaviour?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Persistent low mood?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. Excessively demanding behaviour?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5. Threatened or actual physical violence?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6. Behaviour that does not adhere to treatment e.g. medication, professional advice, views of their illness?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7. Positive symptoms of psychosis e.g. hallucinations, delusions, thought disorder?</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**PLEASE COMPLETE BOTH SIDES OF PAGE**
### How challenging do you find it when service users present with...

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not at all challenging</th>
<th>Extremely Challenging</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td>Withdrawal / isolative behaviour?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>No therapeutic progress or very slow change in their presentation?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Sexually inappropriate behaviour?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Behaviour that does not adhere to ward rules e.g. absconding, entering staff office uninvited?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Self-harm, suicidal ideation, threatened or attempted suicide?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td>Poor communication / social skills?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Alcohol and / or substance misuse?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Apparent poor motivation and / or lack of engagement e.g. in therapy, ward activities?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td>Poor self care e.g. hygiene, sleep, diet, exercise?</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
</tbody>
</table>
Below is a list of reasons that psychiatric staff have said typically cause service users with severe and enduring mental illness to display challenging presentations. We are now interested in YOUR own personal view of WHY service users may present with these challenges. Please read each question, and circle the number on the scale that best reflects your thoughts and views.

**THESE CHALLENGING PRESENTATIONS ARE DUE TO....**

1. Service users using them as a coping strategy?
   
   Not at all  Completely
   0  1  2  3  4  5  6

2. Service users’ laziness?
   
   Not at all  Completely
   0  1  2  3  4  5  6

3. Service users’ past experiences e.g. childhood trauma, difficult experiences, previous relationships?
   
   Not at all  Completely
   0  1  2  3  4  5  6

4. Environmental factors e.g. reaction to how they have been approached by staff/other service users/visitors, ward environment?
   
   Not at all  Completely
   0  1  2  3  4  5  6

5. Service users trying to be manipulative?
   
   Not at all  Completely
   0  1  2  3  4  5  6

6. Symptoms of mental illness?
   
   Not at all  Completely
   0  1  2  3  4  5  6

7. Service users’ personalities?
   
   Not at all  Completely
   0  1  2  3  4  5  6

**PLEASE COMPLETE BOTH SIDES OF PAGE**
8. Service users’ seeking attention?  
   Not at all  Completely  
   0 1 2 3 4 5 6

9. Service users’ medication?  
   Not at all  Completely  
   0 1 2 3 4 5 6

10. Service users’ wish to ‘walk over’ staff e.g. attempt to ‘get one over’ on staff, humiliate staff?  
    Not at all  Completely  
    0 1 2 3 4 5 6

11. Service users’ unwillingness to take responsibility e.g. for their actions, therapeutic progress?  
    Not at all  Completely  
    0 1 2 3 4 5 6

12. Service users’ disagreement with staff e.g. disagree with treatment, advice, ward rules?  
    Not at all  Completely  
    0 1 2 3 4 5 6

And finally in this section:

13. How much control do you think service users have over these challenges?  
    Not at all  Complete Control  
    0 1 2 3 4 5 6
Below is a list of emotions that psychiatric staff have said that they experience when they have to work with challenging presentations. We want to know how YOU typically feel in this situation. Think about YOUR OWN RECENT EXPERIENCE of these challenges displayed by service users. Please consider each of the emotional reactions, and circle the number on the scale that best describes how you feel when you are presented with these challenges.

**WHEN THESE CHALLENGING PRESENTATIONS OCCUR, I FEEL...**

<table>
<thead>
<tr>
<th></th>
<th>No, never</th>
<th>Yes, always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Frustration</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>2. Confusion</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>3. Shock</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>4. Anger</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>5. Confident</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>6. Disappointment</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>7. Incompetent</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>8. Sadness</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>9. Stress</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>10. Protective</td>
<td>0 1 2 3 4 5 6</td>
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<td>16. Helpless</td>
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<td>17. De-motivated</td>
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<td>20. Disgusted</td>
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<td></td>
</tr>
<tr>
<td>21. Sympathetic</td>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
</tbody>
</table>

**PLEASE COMPLETE BOTH SIDES OF PAGE**

250
Below is a list of strategies that psychiatric staff have said that they use to cope with challenging presentations and the emotions they experience as a result of them. We want to know how YOU typically deal with these challenges. Think about YOUR OWN RECENT EXPERIENCE of these challenges displayed by service users. **Please consider each of the coping strategies, and circle the number on the scale that best describes how you deal with these challenges and how they make you feel.**

**IN ORDER TO COPE WITH THESE CHALLENGES AND HOW THEY MAKE ME FEEL....**

<table>
<thead>
<tr>
<th></th>
<th><strong>IN ORDER TO COPE WITH THESE CHALLENGES AND HOW THEY MAKE ME FEEL....</strong></th>
<th><strong>No, never</strong></th>
<th><strong>Yes, always</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I keep trying with the service user</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2.</td>
<td>I confront the service user and tell them how I feel</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>0</td>
<td>1</td>
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</tr>
<tr>
<td>3.</td>
<td>I just react without really thinking about it or dwelling on it</td>
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<td></td>
</tr>
<tr>
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<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4.</td>
<td>I take a break/time away from the service user</td>
<td></td>
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<td>0</td>
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</tr>
<tr>
<td>5.</td>
<td>I talk it over with other staff</td>
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<td>2</td>
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</tbody>
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**IN ORDER TO COPE WITH THESE CHALLENGES AND HOW THEY MAKE ME FEEL....**

8. I try and understand the service user’s difficulties and why they present in this way  
<table>
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<tr>
<th>No, never</th>
<th>Yes, always</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
</tbody>
</table>

9. I try to focus on the positive aspects of the service user  
<table>
<thead>
<tr>
<th>No, never</th>
<th>Yes, always</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6</td>
<td></td>
</tr>
</tbody>
</table>

10. I reflect on it afterwards and think about what I could have done differently  
    | No, never | Yes, always |
    |-----------|-------------|
    | 0 1 2 3 4 5 6 |

11. I use supervision and / or training to learn more about it  
    | No, never | Yes, always |
    |-----------|-------------|
    | 0 1 2 3 4 5 6 |

12. I think of it as part of my job so I just have to get on with things  
    | No, never | Yes, always |
    |-----------|-------------|
    | 0 1 2 3 4 5 6 |

13. I think about it for a long time afterwards, over and over again  
    | No, never | Yes, always |
    |-----------|-------------|
    | 0 1 2 3 4 5 6 |

14. I tell myself that I am doing as much as I can for the service user  
    | No, never | Yes, always |
    |-----------|-------------|
    | 0 1 2 3 4 5 6 |

**THANK YOU FOR COMPLETING QUESTIONNAIRE**
Invitation to take part in a research study

Participant Information Sheet

Study Title: What challenges do staff in psychiatric inpatient settings face? Questionnaire Study

You are being invited to take part in a research study. Before you decide whether to take part it is important you understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with other people if you wish. Ask us if there is anything that is not clear or you would like more information. Take time to decide whether or not you wish to take part.

Why is the study being done?

This study aims to develop the Staff Emotions, Attributions, Challenges and Coping Scale. This will be used to measure the challenges staff face with service users with severe and enduring mental illness in an inpatient setting, and the things that are most likely to help overcome these challenges.

Who will be taking part?

We are hoping that staff members will take part. Participants will have a minimum of 10 hours contact and at least 3 months experience with service users on an inpatient ward per week.

Why have I been asked to take part?

We are asking you because you are currently working within an inpatient setting that provides care and treatment to individuals who have a severe and enduring mental illness.

Do I have to take part?

No. It is up to you whether or not you decide to take part. Taking part in the study will not affect your employment in any way. If you decide to take part you can leave the study at any time without giving a reason.
What will it involve for me?

You will be asked to complete the newly developed questionnaire, Staff Emotions, Attributions, Challenges and Coping Scale (SEACCS). This will involve identifying the challenging experiences and the feelings around those challenges that are most relevant to you. You will also be asked to complete 2 additional questionnaires. These include a demographic questionnaire and the General Health Questionnaire (GHQ-28). This is being used in order to measure the relationship between staff challenges and staff general health. All questionnaires should take approximately 15 minutes to complete. You will be asked to repeat the SEACCS questionnaire approximately one week later. This is so that the necessary testing required for the development of a new questionnaire can be carried out by the researcher. It will take approximately ten minutes to complete.

If you decide to complete the questionnaires, you are not obliged to repeat completion of the SEACCS questionnaire. You can leave the study at any time.

What are the advantages and disadvantages of taking part?

You will be able to inform and reflect upon your professional experiences. This may help you later in your day-to-day work with service users and may increase work satisfaction and well being.

People often welcome the opportunity to reflect upon their job roles. However it is possible that identifying difficult work issues may result in some distress. If you wish, you can contact the lead researcher, Nadia McColgan, Division of Clinical Psychology, University of Manchester, Tel. XXXX or the academic supervisor for this project, Professor Gillian Haddock, Tel. XXXX. Both of whom are trained and experienced in providing support and advice on difficult feelings. Also, you can contact the XXXX NHS Trust Staff counselling service on Tel. XXXX. Any contact that is made will be strictly confidential.

What if something goes wrong?

If you are unhappy about any aspect of this research you can contact the lead researcher (Nadia McColgan, Division of Clinical Psychology, University of Manchester, Tel. XXXX. Email: XXXX or the academic supervisor for this project (Professor Gillian Haddock, Tel. XXXX).

If you wish to make a complaint, you can contact a University Research Practice and Governance Coordinator, Tel: 0161 2757583 or 0161 2758093

Email: research-governance@manchester.ac.uk

In the event that something does go wrong and you are harmed during the research and this is due to someone’s negligence then you may have grounds for a legal action for compensation against the University of Manchester, but you may have to pay for your legal costs. The normal National Health Service complaints mechanisms will still be available to you.
Will my taking part be confidential?

If you agree to take part in the study, any information you give the researcher will be kept strictly confidential and will conform to the Data Protection Act of 1998 with respect to data collection, storage and destruction. Your name will not appear on any of the forms, we will give you a study number instead. Any information you give to the researcher will not be shared with anyone outside the research team without your consent, unless the researcher feels that either yourself or others are likely to be harmed. In this unlikely event, the researcher would be required to contact the necessary persons (for example, a member of senior management within the department). The researcher would inform you of this before this happened.

The data will be stored securely at University of Manchester premises.

If you agree to take part, the researcher will keep a copy of all data for the research records. This may be reviewed by the Trust R&D Department. Responsible individuals from the University of Manchester may also look at the research records to audit the conduct of the research.

What will happen to the results of the study?

The results of the study will be used to assess the appropriateness of the SEACCS questionnaire of staff challenges. They will be published in a doctoral thesis archived in the University of Manchester Library, and it is also intended that the results will be published in a peer-reviewed journal. You will not be identified in any publication. If you would like a summary of the overall results, please let the researcher know. Where there are high numbers of participants from a single site, it will be possible to arrange a presentation of findings following completion of the study.

Who is organising and funding the research?

The research is organised and funded by the University of Manchester.

Further Information

Please contact Nadia McColgan by sending an email to XXXX or by leaving a message on XXXX, if you would like more information about the study, or if you have any concerns during the study.

Thank you for taking time to read this sheet and considering whether to take part in this study
Dear staff member

Thank you for taking the time to read this pack. We would like you to read the Participant Information Sheet and take at least 24 hours to think about completing the questionnaires enclosed.

This questionnaire has been developed as we have recognised that staff who work on psychiatric inpatient wards face a number of challenges when working with patients who have severe and enduring mental illness. Through interviewing psychiatric staff, we know that they experience a range of different emotions and ways of coping with these feelings. We want to know what YOU find challenging in this situation and your thoughts on why the inpatient presents with these challenges. We would also like to know how this typically makes you feel and how you try and manage these situations and feelings. Any information you provide will help us to know more about what psychiatric staff actually experience working in this environment and with this client group.

We would like you to complete all of the questionnaires enclosed. That is, the General Health Questionnaire (GHQ-28), Staff Emotions, Attributions, Challenges & Coping Scale (SEACCS), and a demographic questionnaire. Should you agree to take part in this study, ALL of the information you provide will remain CONFIDENTIAL (none of your colleagues, supervisors, managers etc will have any access to this information). You will also find enclosed a Participant Details form. This will ONLY be seen by the researcher, and is purely so that the questionnaire can be re-sent to those individuals who complete it (for analysis purposes, to test appropriateness of the newly developed questionnaire). This form will be destroyed IMMEDIATELY after the name is coded and re-sent. Therefore, NO identifiable information will be kept or be seen even by the researcher at this point. If you do not wish to repeat the questionnaire at a later date, you do not have to complete this form as part of the study.

If you have any questions about the questionnaires or would simply like to know about them, please do not hesitate to contact me, Nadia McColgan, Division of Clinical Psychology, University of Manchester, Tel. XXXX or by email on XXXX

If you do wish to take part, please read all of the instructions (at top of page of each section) and answer all of the questions. Most questions ask that you CIRCLE a number or a description that best reflects your views and experience.
APPENDIX 15 – Participant Details form

Title of Project: *What challenges do staff in psychiatric inpatient settings face?*

Client Identification Number for this study: ………

Name of Participant:

Place of work:

These details are *solely* for the purposes of knowing who to send the Staff Attributions, Challenges & Coping Strategies questionnaire to in order to request that it be repeated.

THIS DOCUMENT WILL BE DESTROYED IMMEDIATELY AFTER THIS INFORMATION IS OBTAINED BY THE RESEARCHER.
Thank you for completing the Staff Emotions, Attributions, Challenges & Coping Scale (SEACCS), and for agreeing to complete this scale again. For reliability and validity purposes, please complete this scale as soon as possible (as it has to be completed very soon after the first completion of the scale in order to be valid). Please return the completed scale in the stamped address envelope. If you have any queries or wish to discuss this further, please contact me on XXXX, or email: XXXX.

Thank you
<table>
<thead>
<tr>
<th>SEACCS Item</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
<th>Score 4</th>
<th>Score 5</th>
<th>Score 6</th>
</tr>
</thead>
<tbody>
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## APPENDIX 18 - Individual uncategorised SEACCS items

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<td>C2</td>
<td>I confront the service user and tell them how I feel</td>
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<td>C3</td>
<td>I just react without really thinking about it or dwelling on it</td>
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<td>C4</td>
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<td>I plan and prepare for the next time I see the service user</td>
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<td>C7</td>
<td>I tell myself that I will get better at dealing with it over time</td>
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<td>C8</td>
<td>I try and understand the service user’s difficulties and why they present in this way</td>
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<td>C9</td>
<td>I try to focus on the positive aspects of the service user</td>
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<td>C10</td>
<td>I reflect on it afterwards and think about what I could have done differently</td>
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<td>C11</td>
<td>I use supervision and / or training to learn more about it</td>
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<td>I think of it as part of my job so I just have to get on with things</td>
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<td>I think about it for a long time afterwards, over and over again</td>
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A = Attribution; E = Emotion; C = Coping
## APPENDIX 19 – Pearson’s correlations within SEACCS sub-scales and uncategorised individual item

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**Correlation significant at the 0.01 level *Correlation is significant at the 0.05 level (2-tailed)**
## APPENDIX 20 – Spearman’s correlations within SEACCS sub-scales and uncategorised individual item

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**Correlation significant at the 0.01 level *Correlation is significant at the 0.05 level (2-tailed)**
### APPENDIX 21 – Independent t-tests of Professional Qualification across SEACCS variables

#### Independent Samples Test

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## APPENDIX 22 – Pearson’s correlations between demographic data and SEACCS variables

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**Correlation significant at the 0.01 level  *Correlation is significant at the 0.05 level (2-tailed)**
**APPENDIX 23 – Correlations between GHQ-B & GHQ-Total with SEACCS variables**

Pearson’s correlations (hypotheses testing)

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*Correlation is significant at the 0.05 level (2-tailed)

Spearman’s rho correlations (hypothesis testing)

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*Correlation is significant at the 0.05 level (2-tailed)

Pearson’s correlations (exploratory investigations)

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<td>-.225</td>
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<td>Sig. (2-tailed)</td>
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<tr>
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<td>.081</td>
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<td>Sig. (2-tailed)</td>
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<td>Sig. (2-tailed)</td>
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<td>.590</td>
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<td>.351**</td>
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**Correlation significant at the 0.01 level *Correlation is significant at the 0.05 level (2-tailed)
**APPENDIX 24 – Spearman’s correlations between GHQ-D and SEACCS variables**

### Hypotheses testing

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<thead>
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<th>Variable</th>
<th>Correlation Coefficient</th>
<th>Sig. (2-tailed)</th>
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<td>Total No of Negative</td>
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<td>Positive Emotions</td>
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**Correlation significant at the 0.01 level *Correlation is significant at the 0.05 level (2-tailed)**

### Exploratory investigations

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**Correlation significant at the 0.01 level *Correlation is significant at the 0.05 level (2-tailed)**