Attributions Regarding 'Challenging Behaviour'

within an Acquired Brain Injury Setting:

A Grounded Theory Analysis

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Attributions Regarding 'Challenging Behaviour' within an Acquired Brain Injury Setting:
A Grounded Theory Analysis

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Doctorate in Clinical Psychology

Thesis Abstract

The current literature suggests that neurorehabilitation can benefit people diagnosed with acquired brain injury (ABI); however the presence of behaviour deemed challenging (CB) may constrain access to services and attainment of rehabilitation potential. Following a systematic search, a narrative review of the literature concerning the cognitive concept of 'Attribution Theory' is presented in terms of its theoretical and clinical findings, and methodological limitations. An alternative approach to the literature is then considered according to a discursive view of traditional psychology. Instead, attributions are considered as something speakers perform in their accounts as a form of social action. This discursive consideration of language informed a Social Constructionist Grounded Theory methodology. Eleven clinical staff from a specialist brain injury rehabilitation hospital participated, eight in one-to-one interviews and three in a focus group. Within their accounts, participants were observed to make attributions relating to CB. Three central categories of talk were found; attributions about internal location and about external location in relation to CB, and combinations of the two. Participant accounts were considered according to specific attributions, as well as the actions performed by these attributions. The conclusions are discussed in relation to the literature, the study's methodological limitations and a critical reflection. This study reflects the capacity of talk as more than mere description of inner experiences or outside observations. The findings open up the possibility of these attributions being apparent in relation to behaviour deemed problematic. This has implications for individual members of staff and services, and consequently for patients, where language might be rarely considered beyond its apparent content. It is proposed that the position of often taken-for-granted attributions produced within clinical settings in relation to patients classified as 'challenging' needs to be acknowledged, and such reflection needs to be integrated into training, intervention planning and supervision.

Paper 1

Care Staff Attributions for Patient Challenging Behaviour:

A Narrative Review of the 'Attribution Theory' Literature

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1. Abstract

Exposure to neurorehabilitation is considered to benefit patients classified as having sustained an acquired brain injury (ABI); however the presence of behaviours regarded by others as challenging (CB) may constrain access to neurorehabilitation services and attainment of rehabilitation potential. The necessity for managing CB is therefore well recognised. Yet the literature suggests intervention programmes are often inappropriately implemented by staff. Numerous studies within learning disability, older adult and mental health contexts demonstrate the utility of attribution theory in investigating staff-patient interactions and its role in incidents of CB. Although it is acknowledged that these models may need to be adapted, some evidence supports associations between attributions of internality, control, stability and optimism with staff affect and with willingness to help, and ultimately staff's resulting levels of commitment when implementing care programmes. However, studies directly exploring care staff attributions for CB within ABI contexts are neglected from the literature. The research is collated and reviewed in terms of its theoretical and clinical findings as well as its methodological limitations. It is proposed that accounts of staff working with patients described as having an ABI and judged to exhibit problematic behaviours need to be explored.

Key Words: "Attribution Theory"; "Challenging Behaviour"; "Care Staff"; "Acquired Brain Injury"; "Learning Disability"; "Older Adults"

2. Challenging Behaviour

The presence of patient actions that are constructed as 'challenging behaviour' (CB) within patient populations labelled as having sustained an acquired brain injury (ABI) has been well documented (Alderman, 2001; 2004; Johnson & Balleny, 1996; Oddy, Coughlan, Tyerman & Jenkins, 1985). 'Challenging behaviours' may be considered to include: self-injury, aggression towards others, property destruction and sexually inappropriate acts (Hastings, 1997). Aggression has been considered the most interpersonal form of CB, and therefore most likely to have a direct impact on staff-patient relationships (Emerson & Bromley, 1995). Emerson, Barrett, Bell, Cummings, McCool, Toogood and Mansell (1987) described the notion of CB exhibited in learning disability (LD) labelled populations:

'Behaviours of such intensity, frequency or duration that the physical safety of the person

is likely to be placed in serious jeopardy, or behaviour which is likely to limit or delay

access to or use of ordinary community facilities'. (cited in Alderman, 2001: page 176)

It is suggested that there are similarities in many of the difficulties experienced by people regarded as either LD or ABI, although the nature of onset may be very different and as such many aspects of the person's previous personality and abilities may be considered to be left intact with ABI cases (Alderman, 2001). Alderman (2001), applying the Emerson *et al.* (1987) definition to patients with ABI, expanded it as follows:

'... it may also effectively constrain their ability to participate in post-acute neurological

rehabilitation and therefore fail to exploit their potential for recovery...'

(Alderman, 2001: page 176)

Therefore, it is acknowledged that whilst exposure to rehabilitation can benefit people who have sustained brain injury (Cope, 1994), the presence of CB may constrain access to services and attainment of rehabilitation potential (Alderman, 2001; Eames & Wood, 1985).

2.1 Prevalence of Challenging Behaviour in Acquired Brain Injury Populations

The number of ABI cases with severe behavioural problems is small (estimated as 0.3 per 100,000 per annum: Greenwood & McMillan, 1993). However, ten times this figure manifest persistent behaviour disorders which impact on everyday functioning (Johnson & Balleny, 1996). Actual or threatened aggression, particularly by people who have acquired severe and very severe brain injuries, is still frequent (Thomsen, 1984; Weddell, Oddy, & Jenkins, 1980). Although spontaneous improvement is evident in many people who have sustained an ABI, for some there is a worrying tendency for incidents to increase in frequency and severity with the passage of time (Johnson & Balleny, 1996). It is for this minority of patients that admission to services specialising in patient CB might be necessitated.

Brooks, McKinlay, Symington, Beattie and Campsie (1987) explored the nature of behavioural and psychosocial problems observed after brain injury from the standpoint of relatives. Five of the top ten problems described reflected the presence of behaviours labelled as 'challenging'. In addition, data suggested that improvements in behavioural and psychosocial problems did not always come with time, with the presence of these problems reported after five years. Some aggression even appeared to increase in prevalence over time, with the proportion of relatives reporting 'threats of violence' increasing from 15% at one year to 54% at five years post injury. Not surprisingly, these behavioural disorders represent a significant source of stress within families (McKinlay, Brooks, Bond, Martinage & Marshall, 1981; Oddy *et al.*, 1985) and within rehabilitation settings (Miller & Cruzat, 1981).

2.2 Influence of Challenging Behaviour on access to Neurorehabilitation

Patients with an ABI label who are considered to exhibit behaviour disturbance may be unpopular and avoided by rehabilitation professionals (Miller & Cruzat, 1981). Fewer social interactions between care staff and people categorised as LD who engage in CB have also

been found (Hastings, 1997; Hastings & Remmington, 1994a). Aggressive behaviour in neurorehabilitation services causes particular concerns: compromising safety of patients and staff, increasing the vulnerability of the aggressor, as well as reducing attainment of rehabilitation potential (Alderman, 2001; Burke, Wesolowski & Lane, 1988; Hastings, 1997). Paradoxically, aggression has also been seen to serve a function of gaining interpersonal contact (Hegel & Ferguson, 2000).

For patients, aggressive behaviour may also provide escape from or temporary avoidance of rehabilitation activities, especially if the outburst repeatedly results in the termination of the activity. Yet, behavioural problems that lead to escape or avoidance through negative reinforcement may be particularly difficult to treat (Iwata, 1987). Such behaviours may be driven by a variety of factors, including irritability, anxiety and reduced awareness or poor insight (Alderman, 2003; Alderman, 2004).

In summary, the management of behaviour disorders attributable to brain injury is considered crucial to maximise opportunities for neurorehabilitation.

2.3 Impact of Challenging Behaviour on Care Staff Emotional Responses

High emotional arousal has been found to be experienced by staff in response to CB (Jahoda & Wanless, 2005). Patients can provoke strong negative feelings in staff, especially when behaviour is violent or agitated (Watts & Morgan, 1994). Staff may regard aggressive acts as a threat to self or a deliberate show of lack of respect (Jahoda & Wanless, 2005). Research with LD populations has highlighted emotional reactions of staff such as sadness, despair, anger, annoyance, fear and disgust. These have commonly been found in response to the 'daily grind' of caring, in addition to difficulty in understanding unpredictable behaviours (Bromley & Emerson, 1995). Similarly, research has demonstrated feelings of anger, anxiety, stress and strain within staff working in mental health settings with patients exhibiting CB

(Whittington & Wykes, 1994) potentially leading to staff becoming overly defensive or punitive towards patients (Benson, Secker, Balfe, Lipsedge, Robinson & Walker, 2003), and with CB in older adult dementia populations (Bird, 1999).

It has been suggested that staff's negative emotional reactions may have the function of mediating the impact of CB on levels of stress (Hastings, 2002). There is some evidence to suggest that burnout or stress in itself may significantly impact staff perceptions and responses to CB (Snow, Langdon & Reynolds, 2007; Todd & Watts, 2005). Hastings (2002) suggests that exposure to CB on a daily basis elicits negative emotional reactions that accumulate over time to affect stress and burnout levels, which in turn affect staff interactions with patients. It has been argued that the importance of emotional responses to CB should therefore be acknowledged and how these feelings might impact on staff-patient interactions should be explored (Dublin, 1989).

2.4 The Effect of Staff Beliefs on Managing Challenging Behaviour

Interventions utilising a variety of operant conditioning procedures and other methods derived from learning theory have been found to be effective in the management of CB. These appear to be most effective when used within the context of a service specialised to manage such challenges, especially when this embodies the neurobehavioural paradigm (Alderman, 2001; Wood, 1987; Wood & Worthington, 2001a; Wood & Worthington, 2001b). The provision of a structured environment in which reinforcement for adaptive social behaviour is available can promote regular and appropriate positive interaction for patients who may have previously used aggression as a means of initiating social contact.

Thus, the function of the social environment in reducing inappropriate and enhancing adaptive behaviours has been well documented. The actions of significant others, especially staff, are thought to represent the antecedents, maintenance and consequences of a large

proportion of CB (Hastings, 1997; Hastings & Remington, 1994b; Jahoda & Wanless, 2005).

In addition, staff responses may have the function of allowing the staff themselves to avoid or

escape aversive patient CB (Watts, Reed & Hastings, 1997). It is suggested that staff actions

may be partially determined by their beliefs about CB (Hastings, 1997). Nevertheless,

although staff seem to be able to identify the main causes of CB, research indicates staff fail to

make accurate attributions about its functions (Hastings, 1997). Furthermore, limited

understanding of the problems associated with ABI may lead to what seem to be 'common

sense' views regarding patient behaviours. For example, the belief that behaviour is entirely

under patient control, and that they are 'doing it deliberately' or are 'lazy', can be found with

staff who are lacking in information (Alderman, 2001).

3. Care Staff Attributions for Challenging Behaviour: Attribution Theory

The predominant body of work relating to staff responses to CB has taken a behavioural perspective in framing how staff behaviour reinforces and is reinforced by CB (Dagnan & Cairns, 2005). However, LD research in particular has studied the responses of staff from a cognitive perspective, identifying links between staff cognitions, emotions and behaviours. Both cognitive and behavioural models have been used to indicate the role of staff emotional responses in determining behavioural reactions to CB (Wanless & Jahoda, 2002). More specifically, the cognitive model stipulates how staff views of the behaviour drive this emotional response. In particular, causal attributions are seen as having a central role in predicting emotional and behavioural responses (Dunne, 1994). For example, Bromley and Emerson (1995) asked 70 staff working in LD settings why they felt an individual known to them engaged in CB. The five most frequent responses were: internal psychological state or mood, past environment, current environment (e.g. reaction to change), self-stimulation and a form of communication or control of others. Similar staff causal attributions have been found using fictional vignette or non-specific individual targets, for example Hastings (1997) found social, emotional and physical environment factors were described most frequently and organic factors less often. However, there has been little research exploring the accounts of staff who work with people who are considered to have sustained an ABI and are deemed to exhibit CB.

The current paper aimed to review the current literature regarding care staff attributions for CB and the impact of this on intervention and outcome. The target journal was *Social Science and Medicine* (Appendix 1). The literature was systematically searched using the key words "acquired brain injury", "traumatic brain injury", "brain injury", "head injury", "aggression", "challenging behaviour", "violence", "attribution", "attitudes", "attribution theory", "carers" and "care staff". Several electronic databases, namely Allied &

Complementary Medicine (1985+), British Nursing Index (1994+), CINAHL (R) (1982+), EMBASE (1996+), Medline (1951+), PsycINFO (1872+) and the Cochrane Library were searched using these key concepts. Studies selected were limited to those in brain injury, learning disability, older adult and adult mental health populations that referred directly to patient CB.

3.1 The Attribution-Emotion-Behaviour Structure

Clements (1992) argued there was a 'conceptual vacuum' developing in current practice for CB. Heider's (1958) theory of causal attributions has been put forward to help explain why interventions for CB may fail, due to the attributional biases of care staff (Dunne, 1994). Heider explored the concept of 'attribution of causality': the perception of another's behaviour as determined by what a person attributes the causes of the behaviour to. Heider highlighted attributions of internal personal causes, external personal causes or a combination of the two. Within this model, attributions are based on the *perceived* motives and intentions of the other, and thus some underlying motivating trait is attributed which is consistent with the behaviour.

Weiner (1980) expanded upon this premise, suggesting an explicit dimensional structure of attributions regarding the cause of an event: internality, stability and controllability. Here, internality refers to the aforementioned internal-external distinction, whilst stability is concerned with the changeability of the cause across time. Lastly, control refers here to the amount of control an individual has over the cause of their behaviour. According to the model these have a role in determining the emotional responses of anger or sympathy, which in turn determines the likelihood of help being offered. A simplified model, adapted from Weiner's 1980 'cognitive (attribution) – emotion – action' model, is presented in Figure 1.

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┌─────────────┐      ┌─────────────────┐      ┌──────────┐      ┌─────────────┐
│    EVENT    │─────▶│  causal analysis │─────▶│  affect  │─────▶│ help / neglect │
└─────────────┘      └─────────────────┘      └──────────┘      └─────────────┘
```
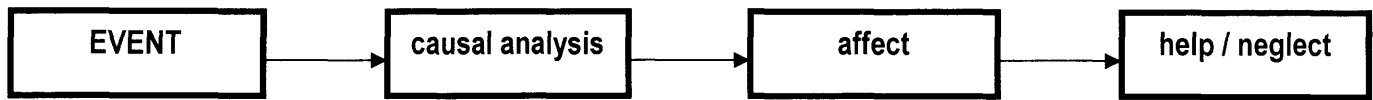
Figure 1 Simplified version of Weiner's 'cognitive (attribution) – emotion – action' model (1980)

Dagnan and Cairns (2005) give an example: if a patient is seen as acting in a way that is under their deliberate control (e.g. "they are trying to wind me up") the carer will experience more anger and is consequently less likely to offer help. Weiner's model (Weiner, 1985; 1986) also incorporated the role of achievement motivation, where attributions (optimism) may affect the perceived costs and benefits of helping and thus affect helping behaviour.

Weiner (1993) argued that this general attribution-emotion-behaviour model can be applied to understand behaviour in a broad range of social situations. Further, it has been argued that it may be extended to the behaviour of helping professionals (Sharrock, Day, Qazi & Brewin, 1990). Fenwick (1995) suggested staff's therapeutic commitment or helping behaviour could be predicted from Weiner's model to vary according to their causal attributions for CB. Weiner's models have therefore been applied as a framework for examining how staff's reported beliefs about CB mediate reported emotional responses, willingness to help and ultimately resulting levels of commitment when implementing care programmes.

However, concerns have been raised at the conceptual level around the definitions of 'emotional responses' and 'helping' behaviour (Jones & Hastings, 2003). For example, the predominant focus on two emotional responses of anger and sympathy omits negative emotions within the context of CB, such as fear, anxiety or depression. In addition, whether staff reactions to CB can be described as helping behaviours has been questioned (Jones & Hastings, 2003; Rose & Rose, 2005). Alternatively, staff actions might be considered in terms of their functional relationship with the CB. Here, an action such as ignoring an inappropriate

behaviour may 'help' an individual, if the CB is maintained by attention and thus the action will extinguish it. Alternatively, ignoring an inappropriate behaviour may serve to maintain it if the CB is avoidance motivated and thus the action will reinforce it.

3.1.1 Studies of attribution theory in challenging behaviour contexts.

A number of studies have supported the fundamental attribution-emotion-behaviour structure of Weiner's models. However, direct confirmation of the models is unclear due to lack of consistency between studies. This lack of consistency also results in a complex picture of the attribution theory literature. Nevertheless, an outline of the main findings are presented below.

Investigations have associated attributions of internality and controllability for patients regarded as displaying CB, although the direction of these attributions have been variable (Snow, Langdon & Reynolds, 2007; Weigel, Langdon, Collins & O'Brien, 2006). Sharrock *et al.* (1990) asked 34 staff working with offenders in a mental health setting to report their emotional responses, optimism and likelihood of helping a patient that they knew well. According to Weiner's (1980, 1985, 1986) controllability hypothesis, Sharrock *et al.* hypothesised that attributions of controllability would be associated with affective reactions that would in turn predict the effort that a person would expend in helping; attributions of control/lack of control would elicit an emotional response of anger/sympathy, and thus helping behaviours would be less/more likely to occur. In addition they tested Weiner's hypothesis from the achievement motivation model that attributions of stability would be associated with lower levels of optimism for change, and less helping behaviour. Results supported the stability-optimism hypothesis rather than the controllability-affect hypothesis. They were thus unable to confirm a mediational role for positive affect that was deemed crucial to Weiner's models.

Similarly, Fopma-Loy and Austin (1997) found no significant association between affect and either causal attributions or care giving behaviour in a study with staff working in a specialised dementia service. However, the study did find strong correlations between causal attributions and both expectations and care-giving behaviour.

Dagnan, Trower & Smith (1998) asked 40 care staff to rate scenarios describing different examples of CB with LD patients. Analysis showed helping behaviour was best predicted by optimism regarding potential for improvement, which was in turn best predicted by negative affect and this by the attribution of controllability. Attribution of control was also correlated with positive affect, a partial confirmation of Weiner's model. However positive affect did not correlate with optimism or helping. The mediating role for optimism and not affect found by Dagnan *et al.* (1998) supports the findings of Sharrock *et al.* (1990). Dagnan *et al.* (1998) also found both the patients and their behaviour were evaluated negatively when staff perceived them to be in control. This could indicate that staff make evaluations of the individual on the basis of their behaviour. However, criticisms of Dagnan *et al.*'s (1998) study have been expressed. For example, they did not distinguish between the two hypotheses generated by Weiner's models (controllability-affect and stability-optimism: Sharrock *et al.*, 1990) instead combining the two (Jones & Hastings, 2003). Furthermore, Dagnan *et al.* (1998) did not separate anger and sympathy emotions in their analysis.

Todd and Watts (2005) applied Weiner's model to staff working with people with dementia using questionnaire methods with 25 nurses and 26 psychologists. Data supported the findings of Dagnan *et al.* (1998) and Sharrock *et al.* (1990) in that optimism was more closely associated with self-reported helping behaviour, although this was not found for physical aggression. They also found sympathy to be associated with increased willingness to help. However, they found no consistent role for attributions overall. They also investigated the impact of burnout and found this to be associated with less willingness to help, low

optimism and negative emotional responses to behaviour, but found no relationship between attributions and burnout. This lack of a causal relationship between attributions and burnout has been replicated in LD (Snow *et al.*, 2007).

Conversely, Harborne (1996) presented 48 nurses from 'care of the elderly' wards with a vignette of a fictitious patient and found negative emotions *were* associated with negative behavioural responses and non-medical internal attributions. However, the study did not investigate Weiner's dimensions of controllability and stability (Todd & Watts, 2005).

Stanley and Standen (2000) suggest that neither the methodologies of Sharrock *et al.* (1990) nor Dagnan *et al.* (1998) developed a factorial approach to behavioural topography. They argue that consolidating behaviours may mask potential differences, and thus studies need to be explicit about the form of behaviour being studied. Investigation has suggested that distinct topographies of CB often have different causes (Hastings, 1997). Stanley & Standen (2000) looked at attributions of 50 care staff working in CB day services, and distinguished three main forms of CB: aggression, self-injury and destructiveness (elicited from Bromley & Emerson, 1995; Emerson & Bromley, 1995). They presented six case studies for staff to rate and found controllability to correlate with affect, and positive affect with helping. They found an association between stability and helping, although no such association between optimism and helping, unless optimism was linked to a perceived stable cause. Stanley and Standen (2000) therefore found some support for Weiner's (1980) helping behaviour model, but no support for a key role for Weiner's (1985; 1986) optimism model. However, again, anger and sympathy emotions were not studied separately (Jones & Hastings, 2003). In contrast to Stanley and Standen (2000), Bailey, Hare, Hatton and Limb (2006) applied Weiner's model to 'real' LD patients and found associations between internal, stable and uncontrollable attributions with negative affect, however in support of Stanley and Standen (2000) no

associations were found between emotion, optimism and willingness to help. These results

did not provide full support for Weiner's (1980, 1985) model of helping behaviour.

Jones and Hastings (2003) used video stimuli and self-report questionnaires to explore

123 staff's reactions to self injurious behaviours within LD services. They found no support

for Weiner's helping model as, where self-injury was perceived as uncontrollable by external

forces (e.g. by the staff themselves) or as something to do with the individual (attributing

internal locus of control), staff reported less negative affect. This seems inconsistent with

predictions from Weiner's (1980) model as attributions of controllability should be associated

with *increased* negative effect. However, the authors point out that the results may be specific

to self-injurious behaviour; staff may experience relief if they are able to attribute the cause to

the self-injuring person rather than to themselves. Making attributions to external factors

including their own actions would be associated with increased negative affect. These

relationships are likely to be different with aggressive behaviour towards others (Jones &

Hastings, 2003).

Where Weiner's (1980; 1985; 1986) attribution theory has been explored within a CB

context by many researchers, there is little continuity between dimensions investigated or

between methodologies employed. In summary, these studies have demonstrated associations

between Weiner's attributions of control and helping (Fopma-Loy & Austin, 1997), affect and

helping (Todd & Watts, 2005 [with 'sympathy' only]; Harborne, 1996), and between control

and affect (Dagnan *et al.*, 1998 [partial support]; Stanley & Standen, 2000). However,

opposing evidence has been found regarding the role of affect (Bailey *et al.*, 2006; Fopma-Loy

& Austin, 1997; Sharrock *et al.*, 1990) and an association has been found between control and

affect in the opposite direction to that suggested by Weiner's model (Jones & Hastings, 2003).

Associations have also been determined between attributions of stability and helping (Stanley

& Standen, 2000), optimism and helping (Dagnan *et al.*, 1998; Todd & Watts, 2005), and

between stability and optimism (Sharrock *et al.*, 1990). There is conflicting evidence

regarding the role of optimism (Bailey *et al.*, 2006; Stanley & Standen, 2000).

3.2 The Judgement of Responsibility

More recently Weiner (1993; 1995) suggested the judgement of responsibility is of

equal importance in determining emotional and behavioural responses to events. Here,

responsibility refers to a judgement made on 'moral' grounds as to the degree to which a

person can be justifiably held to account or blamed for the cause (controllability) of their

actions. Weiner (1995) gives the example of a person who might intentionally crash a car (a

controllable cause for the crash), but who might not be held responsible because the

controllable act was carried out in order to avoid hitting a child who had suddenly stepped out

into the road (a mitigating circumstance).

3.2.1 Studies of attributions of responsibility in challenging behaviour contexts.

Dagnan and Cairns (2005) examined judgements of responsibility by 62 staff regarding

a LD scenario. They found responsibility to predict the emotional and intended behavioural

responses of carers. Their results were broadly consistent with Weiner's (1993; 1995) model.

The attribution of internality was associated with emotional response and 'sympathy' was

associated with helping intention. However, there were no significant correlations between

attributions of controllability and anger or sympathy. Yet, when only aggressive behaviour

has been used as an activating event for attributional and emotional responses, studies have

found significant relationships between controllability and anger (Dagnan & Weston, 2005,

2006).

Jones and Davis (1965) proposed that an individual must be viewed as having an

awareness of the consequences of their actions in order for someone to conclude that the

outcome was intended. Accordingly, Tynan and Allen (2002) suggested that staff may be less likely to attribute responsibility for CB as the severity of the intellectual impairment increases, because they would be less likely to conclude that the patient intended the outcome of their actions. They therefore used two scenarios to examine the effects of level of intellectual disability on causal attributions by 42 residential care staff. Findings indicated that the patient depicted with mild disabilities was perceived to have significantly greater control over factors causing the aggressive behaviour than the patient with severe disabilities. Severe disability was also associated with the biomedical model having greater causal relevance. Thus, beliefs surrounding individuals' behaviours seemed to be influenced by the observers' perception of the person's cognitive abilities. However, attributions of internality and stability were not found to significantly vary as a function of level of intellectual disability.

In summary, studies investigating the role of responsibility (Weiner, 1993; 1995) in staff responses to CB have demonstrated associations between attributions of responsibility and affect, internality and affect, affect and helping (Dagnan & Cairns, 2005) and between control and affect (Dagnan & Weston, 2005; 2006). In addition, cognitive ability is associated with attributions of control, although not with attributions of internality or stability (Tynan & Allen, 2002).

3.2.2 An alternative cognitive model of responsibility and helping behaviour.

Responsibility as an important attribution in determining patterns of helping behaviour has also been explored in the work of Brickman (Brickman, Rabinowitz, Karuza, Coates, Cohn & Kidder, 1982). Here, the judgement of responsibility for the development of a problem is differentiated from the responsibility for the future resolution of the problem. Brickman *et al.* (1982) highlight four models of helping and caring behaviour. Firstly, the 'moral' model refers to when a person is judged as responsible for the development of a

problem and as having responsibility for its resolution. Thus the person would likely be viewed as an autonomous agent and preferred helping behaviours would include encouraging self-motivation. Secondly, the 'enlightenment' model, when a person is viewed as having responsibility for the development of a problem but not as responsible for its resolution, is a personal weakness model and is associated with punitive interventions. Thirdly, the 'compensatory' model occurs when a person is not responsible for the development of a problem but they do have responsibility for the solution. Here the person is seen as able to influence their condition and as a result they are likely to be offered the resources with which they can implement change. Finally, the 'medical' model occurs when people are viewed as neither responsible for the development of or resolution for the problem. This model represents a passive view of the person who requires an expert helping intervention. Dagnan and Cairns (2005) suggest that the values applied in LD services can be viewed from the perspective of this latter model. With a biomedical basis for much ABI rehabilitation, values applied in ABI services might also be viewed predominantly from this 'medical' model.

Where Weiner's (1980; 1985; 1993) models emphasise the importance of attributions of internality, stability and controllability and exploring judgements of responsibility, Brickman *et al.*'s (1982) model stresses the importance of separating judgements of responsibility regarding the development of a problem from responsibility for its resolution (Dagnan & Cairnes, 2005). Dagnan and Cairns' (2005) results were therefore broadly consistent with Weiner's *and* Brickman's models, as sympathy was less likely when staff made internal attributions and attributions of responsibility for the development of the CB, but more likely if staff judged the person to have some responsibility for changing their behaviour.

3.3 Care Staff Attributions: Limitations of Previous Research

Previous research appears to support the view that care staff attributions have *some* role in determining responses to patients. However, a number of criticisms can be directed at previous investigations. For example much of the research has focused on hypothetical situations or patients rather than actual episodes with real patients (Leggett & Silvester, 2003). Furthermore, studies have typically inferred behavioural responses, thus exploring what staff say they *would do* rather that what staff *actually do*. In addition, most studies have not explored staff attributions for themselves following incidents (Leggett & Silvester, 2003). Further, a barrier that needs to be considered when studying patient CB came from examinations of staff definitions of CB, suggesting they are at odds with those of professional and contemporary literature. In addition, it seems that staff may find it more difficult to identify negative as opposed to positive reinforcement processes (Hastings, 1997).

Many of these studies have been criticised because of the reliance on vignettes (Bailey *et al.*, 2006; Wanless & Jahoda, 2002) that provide limited information about episodes of CB and fail to take account of personal and contextual factors (Jahoda & Wanless, 2005). The ecological validity of these measures is open to question, and as such it is unknown whether staff would produce similar attributions spontaneously during real interactions (Leggett & Silvester, 2003). This approach also standardises the characteristics of the patient and their behaviour, so variation in responses from participants is minimised (Todd & Watts, 2005). The role of individual differences in attributional style therefore remains insufficiently considered (Leggett & Silverster, 2003). However, Todd and Watts (2005) hypothesise that participants might be basing their judgements on their own past experience, thus introducing variation, although also potentially responding artificially to hypothetical scenarios.

Todd and Watts (2005) advocate obtaining participants' real-life explanations of patient behaviour. Wanless and Jahoda (2002) attempted to replicate previous findings

supportive of Weiner's (1980; 1985) model with 38 day care staff. To determine how staff reactions to vignettes compared with responses to actual incidents, they also examined two conditions: responses to vignettes and ratings of a real incident involving someone participants worked with. Data indicated associations between attributions and emotions were consistent with the model. However associations between key variables and helping behaviours were in the opposite direction to predictions. For example, they found high staff anger and attributions of controllability to be associated with an *increase* in staff's willingness to help, although this 'helping' could be an attempt to change patients who are perceived to be changeable due attributions of control. Incidents involving a real person evoked stronger emotions, however causal attributions were consistent across hypothetical and real scenarios.

Some have suggested Weiner's (1980; 1985; 1993) models might need to be adapted (Bailey *et al.*, 2006; Dagnan & Cairns, 2005; Jones & Hastings, 2003; Snow *et al.*, 2007). Others have suggested that there is a need to move away from Weiner's attribution theory, proposing it is too simplistic to capture the emotions experienced by staff (Wanless & Jahoda, 2002). In addition, Wanless and Jahoda (2002) suggest the model fails to incorporate the dynamic nature of the carer-patient interaction. They highlight the potential mutual reinforcement resulting from interventions to prevent harm to the patient, where staff behaviour is reinforced by the termination of the stressful experience. Similarly, Todd and Watts (2005) highlight how the model was initially developed in one-off helping situations. They suggest attributions may become less important as the involvement of the helper in the situation and the amount of contextual information available increases. For instance, staff responses to incidents of CB will likely be influenced by the context of an interpersonal history with the patient (Jahoda & Wanless, 2005). In addition, there are likely to be confounding beliefs surrounding the CB exhibited. For example, even if staff make

controllable attributions (such as "he is attention seeking"), they are also likely to hold beliefs about the 'uncontrollable' affects of the impairment (Todd & Watts, 2005).

There may be other factors that influence helping behaviour in more complex situations. Hastings and Remmington (1994b) highlight the influences of service environment such as formal and 'unwritten' ways of working and social contingencies. Jahoda and Wanless (2005) explored perceptions of 36 staff about LD patients who were frequently aggressive. They found many staff expressed mixed or contradictory views about patients, for example, initially attributing aggressiveness to external causes (e.g. the disability) followed by attributions of intentionality and negative appraisals of the patient (e.g. the patient knowing what they are doing and bullying staff). This indicated staff may hold more than one position on a patient's behaviour, which is in contrast to Weiner's (1980; 1985; 1993) linear models linking particular attributions and emotions.

Todd and Watts (2005) also propose that additional beliefs about the professional role and helping may have a more powerful impact on staff behaviour than possibly cognitively dissonant attributions about the patient. It is possible, however, that the impact of beliefs about the professional role will have more of an effect on *reported* responses to CB than *actual* responses to real life everyday situations. Yet, it is argued that methods used to examine the construct of staff attributions tend to tap this socially desirable professional perspective, and fail to address staff's emotive interpersonal perspectives (Jahoda & Wanless, 2005). Therefore, it is possible that attributions generated by these studies do not accurately reflect the beliefs held during active engagement with patients (Todd & Watts, 2005).

4. Implications for Current Clinical Practice: How Are Staff Making

Choices about Interventions for Challenging Behaviour?

The research reviewed has utilised the cognitive concept of attributions to describe and account for how staff make causal sense of incidents of CB. Largely, these studies have suggested the conditions conducive to helping include attributions of externality, lack of control or responsibility for the cause of the behaviour (although some responsibility for changing the behaviour) and low stability resulting in higher optimism for change.

Nevertheless from a behavioural perspective, studies have demonstrated how the choice of intervention ('help') is not always beneficial to neurorehabilitation. Although staff responses to aggressive behaviour may lead to CB cessation, these may also serve to reinforce the behaviour (Tynan & Allen, 2002). For instance, staff have reported distraction or changing the task as an 'appropriate strategy', but the appropriateness of this could be questioned given that many CBs are maintained by escape or avoidance contingencies (Hastings, 1996; Wood, 1987). Research on shaping behaviour indicates even low rates of reinforcement may be effective in developing and maintaining behaviour patterns and how behaviour established in this way can be harder to extinguish (Hastings, 1996; Iwata, 1987).

4.1 Impact of Care Staff Attributions

Typically, attribution theory studies have suggested that staff deem the patients themselves, environmental factors (such as staffing or ward atmosphere), treatment related factors (such as use of restraint) and interactional factors (such as controlling style of staff) to be causes of violent behaviour (Jansen, Dassen & Jebbink, 2005). The research highlighted by the current review has presented a relationship between reported staff attributions and the nature and extent of help offered to patients. These have been argued to influence the nature of interventions implemented to manage CB (Benson et al., 2003). For example, Leggett and

Silvester (2003) investigated naturally occurring attributions in a psychiatric secure unit and found attributions of control for patients and attributions of lack of control for staff were associated with seclusion. Clinically, 'inappropriate' care staff beliefs about the causes of CB have been related with the adoption of similarly inappropriate interventions (Hastings & Remington, 1994). It is therefore suggested that further understanding of the factors that promote or undermine the process of intervention would be beneficial (Todd & Watts, 2005). In addition, interventions are likely to be rejected where they do not match with staff attributions about a behaviour (Hastings, 1997).

4.2 Topography of Challenging Behaviour

The topography of CB and staff's previous experience have also been found to affect staff intervention beliefs (Hastings, 1997; Hastings & Remington, 1994a; Wanless & Jahoha, 2002). For example, Hastings (1996) examined 109 staff working in a large institution for people with LD. Hastings found topography of behaviour to affect staff reported intervention beliefs. Staff were more likely to restrain or stop a person engaging in self injurious behaviour compared to aggressive behaviour. Watts *et al.* (1997) replicated these findings with a community sample of 56 staff. They found the range of strategies and explanations to be similar to that of institution staff, although community staff were more likely to describe interventions involving building relationships and identifying underlying causes of behaviour. Dagnan and Weston (2006) also found typography of behaviour to associate with the use of intervention (in this case physical intervention), however they found no relationship between cognitive, attributional or emotional variables and the typography of intervention.

4.3 Immediacy of Intervention Strategy

Staff-reported beliefs about immediate or reactive intervention strategies have been found to be different to reported beliefs about longer-term proactive strategies. Beliefs about how to intervene in the longer-term seem to be more 'appropriate' (consistent with best practice) than beliefs about reactive intervention strategies (Hastings, 1997). As the studies included in this review indicate, both staff-stated beliefs about, and emotional responses to, CB may influence accounts of intervention behaviour (Hastings et al., 1995).

Both Hastings (1996) and Watts et al. (1997) found immediate interventions to be likely to maintain CB in the long-term (e.g. negatively reinforcing responses such as distraction or leaving the person alone), although appropriate longer-term intervention strategies were reported by staff. The authors suggest that these apparently counter-habilitative immediate responses may have been based on valid concerns that may conflict with the long-term concerns addressed by intervention programmes (Hastings, 1996; Watts et al., 1997). Similarly, Jahoda and Wanless (2005) found that often staff's stated initial wish was to confront patients, although actual responses were usually tempered in line with professional responsibilities.

It is suggested that immediate responses to CB may be determined by demands not relevant to planned interventions, such as preventing harm, whereas long-term priorities may include strategies to address identified causes of the behaviour or increasing quality of life (Watts et al., 1997). Alternatively, immediate responses may be determined by additional aspects of the situation such as the aversive nature of the behaviour (Hastings, 1997), and the emotional reactions of staff. In addition, there may be a mismatch between staff's initial 'fight or flight' responses at the time of an incident and their understanding of effective interventions (Hastings, 1996; Watts et al., 1997). Staff accounts about how to intervene with CB are

therefore liable to be determined by a number of factors that are unlikely to match with the rules of a behavioural programme (Hastings, 1997).

4.4 Perceived Cognitive Ability

Staff may perceive those with mild impairment as having more control over and thus more responsibility for their aggressive behaviour than those with severe impairments (Tynan & Allen, 2002). Weiner's model would suggest that such attributions are likely to lead staff to experience more anger towards those with mild impairments, thus decreasing the likelihood of offering help (Weiner, 1980). It is proposed that anger is likely to have a negative impact on the therapeutic relationship, may cause staff to be less willing to engage in interventions, and could even place patients with CB at greater risk of inappropriate treatment (Tynan & Allen, 2002). Moreover, if anger is conveyed to the patient it could be detrimental to their self-image and self-esteem, and avoidance behaviour from staff could act as a trigger for further aggression (Tynan & Allen, 2002). Tynan and Allen (2002) also found the biomedical model to be of particular causal relevance with severely impaired patients. Consequently, they suggest that staff may be less willing to implement behavioural interventions, instead seeking pharmacological solutions.

5. Further Research

The literature base has indicated that the management of patient behaviour considered to be problematic or challenging (CB) is important in maximising opportunities for neurorehabilitation in acquired brain injury (ABI) populations. Yet the evidence suggests intervention programmes are often not appropriately implemented by staff. 'Attribution Theory' is a cognitive model that has been applied to the investigation of staff-patient interactions in relation to notions of patient CB within mental health, older adult and in particular learning disability clinical contexts. Surprisingly, the review has uncovered no research exploring care staff attributions for CB within ABI contexts. Support for the utility of attribution theory in cognitive investigations of staff-patient CB interactions has been varied. Some evidence has however supported associations between attributions of internality, control, stability and optimism with staff affect and with helping behaviours. It is also suggested that staff factors may influence the choice of intervention implemented. Within a cognitive framework, staff beliefs elicited in a structured way may therefore prove to be useful in the analysis of CB (Hastings, 1997). Associations between the reported attributions of staff in relation to behaviour displayed by patients who are considered to have sustained an ABI therefore remains unexplored in the literature and thus unclear. The present review of the literature has highlighted a need to explore accounts of staff working within this context in order to begin to build an understanding of staff-patient interactions in relation to behaviours regarded as 'challenging'.

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Paper 2

Attributions Regarding 'Challenging Behaviour'

within an Acquired Brain Injury Setting:

A Grounded Theory Analysis

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Doctorate in Clinical Psychology

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1. Introduction

1.1 Previous Research

The current literature would suggest that neurorehabilitation can benefit people diagnosed with acquired brain injury (ABI) (Cope, 1994); however the presence of behaviour deemed challenging (CB) may constrain access to services and attainment of rehabilitation potential (Alderman, 2001; Burke, Wesolowski & Lane, 1988). The actions of staff can be thought to represent the antecedents and maintenance of a large proportion of CB (Hastings, 1997; Hastings & Remington, 1994b; Jahoda & Wanless, 2005). Yet a dilemma persists that some staff fail to implement clear intervention programmes (Hastings & Remington, 1994a). Heider's (1958) theory of causal attributions has been put forward to help explain why interventions may fail, due to the attributional biases of staff (Dunne, 1994).

1.1.1 The 'attribution theory' literature.

Numerous studies within learning disability, mental health and older adult contexts have demonstrated the utility of the cognitive model 'Attribution Theory' (Weiner, 1980; 1985; 1986; 1993; 1995) in investigating notions of staff-patient interactions and CB. Attribution theory describes a presumed process through which people try to identify the reasons behind other people's behaviour. Published research has presented attributions relating to patient CB of internality, control, stability, optimism and responsibility with staff affect and willingness to help (Dagnan & Cairns, 2005; Dagnan, Trower & Smith, 1998; Dagnan & Weston, 2005; 2006; Fopma-Loy & Austin, 1997; Harborne, 1996; Stanley & Standen, 2000; Todd & Watts, 2005). However, despite an apparent aim to find consistency, there is much contradiction in reported outcomes (for a full account of the attribution theory literature see Stewart, 2007a). An alternative conception of this literature is therefore be considered.

1.1.2 How might people perform attributions in their accounts?

The aim of much psychological research has been the identification of broad

'objectively observable' and static patterns of behaviour, including the study of individual

thoughts and actions (Potter & Wetherell, 1987). Historically, schools of psychology have

operated upon the assumption that these can be understood by looking for intra-psychic

explanations, placing investigation within the 'psyche' of the individual (Burr, 1995; Edwards

& Potter, 1992; Wilcox, Finlay & Edmonds, 2006). Attribution theory could be understood as

a study of social cognition, where experimental methods have been applied to understanding

how people provide causal explanations for behaviours and how these may be compared in

order to find replicable patterns. However, much of cognitivism's reductive and

individualistic tendency has prevented unstructured talk from being considered by predefining

what the researcher is going to count as data (Edwards & Potter, 1992).

Within attribution theory studies, attributions seem to have been employed as internal

cognitive processes that can be identified and measured (Potter & Wetherell, 1987).

Researchers have sought to access these cognitions in a way that presumes their independent

existence from those providing them and those seeking to retrieve them (Edwards & Potter,

1992; Wilcox *et al.*, 2006). Yet, participants may orientate responses towards a particular

reading of a question asked (Willig, 2003). Furthermore, it cannot be assumed that on other

occasions people would necessarily produce the same attributions, even within similar

contexts (Potter & Wetherell, 1987; Willig, 2003). In addition, researchers approach a study

with numerous personal, professional and philosophical ideas, assumptions or values

(Charmaz, 1990). Accordingly, research findings cannot be considered to unproblematically

reflect phenomena.

Within the cognitive notion of attributions, there seems to be an implicit assumption

that even though different attributions are produced in talk in relation to 'something' (for

example CB) the 'something' itself does not need to be questioned. There is consequently a supposed consensus regarding the phenomenon being considered. Therefore, people seem to unquestionably agree on what is being talked about, but disagree on why it happened: the attribution (Willig, 2003). Alternatively, the 'something' could be considered as constructed through language. Therefore one person's version of CB may be different to the version of another's. Instead of unproblematically representing internal cognitions, participant accounts may make sense in terms of the social action versions of events accomplished in the time and place they occurred. When producing a version of something that happened, a speaker may be at risk of having claims discounted as a consequence of another's stake in different versions. Direct explicit attributional statements, such as "it was your fault", may be produced and then given credibility by implicit inferences and descriptions in surrounding talk (Edwards & Potter, 1992). Attributions are therefore seen to be constructed and reworked by individuals in their interactions.

If there is indeed no one version of phenomena which is reported in accounts, it could be argued that there may be an infinite number of possible ways of representing phenomena. Much of the inconsistency in the outcome of attribution theory studies might be accounted for, in part, by this variability. Thus, one could consider that different accounts should not be compared with each other in terms of accuracy, but instead in relation to each other (Burr, 1997). Variation therefore becomes expected instead of problematic. The 'psychology of attribution' may be considered to focus us away from the way versions of events are actively put together to support particular stories and challenge others (Edwards and Potter, 1992). Instead of pursuing the capture of internal 'attributions' through speakers' reportings, how they might *provide* these accounts in social interaction may be explored.

1.2 Further Research

Attribution theory presents a cognitive model with which to explore attributed meanings in relation to incidents of CB, however outcomes have been unclear. Alternative thinking regarding attributions has considered how people attribute within their interactions as a form of social action. It is proposed that the accounts of staff working with people categorised as ABI and who are considered 'challenging' need to be explored in order to begin to build a picture of the multiple versions of accounts. From this, an abstract account may begin to be generated in order to guide clinical practice, staff education and support. A Social Constructionist (SC) Grounded Theory (GT) informed by a discursive view of language was proposed (see Appendix 2 for an account of SC GT).

Instead of arbitrarily applying existing theory to new clinical populations it is considered advantageous to explore the phenomenon less biased by employing pre-existing versions of knowledge. Nevertheless it may be valuable to focus studies sufficiently to develop rich data (Henwood & Pidgeon, 2003). The importance of using theoretical literature before embarking on a study has been highlighted in promoting clarity (Cutliffe, 2000; Henwood & Pidgeon, 2003; Hutchinson, 1993). As such, the attribution theory studies were kept in mind during the course of this study. What seems important is to avoid commitment to a particular theory in the literature in a way that overly directs the phenomena being studied (Henwood & Pidgeon, 2003). This may be facilitated through a process of reflexivity.

Using a SC GT, the current study intended to open discussion about the ways in which staff accounted for patient[1] actions, and how they positioned themselves in relation to these. In order to point the participants towards the study area, ideas generated by the literature provided a starting point via exploration of participants' accounts of control and responsibility, notions of changeability, how participants linked their accounts of patient behaviour, staff

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[1] The label 'patient' has been used in this study to reflect the term predominantly employed by participants in their accounts.

actions and patient counter-reactions and also their descriptions of barriers and facilitators to

implementing interventions. Fundamentally, participants were encouraged to expand their talk

onto their own related topics.

2. Method

Although (in practice) the research process is rarely linear, the logic of GT (on paper) follows a linear course of selecting a question, data gathering, analysis and through to write-up. For ease of digestion, a linear representation of the process is presented and illustrated in Figure 1.

Figure 1 A Linear Representation of Grounded Theory Methodology

1) Interviews

A letter of introduction, 'Information Sheet' & 'Consent to be Approached' form is distributed to ward based clinical staff via the internal mail service. If staff are interested they sign and return the 'Consent to be Approached' form

2) Focus Group

Initial participants are approached for a short briefing and discussion and are asked to sign a 'Research Briefing and Consent Agreement' form

Further participants interviewed

Process continues until saturation or as near to saturation as feasible

The participant(s) is interviewed and audio recorded and the interview transcribed

Initial coding of the transcription

Theoretical Sampling

Draw preliminary interpretations (these form the basis of the next interview). Constant comparative data analysis employed; as codes are generated data is filtered into pre-existing codes or new categories are created. Individual segments are compared at the beginning of the analytic process as well as comparing higher order categories at the end of the analytic process, thus the analysis remains grounded in the text

Case vignette compiled from interviews

Further analysis of the data occurs to develop concepts and links towards a substantive account of the participants' talk

Write up involving a highly interactive and iterative process due to data collection, analysis and write up phases co-occurring

2.1 Developing and Refining the Research Question and Data Collection

2.1.1 How the idea was conceived.

From observations during my[2] time working as an Assistant Psychologist with patients described as ABI and judged to exhibit CB there seemed to be some discrepancies in the way that staff accounted for the CB observed in different patients. In particular I noticed that some staff appeared to be less tolerant of the behaviour exhibited by patients who appeared less "damaged" than those who were notably disabled, despite neuropsychological and clinical assessment indicating similar impairments. I wondered about the differing accounts, what staff did and how these notions may be communicated within interactions.

2.1.2 Participants.

Staff were recruited from a specialist brain injury rehabilitation hospital. Staff approached were limited to those based on the wards. Eleven participants took part (eight females, three males), eight in one-to-one interviews and three in the focus group. Participant professions included nursing (n=5), social work (n=1), occupational therapy (n=2) and physiotherapy (n=3). The sample included both qualified (n=9) and unqualified (n=2) participants. Years of ABI experience ranged from 18-months to 12-years.

Following approval from the hospital's Research Group and an NHS Research Ethics Committee (Appendix 3) a letter of introduction (Appendix 4), 'Information Sheet' (Appendix 5) and two copies of a 'Consent to be Approached' form (Appendix 6) were distributed to ward based staff via the internal mail service. This occurred separately for the interviews and focus group. Those interested in the possibility of participating and consenting to be

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[2] The use of the first person in writing up research is becoming increasingly accepted in published work, and even favoured when authors make reference to themselves (BPS, 2003). It is also considered important to interject the voice of a researcher within the text in order to achieve a high degree of transparency (Iantaffi, 2006). Therefore where appropriate the first person will be utilised here.

approached were required to sign and return one copy of the 'Consent to be Approached' form. With this consent participants were approached individually for a short briefing, following which the 'Research Briefing and Consent Agreement' (Appendix 7) form was signed by those wishing to participate. The process of recruitment was overseen by the Consultant Clinical Neuropsychologist. The focus group and interviews took place within the hospital grounds.

2.1.3 Developing the research questions: the interview and focus group schedule.

In order to guide the data collection process a schedule was utilised (Appendix 8). It seems questions should be sufficiently explicit to let the participant know what the area of interest is, yet not be too leading or restrictive. Still, the same question may elicit differing meanings depending on the interview context, the participant's position and the research relationship (Burman, 1994). In order to gain an account of the participant's interpretation of key terms, they were asked what they meant to them. For example, before asking about CB in relation to ABI, participants were first asked what they might associate the term 'CB' with. It is acknowledged that participant accounts may not follow the versions produced in the literature, but the existing literature was kept in mind when compiling the schedule questions in order to open up discussion. For example, the attribution theory literature pertaining to notions of optimism for change led to the question "I wonder if a patient can change their behaviour?". Unanticipated statements and stories were encouraged to emerge by creating open-ended questions (Charmaz, 2006). Funnelling was used to initially elicit general accounts followed by exploring more specific ideas. For example, the question "What terms or phrases could you use to describe the concept of 'responsibility'?" was designed to explore the general meanings participants might ascribe. Subsequent questions concerning responsibility for incidents of CB aimed to elicit specific accounts. Participants were

encouraged to expand onto related topics. As the data collection progressed each interview informed the next as new topics were added to the schedule, promoting sensitivity to the growing data and guiding the inquiry (Chiovitti & Piran, 2003; Morrow, 2005).

2.1.4 Data collection.

The one-to-one interview phase occurred first. Participants were interviewed face-to-face by the researcher. They were asked to discuss their most 'memorable' incident of patient behaviour that they deemed challenging. The events discussed were used to compile a case vignette. This facilitated the interview process by providing an event to anchor their account on if they wished. Using these interview vignettes as a guide, a vignette was created for use in the focus group (Appendix 9). Interview participants were required to talk for no longer than one hour, although they were given the choice to stop the interview at any time or to talk for longer. The focus group participants were then recruited. The aim was to encourage free discussion of the shared and opposing accounts of the group, not generally attainable in one-to-one interviews (Henwood & Pidgeon, 2003; Morgan, 1997; Wilkinson, 2003). Eight members of staff agreed to participate, however only three attended, the remaining five accounting for their absence as being due to clinical responsibilities or illness. The case vignette was introduced to the focus group to focus the start of the discussion at a shared point. Members were required to participate for no longer than one and a half hours, although they could leave the discussion at any time.

With participants' consent, interviews and the focus group were audio-recorded and transcribed. Transcription notation was guided by Burman (1994) and is presented below in Table 1.

(.)	Pause
(2)	Two second pause (number indicates duration)
XXX	Untranscribable
(XXX)	Indistinct/doubtful transcription
Word underlined	Emphasis

Table 1 Suggested Transcription Notation (Burman, 1994 pg 69)

This level of detail for transcription was used to provide 'near-verbatim' (Poland, 1995) data

for coding. The level of detail seemed fit-for-purpose given the focus on participants'

language. This had the drawback of not recording interactional aspects of speech delivery,

such as overlap details, however this was not an anticipated focus of the study.

2.2 Data Analysis: Coding Data and Raising Terms to Conceptual Categories

2.2.1 Coding data.

Coding is a process of defining segments of dialogue (Charmaz, 2003; 2006).

Although this may be different according to the individual coding, it begins to sort the data

and initiate analytic interpretations (Charmaz, 2003; 2006; Strauss & Corbin, 1998). Charmaz

(2006) describes an '*initial coding*' phase of naming segments of data, followed by '*focused*

coding' that uses the most significant initial codes to organise the data. See Box 1 for an

example of initial and focused coding for one extract of data early in the analysis.

'*Theoretical coding*' then integrates and provides form to the focused codes by telling a

coherent analytic story.

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Box 1  Initial Coding Example

Participant F (12, 269 – 273)
"But then you sit and think about it, God, they're locked in      Thinking about patients' situation, considering patients as
this place day in day out (.) you know, but their whole life       continuously confined in hospital, suggesting patients'
is so different to what. They are going to get frustrated,         whole lives changed (different to before ABI?), expecting
and they are going to be depressed and. I think they know          patient frustration, expecting patient depression,
why they're doing it [the CB]"                                     suggesting patients know why might be exhibiting CB.


  Focused Coding Example
"But then you sit and think about it, God, they're locked in
this place day in day out (.) you know, but their whole life
is so different to what. They are going to get frustrated,         Expecting patient frustration and depression due to
and they are going to be depressed and. I think they know          situation
why they're doing it [the CB]"                                     Understanding CB as due to situation
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2.2.2. Raising terms to conceptual categories.

Codes were then succinctly defined and analysed, the subsequent categories became

part of the larger theoretical framework and moved away from mere description (Charmaz,

1990). An idiosyncratic process remains, with factors affecting interpretation beyond just the

data. It is hoped that interaction, not just with the participant but with the data, may take

analysis into unforeseen areas (Charmaz, 2006).

Comparative Methods

'Constant comparative' methods (Glaser & Strauss, 1967) were used at each level of

analysis by establishing analytic distinctions within the data (Charmaz, 2006). Comparisons

can be made to find similarities and differences among data properties, within or between

interviews (Charmaz, 2003; 2006; Pidgeon, 1996; Strauss & Corbin, 1998).

Memo-Writing

Rather than discovering order within data, the researcher actively shapes the analysis

(Charmaz, 1990). The writing of memos facilitated the process of taking categories apart and

included comparison between codes, integration of raw data and identification of gaps in the

analysis (Charmaz, 1990; 2003; Pidgeon & Henwood, 1996). See Box 2 for an example of a

memo.

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Box 2 Memo Example   early category: "that's the nature of his injury"

<u>**ABI as causing patient CB**</u>
Relates to the use of ABI as a cause or justification for CB, where CB is presented as a symptom of ABI as well as resulting from specific aspects of ABI such as memory impairment, sensory deficit or slow processing ["impairment" ?? can't help CB, need to be cared for by 'unimpaired', given concessions]. Insight described as variable, but possessing and lacking insight were both causes for CB. Insight was however considered necessary for patient change. Issues of loss frequently introduced by participants. PTA talked about as separate phase of BI – expected following injury, short-lived and CB acceptable as clear physiological causes. Physical causes (related to injury) were also presented as causes, such as pain, constipation, UTI. Participants also talked about traits in personality, current and pre-morbid. Within this ABI was often set in contrast to "PD" "mental health problems" or results of social upbringing.

Relation to <u>Normality</u>: CB normal with ABI population, but abnormal in "community". Links with acceptability of CB in different contexts. Normality also related to staff becoming "blasé" about CB as habituate to it – CB is "part of the job".

Relation to <u>Rehabilitation</u>: idea that rehab brought patients to hospital, therefore staff responsible for providing it (consequently patients reliant on staff). Rehab was also considered the antecedent to patient CB but justified as necessary ("cruel to be kind").

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2.3 Asking More Conceptual Questions

As conceptual categories were raised, data were compared with data and categories

with categories so ideas could be pursued as they developed (Charmaz, 1990). This process

was enriched by using emerging ideas to inform questioning during subsequent interviews.

Memos continued to be written so the existing data could be viewed from a variety of

perspectives as new data was produced.

Theoretical Sampling and Saturation

GT researchers actively sample for the purpose of developing emergent theory, a

process known as 'theoretical sampling' (Charmaz, 2003; 2006; Pidgeon, 1996; Rennie,

1998). In the current study sampling was restricted by the number of participants who gave

consent to be approached. Theoretically, when new data is deemed to add no further meaning

to the codes ascribed to the data in its entirety, the exploration is judged to be 'saturated'

(Rennie, 1998). However, there remains disagreement regarding the actual potential for

saturation (Charmaz, 2003). Notions of 'achieving saturation' within the current study were guided by the reduction of new ideas becoming apparent in the data. Although emerging ideas were tested out in subsequent interviews, participants were also given space to bring and explore new material. The use of this space provided, in part, an indication that little new data was emerging later in the data collection. In addition, the focus group provided opportunity to compare phenomena within a different forum.

2.4 Writing and Rewriting

As the researcher gains further insights and ideas whilst writing up the research, the discovery process continues (Charmaz, 1990). Writing and rewriting clarifies the analysis (Potter & Wetherell, 1987), allowing the simultaneous process of making the analysis more abstract and the grounding of it more concrete (Charmaz, 2003). Arguments and problems are identified, assumptions are made explicit and concepts are sharpened (Becker, 1986). Thus the researcher may need to return to the data in order to address problems that have been raised (Willig, 2003). In addition, findings are integrated with other theories and the literature (Charmaz, 1990).

2.5 Evaluating Social Constructionist Grounded Theory

Positivist quality notions have been considered in qualitative research according to parallel criteria such as 'credibility' corresponding to notions of 'internal validity', 'dependability' to 'reliability' or 'permeability' to 'objectivity' (Morrow, 2005; Stiles, 1993). When considering research from a SC standpoint, the data may be seen as co-constructed through interactions, shared meanings and the perspectives of the researcher, participant and audience (Burr, 1999; Edwards & Potter, 1992; Iantaffi, 2006; Potter & Wetherell, 1987). Issues of subjectivity are embraced, nevertheless a number of criteria for trustworthiness have

been discussed in the literature under an abundance of terms (Whittemore, Chase & Mandle, 2001). These criteria have included using a transparent systematic process, honouring difference and respecting multiple perspectives in participant constructions, examining contextual issues that might impact the data and integrating theory and practice (Morrow, 2005). 'Internal coherence' has been suggested as a quality criterion that evaluates the extent to which an analysis is non-self-contradictory or has 'no abhorrent contradictions' (Madill *et al.*, 2000; Potter, 1996), although inconsistency and variability in participant accounts remain anticipated (Potter & Wetherell, 1987). In order to combat the natural tendency for researchers to seek confirmation for emerging findings (Morrow, 2005) disconfirming instances of phenomena were also sought in the data (Madill *et al.*, 2000; Potter, 1996; Van Maanen, 1988). Once a study is written, there may be differing meanings ascribed to the data for differing audiences or at different times. As such, participants' attended meanings could become distorted (Chiovitti & Piran, 2003). Therefore, the analysis was supported with extracts from the transcripts.

Reflexivity

Iantaffi (2006) suggested that to enable the sharing of personal accounts, a researcher needs to form a relationship with a participant in order to form an atmosphere of trust. Since so much may depend on the relationship between researcher and participant, this unique relationship could form the basis for data. However, how this interaction affects emerging theory continues to be debated (Cutcliffe, 2000). Some argue that the researcher must separate their preconceptions, biases and values from the analysis (Hutchinson, 1993), whereas others believe it is the researcher's creativity throughout analysis that makes GT valuable (Iantaffi, 2006; Turner, 1981). Charmaz (1990) described the importance of the 'researcher perspective', which includes the substantive interests that guide particular questions to be

asked, a philosophical stance or school of thought, and the researcher's personal experiences, priorities and values. The position I took in this study acknowledged my role as researcher in the co-construction of data, as well as the influence of my preconceptions and values throughout the analysis process. A number of issues were addressed to accomplish the goal of foregrounding this subjectivity. It was intended to make my assumptions explicit as the research process unfolded, as much as it is possible to fully know one's presuppositions (Morrow, 2005). This process of reflexivity was endeavoured through the use of a self-reflective journal. See Box 3 for a reflexivity example.

Box 3 Reflexivity Example (from self-reflective journal that made up part of the research diary)

Reflections following Interview
[Participant] asked me if I'd shown anyone the list of respondents (repeatedly) and if people had told me to choose [participant] for interview. [Participant] also made a comment about not being the sort to "cause trouble". Referring to the participant information sheet, also asked me "what can go wrong". These comments / questions make me consider the potential impact of the research process on the participant and also of the impact of me interviewing when I have a history with the service and therefore contact with the hospital outside of research process. I don't remember [participant] from previous post. [Participant] also asked for me, as a psychologist, to tell [participant] how [participant] feels about working with ABI and CB. I wonder about [participant's] expectations about the interview, and also the supposed authority I am meant to have as a psychologist about what people feel. [Participant] also commented "don't show anyone the tape" and "I bet you keep hold of it for the future". I assured [participant] that the recording would be destroyed (as per the information sheet) once the study was completed. [Participant] also commented that "I won't promise to answer your questions". I tried to give assurances that (as per the information sheet) [participant] did not need to answer questions if they didn't want to. Felt on my toes before and during the interview. Found the experience enjoyable but still quite uncomfortable at times. The whole thing made me question myself, my motivations for doing this research and my intentions at the end. Realised I do feel a need to protect the participants who have trusted me with their accounts.

An ongoing record of experiences, reactions and assumptions was made from the instigation of ideas to the completion of the study. It can be considered good practice to disclose at the beginning of a write-up these descriptions in order to help the reader infer the meaning of data to the researcher (Stiles, 1993). Reflexivity was also encouraged through the use of research supervisors (two field and an academic supervisor), a peer debriefer (DClinPsy colleague) and a Qualitative Methodologies Group (DClinPsy peers and member of university staff). These forums encouraged reflection on my responses to the research process, as well as critical discussion of alternative interpretations of the data.

3. Analysis

Within their accounts of patients described as having sustained an ABI and judged to exhibit CB, participants were observed to make attributions relating to CB. The current study presents three central categories of talk that were used in the construction of CB by participants; attributions about internal location and attributions about external location in relation to CB, and combinations of the two. Participant accounts were considered according to specific attributions, as well as the actions performed by these attributions. The "Participant Attributions in Relation to Challenging Behaviour" model is illustrated in Figure 2. These phenomena did not necessarily occur at the same time or in any particular order. Associations between categories were also apparent as different features of the model became relevant simultaneously within participant talk.
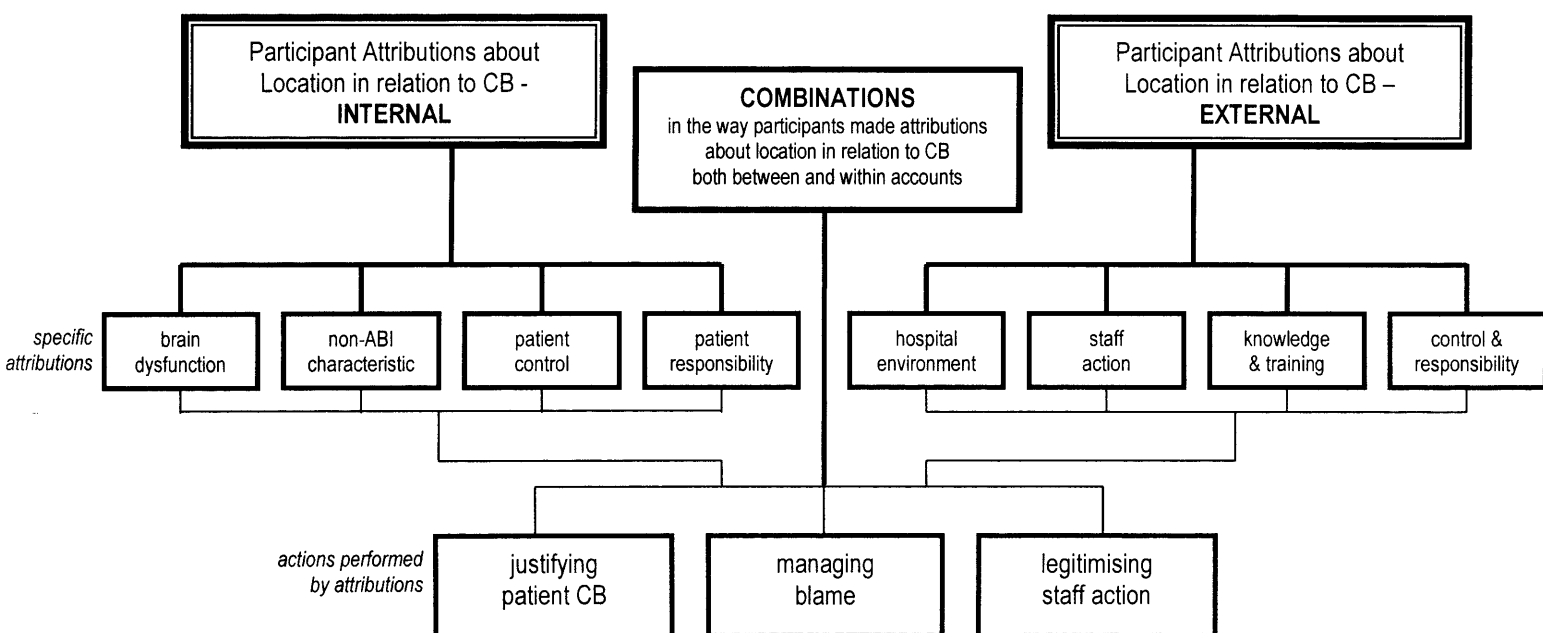
Figure 2 The "Participant Attributions in Relation to Challenging Behaviour" Model

3.1 The "Participant Attributions in Relation to Challenging Behaviour" Model

Throughout their accounts, participants were found to produce attributional talk in relation to particular patient behaviours, referred to as CB. The use of the phrase CB is not

intended to describe a static objectively observable phenomenon. Instead, notions of CB are considered as a way of conveying patient behaviour that seems to be problematic for the people talking about it. Participant B (extract 1)[3] illustrated this idea when relating to the connotations of CB, suggesting it could be considered to alter according to the person labelling the behaviour.

Extract 1

> Well I think it's different for different people, definitely. And we definitely get different sorts of challenging behaviour, so things that I might find challenging other people might not. Or with experience you may become more comfortable with them.   (D: 1, 6 – 10)

The label 'challenging' in relation to patient behaviour was considered to vary according to differences between people and also to change for the same person. For example participant D talked about how the meaning of CB might adjust for someone as their experience altered. Therefore, attributions relating to CB would be expected to vary.

Specific attributions about location in relation to CB will be presented. This will illustrate the ways in which accounts can be categorised. This is not to insinuate that the participants only generated one or other category of attributional talk, merely that distinct examples could be found for each. Participant accounts are considered to perform a number of actions to support particular versions of phenomena, which open up some possibilities and diminish the potential for others (Edwards & Potter, 1992; Gergen, 1985; Potter & Wetherell, 1987). The actions performed throughout participants' attributional talk will be presented according to three overarching categories. These were produced in different ways depending on the location. Exceptions will also be discussed to illustrate ways of attributing that

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[3] Extracts are labelled with the corresponding participant letter and the page of the transcript followed by the line numbers.

operated to minimise the possibility for these actions. Extracts will be presented from the data to support the model's construction.

3.2 The Central Categories

3.2.1 Attributions about location in relation to challenging behaviour – internal to the patient.

Participants attributed patient behaviour to internal factors in a number of ways, including talk relating CB to patient difference as a result of brain dysfunction, lack of judgement and communication problems. In addition, participants talked about non-ABI internal characteristics, such as mental ill health and physical deficit, notions of insight and 'forensic' labels. Moreover, participants made attributions locating behaviour in relation to internal factors of control and responsibility.

3.2.1.1 Brain dysfunction

Throughout the participant accounts, behaviour was talked about in relation to the individual patient's pathology. Participants often constructed patient behaviour as directly caused by the functioning of the brain. This talk was evident in all the interviews and the focus group. For example, participants J and F explicitly attributed CB to brain injury causes ("that's the nature of his injury", extract 2; "this behaviour is caused by their head injury", extract 3).

Extract 2

> Because, you know, that's, that's the nature of his injury.   (focus group J: 44, 1042 – 1943)

Extract 3

> I suppose just working with head injury you're just more <u>aware</u> that that this behaviour is <u>caused</u> by their head injury. And there's a lot of, um, if someone was generally like aggressive in the street you'd just label them maybe a thug, if someone was, um, sexually inappropriate you'd label them a paedophile or (2) someone not right in the head, or whatever. But, when you know they've got a head injury you can relate it to their injury.
>
> (F: 3, 58 – 65)

When describing the experience of a patient displaying inappropriate behaviour, participant J (extract 2) accounted for the behaviour by relating it to his ABI. Participant F (extract 3) described how the same behaviour in a non-ABI community context would be attributed to different internal causes ("thug" or "paedophile"). Therefore, it was proposed that knowing a patient had sustained an ABI provided a causal explanation for the behaviour ("when you know they've got a head injury you can relate it to their injury") and differentiated the patient behaviour from that exhibited by others. In order to explain the way ABI caused CB participants related aspects of talk to notions of "damage" (extracts 4 & 5).

Extract 4

> Because of part of their, their <u>brain</u> that's damaged.   (F: 4, 79)

Participant F was asked why they thought some ABI patients might exhibit CBs. By attributing CB to damage to the brain, participant F unambiguously located the CB within the individual patient (extract 4). Participant B referred to how brain damage resulted in CB (extract 5).

Extract 5

> Yeah I think that different parts of the brain, or whatever, I think control different emotions and, you know, give you a little bit of, sort of, well that's okay that's not so okay. And I think that when certain parts of the brain are damaged, I think, yeah definitely. You just, it, you don't see anything wrong with, um, walking up and punching people or being verbally aggressive to people or. Yeah, I do think that once the brain is damaged it obviously affects the, the chemical, (.) chemicals in the brain, and what's given out where, and what's produced and what's not, yeah, um (.) It's the way it is,   (B: 21, 496 – 506)

When talking about a patient's capacity to change their behaviour and the potential for an ABI to change a patient, participant B introduced the idea that brain damage affected the chemicals in the brain. It was suggested that damage caused the loss of judgement to direct the patient about right or wrong actions ("don't see anything wrong"). This lack of judgement was provided as a rationale for the patient exhibiting problematic behaviours.

Participants also referred to patients' expressive communication problems. Here patient behaviour was often described as a form of expression, typically in terms of patients being unable to communicate in other ways due to the effects of the ABI.

Extract 6

> what brain injuries do to people   (D: 16, 369 – 370)
> what your life would be like every day if you couldn't, that you had to wear incontinence pads all the time because you couldn't control yourself. And you know, you couldn't, you can't communicate that you've been incontinent so you're left sitting in your own faeces or urine and (.) I mean. To me, you know, you would start behaving in a different way which could be seen as challenging.   (375 – 381)

Participant D (extract 6) explained that within these circumstances (the patient "can't communicate") patient behaviour was understandable ("you would start behaving in a different way"). Here the patient's behaviour was constructed as a form of communication in itself as a way of conveying to staff a need (to have personal care attended to) that could be judged as challenging. Similarly, when talking about explaining to colleagues about a

patient's CB following an incident, participant A referred to the patient's capacity to express themselves (extract 7).

Extract 7

> You know, they don't mean it, you know, its just a, a way of expressing themselves if they can't think of anything, if they can't express it the way you or me would express it, so.
>
> (A: 32, 741 – 744)

In this extract CB was constructed as something unintentional ("they don't mean it") which was explained by describing patients as different to "you or me" *because* of their expressive deficits.

For some participants, attributions about CB being internal to patient brain dysfunction were supported with talk about the consequences of failing to attribute CB in this way.

Extract 8

> A lot of them if they're hit by a patient or a patient abuses them, they almost take it personally, you know, they don't think it's because of the injury.   (F: 15, 351 – 353)

Participant F talked about staff mistakenly taking aggressive behaviour "personally" if attributions were not related to ABI (extract 8).

3.2.1.2 Non-acquired brain injury (ABI) characteristic

Participants also talked about non-ABI internal characteristics in relation to patient CB. This was evident in five of the interviews and the focus group. Notions of CB were considered according to staff opinions about its cause. When talking about how staff might consider a patient's CB and how the patient might experience staff intervention, participant H referred to the formulations available to explain a specific patient's CB (extract 9).

Extract 9

> trying to ascertain whether it's his brain injury or whether it's his, um, anxiety disorder, um,
> that, that, that's apparent, um, and his mental health problems. Which of <u>those</u> actually, um,
> feed into, if you like, his need to, to punch people. (2) And, you know, at <u>that time</u>, you know,
> to me it was his anxiety that, that seemed to, to be over, <u>over it all</u>,   (H: 13, 288 – 294)

Alternative reasons were presented as potentially initiating CB ("actually, um, feed into, if you like, his need to, to punch people"). Within this extract participant H separated notions of "anxiety disorder" and "mental health problems" from "brain injury". Each of these causes were located within the patient as participant H talked about "his" ABI, anxiety or mental ill health.

Attributional talk relating to non-ABI internal causes for patient behaviour also included 'physical deficit', which was considered as an antecedent to CB. For example, when asked about why ABI patients might exhibit CB, participants E and D both talked about physical functional deficits (extracts 10 & 11).

Extract 10

> Um, <u>so</u> (2) with all the losses, the physical deficits, the, sort of, the sort of, the <u>functional</u> stuff,
> it's not surprising.   (E: 20, 463 – 465)

Extract 11

> It's just so, so, physical issues, things that they <u>can't</u> do. You know, its somebody who was
> quite proud, you know, quite an independent person who can't wash themselves, is going to
> get pissed off with it.   (D: 15, 347 – 351)

It was suggested that CB might be expected ("it's not surprising", extract 10) when the functional or physical losses experienced by some patients were considered and CB was therefore considered a reaction to this physical disability ("going to get pissed off with it", extract 11).

Participant attributional talk also included notions of insight. The concept of insight into the impact of ABI was considered to relate to patient CB in a number of ways. For example, when asked why some ABI patients might exhibit CB, participant B (extract 12) talked about the idea of patient insight into ABI as triggering a "fight for survival" originating from "human nature".

Extract 12

> You know, and I can understand, you know, if you've got, um some insight into your injury, you know, and (.) I can understand people being aggressive, you know when people see what they've lost, they <u>know</u> what they have lost, and yeah, I can understand that. Fight for survival, you know, being <u>bitter</u>, you know I should think its horrendous. (2) you know, yeah (.) it's the first thing that comes out of human nature I would have thought (.) um definitely.
>
> (B: 8, 178 – 186)

CB was therefore constructed as a natural response to the losses resulting from ABI. Participant B argued that CB was understandable if a patient had an awareness of their losses, suggesting this would cause "bitterness" and thus the exhibiting of CB. Insight was also constructed as something that came and went for patients (extract 13).

Extract 13

> So, and then he, sort of, turned round and looked at the chap that was at his arm and said "it was, for this lanky" you know, "for this lanky streak of <u>piss</u> here", and then of course the aggression started again you see. But it was for that fleeting second or (.) <u>minute</u> he'd got that, sort of, insight. (E: 7, 153 – 158)

Within this account the patient was described as having no insight at the time of exhibiting CB, with a solitary "fleeting second or (.) minute" of insight demonstrated by his admission of person directed aggressive behaviour "for this lanky streak of <u>piss</u>". Notions of insight in relation to patient behaviour therefore seemed mixed in the participant accounts, with some talk ascribing insight into losses associated with ABI as a cause of CB whilst other talk suggesting changeable insight into behaviour was associated with CB. Nevertheless, accounts

relating to insight seemed to locate CB within the patient as it was their intact or lost insight that was used to explain CB.

Participants' internal attributional talk also included ideas ascribing 'forensic' characteristics to some patients. For example, participant E (extract 14) talked about how the behaviour exhibited by patients could be categorised as either "forensic" or "typical head injury".

Extract 14

> But it's also the <u>patients</u> now come in that premeditate, people set traps. And whereas we, a lot of our patients don't <u>have</u> that ability, you know, it, it <u>is</u> very (.) spontaneous, at the time, that's it. You know, <u>you know</u> this person <u>will</u> become aggressive at such and such, such and such, such and such and so therefore you have all the systems in place. But now we have patients who set traps, who will premeditate, who know <u>exactly</u> what they are doing and try and isolate staff and then attack them. And I suppose that is, that is, that is the biggest challenge <u>now</u>. It's more, sort of, forensic behaviour rather than a typical, what they classify as a typical head injury behaviour.   (E: 10, 230 – 241)

Here, descriptions of how some patients "set traps", "premeditate", "isolate" and "attack" staff were provided in contrast to patients who were incapable of premeditating problematic behaviour ("don't <u>have</u> that ability") and instead exhibited predictable ("<u>you know</u> this person <u>will</u> become aggressive") "spontaneous" behaviours. For patients who were considered to display 'forensic behaviour' there was an impression of choice (patients "who know exactly what they are doing").

3.2.1.3 Patient control

Specific participant attributions about location in relation to CB included notions of control. This talk was evident in all the interviews and the focus group. Notions of control were often considered to be located within the patient (although also related to externally

located attributions). When asked about whether patients might have control over their CB, participant E talked about differences between patients (extract 15).

Extract 15

> I don't think you can say in head injury they do have control or don't have control because its very, very much dependant on that patient, you know, their physical and mental, sort of you know, disability.   (E: 22, 523 – 527)

Participant E explained how ascriptions of either patient control or lack of control could not be globally made as such judgements would be guided by the individual patient's specific "disability".

Nevertheless, many of the attributions made regarding control in relation to problematic behaviour *could* be split as either describing lack of patient control or patients possessing control. Within the former type of talk (patient lack of control) participants typically associated it with brain damage. For example, the notion of patients not knowing right from wrong as a symptom of ABI was discussed previously (extract 5). Ideas of patient lack of judgement were also considered to account for patient lack of control (extract 16).

Extract 16

> (5) For me, control is (2) is about (.) I suppose if you're talking about control of behaviour, for me personally in the world control of your behaviour is being able to self monitor, to be able to stop yourself, you know, it's the, the id's telling you to do something, but you've got to have that, that <u>internal</u> control of being able to say no that's, it's the knowing of what's right and wrong, what's socially acceptable, what's not socially acceptable. Em (.) and again that's something that the majority of the patients that have had head injuries, they lose some aspect of that ability to self monitor, to be able to self, you know, self regulate. They lose the, they lose the ability to recognise what's socially acceptable and what's not socially acceptable, you know, what's right and what's wrong.   (D: 20, 462 – 474)

Participant D referred to patients losing the ability to self monitor as a result of head injury.

This was presented as a prerequisite for possessing control ("control of your behaviour is

being able to self monitor"). As patients could be considered to lack the ability to self-monitor as a result of their brain damage, patients might not be expected to demonstrate control over their CB ("they lose the ability to recognise what's socially acceptable"). Notions of 'lack of control' were therefore produced explicitly in participants' accounts. However, participants' brain dysfunction talk, such as setting up ABI as the cause for CB (extracts 3 & 8) and relating CB to brain damage (extracts 4 & 5) or the nature of brain injury (extract 2), also seemed to imply lack of control.

Within the latter type of talk (patients having control) patients were considered as choosing to exhibit CB. For example, participant F described occasions where problematic behaviour was considered to be deliberately displayed (extract 17).

Extract 17

> And there have been occasions where I think patients have deliberately displayed challenging behaviour to get the attention from staff. Em, even if it's the opportunity of, if you're just sitting down with the patient and saying you've done wrong, you shouldn't be doing that, you should know better or whatever. Just simply by spending time with them they're having attention, which a lot of them crave. I do think some of them do have some control over it. (F: 7, 155 – 163)

It was suggested here that the aim for these patients was the gaining of staff attention. The implication seemed to be that if patients had a motive then they could be considered to demonstrate control. Although, interestingly participant F did not close down the possibility for no control, as "some" patients and "some control" were referred to. The retention of control by some patients might be inferred from accounts relating to brain dysfunction, such as the idea that CB was a form of communication (extracts 6 & 7). Similarly, this could be found in some of the non-ABI internal characteristic talk, for example associating CB with a reaction to physical deficits (extract 11) or intact insight into losses (extract 12). Interestingly, within these extracts the speakers seemed to be making allowances for patients despite indicating that

they were in control of their behaviour. Perhaps this was managed by the implication that patients had no other choice or that their 'reactions' were understandable. Whilst discussing in the focus group the idea of patient intent behind CB, participant I (extract 18) talked about the acceptability of CB in relation to notions of control.

Extract 18

> I think you accept it more from knowing that they can't control it, or they're not going to remember doing it. Whereas if it's someone that that's got a fair old grin when they've done it, it   (focus group I: 34, 807 – 810)

Participant I described finding it easier to accept patient CB if attributions were made that the patient had no control over the behaviour. This was contrasted with the idea of a patient who seemed to take pleasure from CB ("got a fair old grin") insinuating some notion of choice and thus control over the behaviour. It was such less justifiable CB that staff might have had more difficulty accepting from patients.

3.2.1.4 Patient responsibility

Participants also made specific attributions of responsibility in relation CB as internal to the patient (also produced in relation to externally located attributions). This talk was evident in all the interviews. As with control, attributions relating to responsibility were often mixed. Once more participants talked about their attributions being dependent on the individual patient.

Extract 19

> Um, I don't think everybody has responsibility. Um, in my, sort of like, experience some people have absolutely no responsibility for their behaviour, whereas some patients can have quite incredible amount of responsibility.   (A: 30, 707 – 710)

Participant A (extract 19) explained how not all patients could be considered to have responsibility for their behaviour, although some could ("absolutely no" or an "incredible amount of responsibility"). Like that of control, responsibility was considered to vary for a single patient. When asked about the potential for patients to be considered responsible for exhibiting CB, participant B (extract 20) suggested that ascribing responsibility was reliant on judging the capacity of the individual patient.

Extract 20

> but I think, it depends on the patient. I mean, I've got a patient downstairs now that's very high level, I think he has some responsibility yes. You know, he's quite pleasant at the moment and, you know (.) yeah I think he's got responsibility definitely. You know, he can either take things plain sailingly or he can, he can, er, cause havoc. And hopefully he won't. But, um, a patient, some of the patients that I see haven't got, no haven't got any responsibility at all, you know, they're too bloody impaired. (B: 17, 393 – 401)

A patient was described who was claimed to demonstrate responsibility because of his variable presentation and implied choice to "cause havoc". Yet, other patients were described as demonstrating no responsibility. It seemed that attributions relating to responsibility could be guided by perceived impairment ("very high level" or "bloody impaired") with increasing impairment being associated with decreasing responsibility.

3.2.2 Attributions about location in relation to challenging behaviour –

external to the patient.

Participant talk attributing patient behaviour to external factors was undertaken in a number of ways, including reference to influences of the hospital environment and the actions of staff. In addition, participants produced talk associating patient behaviour with level of staff knowledge and training and external notions of control and responsibility.

3.2.2.1 Hospital environment

Participants could be found to attribute CB to the environment in which patients were situated. This talk was evident in seven of the interviews and the focus group. For example, when asked if a patient might be considered to have control over their CB, participant B accounted for patient behaviour by relating it to boredom due to the hospital environment (extract 21).

Extract 21

> I think, um, I think some patients sit there and are generally not, generally not stimulated, um (.) and are, and are <u>bored</u>. Definitely, yeah one hundred percent sure of that because I see it all the time, but you, you know, you can't stick a hundred therapists on the ward and do a hundred sessions a day, it's just not viable. But, yes, it's definitely the patients that sit on wards (.) they're bored. What else do you do? You go for a smoke, you go to the toilet (2) have another smoke and to the toilet, and perhaps another smoke and then the toilet. And then (.) you know, somebody says something you don't like and you go, you know. Some patients are definitely <u>reinforced</u> by that, you know, they're pinned to the floor and (.) they <u>enjoy</u> it, definitely.   (B: 12, 275 – 288)

Participant B explained that patients were "definitely" "bored", which was considered to be a recurring happening ("I see it all the time"). The argument was illustrated with examples of an average patient's boring day ("What else do you do? You go for a smoke, you go to the toilet (2) have another smoke and to the toilet, and perhaps another smoke and then the toilet"). Participant B suggested that the boredom due to the environment translated to patient CB ("you go") because the consequence of the behaviour was stimulating ("definitely <u>reinforced</u> by that", "they <u>enjoy</u> it"). Such an extreme formulation of the staff input required ("one hundred therapists") arguably acted to warrant staff could not reasonably be expected to do more that they are doing ("it's just not viable").

3.2.2.2 Staff action

Specific participant attributions about external location included ideas surrounding the actions of staff as either directly causing or exacerbating patient CB. This was evident in all the interviews and the focus group. Participant B (extract 22) talked about staff actions determining the outcome of a CB incident and as having "nothing to do with the patient at all".

Extract 22

> You have two scenarios don't you, you, you can find. And it's nothing to do with the patient at all, it doesn't matter if, a patient can do <u>whatever</u> he's doing, whether he's hooking the curtains down, he's breaking the windows, he's, he's (.) calling you a twat, <u>or</u> he's just being plain awkward. You've got two scenarios, you can either think I'm Mr Big, you can do it my way, and then it all goes pear shaped. <u>Or</u>, you can look for a compromise. And sometimes just that tiniest little compromise could defuse a situation, and make everything just that little better. Definitely, definitely. Oh Yes. I've seen it many a time.   (B: 27, 619 – 629)

It was suggested that staff had a choice regarding their actions, either thinking "I'm Mr Big", which was implied to result in the unsuccessful management of the CB ("it all goes pear shaped"), or considering "compromise", which was presented as a favourable alternative ("make everything just that little better"). CB was also constructed by participants as resulting from specific expectations being placed on patients (extracts 23 & 24).

Extract 23

> You might think it was unpredictable, but we found it was usually quite predictable really, it was when you were putting pressure the patient to do something. Um, so if we were placing any expectations on the patient then they would engage in some sort of behaviour to try and put you off, because they were anxious or they were trying to avoid it.   (G: 107 – 113)

Participant G (extract 23) considered CB to be predictable because it usually followed expectations being made of patients. It was suggested that staff demands were an antecedent to CB because patients would use CB to escape or avoid activities. Participant E discussed

how some staff interventions exacerbated CB as they did not correspond with the way patients might have operated outside of the hospital (extract 24).

Extract 24

> And part of that is obviously the, you know errorful learning. But I have to, I <u>have</u> to admit, prior to coming to ...*hospital* I, I never did that. I <u>never</u> wash my face and then, you know, just systematically through. And a lot of patients that come in, their <u>not</u>, so it's not <u>natural</u> to them, it's <u>not</u> actually natural for them to do it, you know. "Why do I have to fucking wash with that flannel, why can't I just fucking use my". And of course you're stood there and you're going, you're thinking actually that's quite reasonable, do you know what I mean. I <u>do</u> actually think that's quite <u>reasonable</u>.   (E, 21, 478 – 488)

It was described how the participant themselves would not have operated according to "errorful learning [*sic*]" techniques prior to seeing it demonstrated at the hospital ("I never did that") and therefore its unnatural features might be understandably provoking for patients. Consequently, it was suggested that reactions from patients were "quite reasonable".

3.2.2.3 Staff knowledge and training

When making attributions about external location in relation to CB, participants also included notions of staff knowledge and necessity for training in their accounts. This talk was evident in all the interviews and the focus group. Throughout the accounts there was a theme surrounding expectations that staff should possess certain knowledge. For example, when asked about notions of predictability in relation to CB, participant A (extract 25) referred to knowledge about triggers.

Extract 25

> Um, it's just a case of knowing patients, and knowing that (.) certain things will will trigger this off   (A: 19, 445 – 446)

It was suggested that predicting CB was based on "just a case of knowing patients". Avoiding CB was therefore attributed to external staff factors. However, there were also examples of participant talk relating to lack of staff knowledge. For example, when discussing in the focus group ideas associated with reactive as opposed to preventative interventions, participant J considered notions of staff "experience" (extract 26).

Extract 26

> Lack of experience (2) somebody that doesn't know, or had the role modelling of how to deal
> with a, an outburst of aggression in the correct way, (.)   (focus group J: 19, 450 – 452)

Lack of experience was associated with lack of staff knowledge. This was also related to lost opportunities for staff to receive role modelling from more experienced staff. Participant J inferred that this lack of experience and knowledge could translate into the incorrect management of patient CB.

One solution to increasing staff knowledge and their ability to anticipate patient CB (extract 25) and react appropriately in order to manage CB (extract 26) was often related to issues of training.

Extract 27

> we do need to do more awareness of (2) brain injury, at these other, sort of, mental
> disorders, um, that we do because, because we don't just have pure-bred aggressive
> behaviour anymore, and, and therefore there is going to be a difference, I feel, in the way that
> you, you (2) address somebody with challenging behaviour, um. If you, you know, trying to
> understand where the, the root cause of it is.   (H: 21, 493 – 500)

Participant H (extract 27) referred to a change in the type of patient admitted to the hospital ("we don't just have pure-bred aggressive behaviour anymore") and suggested that this change had a direct impact on the way that CB needed to be managed ("therefore there is going to be a difference"). It was suggested that staff needed further training in order to comprehend the

reasons behind patients' CB ("trying to understand where the, the root <u>cause</u> of it is"). It was implied that increased staff awareness and understanding might alter the outcome of incidents.

3.2.2.4 Staff control and responsibility

Participants were also found to make specific attributions in relation to notions of control and responsibility as external to the patient. This talk was evident in seven of the interviews. For example, participant G (extract 28) argued that "we [*staff*] <u>do</u> have the control over the patients".

Extract 28

> Well we have, we have the control. Um (3) it's how we <u>use</u> it really. We <u>do</u> have the control over the patients, we. I think (.) we can feel out of control if we've got a patient and we haven't got an adequate programme in place, and then when people feel like they're not in control of the situation they, for, you know, for <u>safety</u> reasons, then I think that they can feel, then, people then, because there's no regulated programme in place then (.) all sorts of things can happen, all sorts, you know, with patients. Um, I think if the staff feel that they're trained and they're supported and they are with experienced staff then they feel more relaxed about, they don't feel so controlling towards the patient. I think the more anxious people are the more controlling they become over the patients, which makes the situation <u>worse</u> really, (.) because they're trying to just like regulate everything. (G: 14, 311 – 345)

Participant G talked about intervention programmes in relation to staff control. An inadequate programme was presented as the reason for staff feeling out of control. One might presume that here an "adequate programme" might equate to controlled patient CB. Staff becoming overly controlling was constructed as detrimental ("which makes the situation <u>worse</u> really"), implying that staff control related behaviour could have a relationship with patient CB. Excessively controlling behaviour by staff was associated with staff anxiety due to deficient training or support. There seemed to be an implicit suggestion that staff had a responsibility to maintain control. Participant F referred explicitly to notions of staff responsibility (extract 29).

Extract 29

> I think it, there's a lot of responsibility because all of the patients are in our care and they're
> all vulnerable and they're all here for a reason. We're the one writing careplans and writing
> behaviour programmes and kind of the ones calling the shots and directing the rehab. So, a
> lot of the responsibility lies with us. (F: 9, 209 – 214)

Here, participant F suggested that staff were responsible for patients because they had been

placed in staff's care ("all of the patients are in our care and they're all vulnerable"). The

attribution of responsibility as located with the staff was also reasoned according to the

necessity for patient admission ("they're all here for a reason"). Although there were many

accounts of staff having responsibility, participants also talked about circumstances where

staff were not considered to be responsible for CB. For example, participant C (extract 30)

reasoned that ascriptions of responsibility were dependent on potential for prevention of CB.

Extract 30

> You know, there's situations where there are some patients who just switch and go, and I
> don't think you can do anything about preventing that, you know, and sometimes you can't
> even tell what the trigger is. You know you can work a lot and never get anywhere, and in a
> sense I wouldn't take any responsibility for that. But there are some situations where you can
> see, um, it progressing and, um, you know. (C: 14, 332 – 338)

It was suggested that incidents of CB that occurred without an identifiable antecedent could

not be prevented and as such staff could not be responsible for it. Whereas, it was implied that

if a member of staff could recognise an antecedent then they would consequently be

responsible.

3.2.3 Combinations of attributional talk about location.

Within and between their accounts, participants could be observed to make different

attributions in relation to CB at different times. Categories of internally and externally located

attributional talk have been revealed by the analysis thus far. However, this is not to imply

that participants were found to make only internal *or* external attributions in their talk. Each

participant produced accounts that could be positioned within both the internal *and* external

central categories and combinations could also be found within the same extracts of talk. For

example, participant D (extract 31) can be seen making internal and external attributions in

relation to a patient's aggressive behaviour.

Extract 31

> If you remind somebody of their ex-wife, or ex-husband or sister that no longer speaks to
> them and they target you because of that and your seeing lots of aggression that's targeted
> towards you, if you don't know <u>why</u>, if you can't understand why this is happening and how
> they're processing information and how they, you know, the things that their brain will or will
> not allow them to do then (.) of course you're going to take it personally.
>
> (D: 12, 270 – 278)

This talk opened up the possibility that CB could be accounted for according to the internal

functioning of the brain ("the things that their brain will or will not allow them to do") due to

information processing difficulties. However, the opportunity to make external attributions in

relation to CB was created as participant D talked about staff taking it "personally" because

they did not possess the understanding regarding the patient's pathology ("if you can't

understand why"). Another example is participant K's account relating to the potential for

patients to control their CB (extract 32).

Extract 32

> Some are premeditated and some are more, sort of, <u>reacting</u> to a change in their
> circumstances. People can still react quite negatively um to that end, even though you can
> clearly see that a lot of the time it's completely out of their control, they just can't control that
> element within them. (focus group K: 33, 782 – 786)

Participant K attributed CB internally to the patient ("Some are premeditated", "it's

completely out of their control") and made external attributions in relation to CB

("reacting to a change in their circumstances"). Participant K seemed to manage the combining of attributions by weakening the internal attribution, referring to it as but an "element within them [*patients*]".

3.3 Actions Performed by Participant Attributions

Within the current study attributions are considered to be constructed and reworked within accounts to support particular possibilities and close down others. Three fundamental categories of action were observed in the data, including the justification of patients behaving in a challenging manner, the legitimisation of staff actions and crucially the management of blame that might have been directed at staff or patients.

3.3.1 Justifying patient challenging behaviour (CB).

Patients' exhibiting behaviours that were considered by participants to be problematic had the potential of leaving staff with a dilemma concerning how they might be expected to react. For example, participant B (extract 33) described the initial appraisal of an incident of directed physical aggression.

Extract 33

> he swung his legs out, put his shoes on, stood up and chinned me (2) you know, I didn't know, I never knew quite how I'd react to somebody punching me, because, you know, your first reaction is self-defence and, you know, I thought yeah would I punch him back? But I didn't punch him back, I ducked his second one thank God because the first one hurt. And then he kicked me, and kicked me and kicked me, you know, and then he was restrained. But, (.) I don't take that personal, I don't take that personal at all, because, you know he's (.) it's just how he is.   (B: 7, 154 – 164)

Participant B described how the first reaction to being punched was "self-defence" and to "punch him back". It was explained that the patient was not retaliated against as participant B illustrated the continuation of the physical assault ("And then he kicked me, and kicked me

and kicked me"). This lack of action was rationalised by locating the cause of the CB as not personal ("I don't take that personal at all") but instead situated within the patient ("it's just how he is").

Interestingly, participant accounts seemed to contain talk that opened possibilities for justifying the CB exhibited by patients. Internal attributions often inferred that the behaviour was understandable. For example, when participant B (extract 12) talked about CB in the form of a "fight for survival" due to internal "human nature" is was implied that *anyone* would react in this way following ABI. Participant D, in the account relating to communicating incontinence through CB (extract 6), also suggested that anyone would be expected to exhibit CB in a similar circumstance ("you would start behaving in a different way"). Similarly, participants E and D (extracts 10 & 11) suggested that CB was understandable as demonstrated by their accounts of physical deficits. In addition, participant H (extract 9) talked about CB as necessary in the description of a patient's "need to, to punch people". The idea of a "need" may have connotations of necessity, requirement or even compulsion, thus potentially validating the actions of a patient. Allowances for patient behaviour were also apparent in the external attributions participants' made relating to CB. For example, where participant B (extract 21) talked about boredom due to the environment as a precursor to CB it was suggested that patients had nothing else to do but exhibit CB ("What else do you do?"). External environment talk also implied that anyone might display CB if they too were in the hospital environment.

Participants seemed to comfortably explain some patient behaviour yet grapple with reasoning others. What seemed to pervade some accounts was an impression that working experiences were somehow different to the norm. For example, the idea that the hospital environment was unlike the "outside world" was considered (extract 34).

Extract 34

> Because it's not (.) it's not like the outside world and, you know, we <u>are</u>, sometimes we are
> just a little bit, sort of, <u>contained</u> within the ward that we're on and you sort of, you know,
> people are here because they, because they <u>present</u> with challenging behaviour and so you,
> you almost enter your own little world when you walk onto the ward in the morning, but (.) it's
> the realisation that in actual fact, you know, there are twelve, you know, twelve very <u>ill</u>, for
> want of a better word, people there and you do have to get involved in, in, in thing,
> challenging behaviour. But it <u>is</u> so <u>different</u> from, from the outside world and.
>
> (H: 6, 139 – 149)

Here, participant H described how staff felt "contained" within the environment created by the

ward as they entered their "own little world". Within this distinct situation, CB became

normal. By combining the way attributions about location were made, participants were able

to account for these unique circumstances. For example, by drawing on internal attributional

talk ("twelve very <u>ill</u>, for want of a better word, people") as grounds for patient CB the

existence of CB was justified. By employing external attributional talk regarding the duty of

the staff "to get involved in" CB a rationale for why they might endure the CB was provided.

      However, not all patient CB was considered to be justified within participants'

accounts. For example, participant G (extract 35) talked about how a patient might "seriously

injure a member of staff" without recrimination.

Extract 35

> I, I mean I know that any patient can go out and do something in the community (.) and er, or
> seriously injure a member of staff but <u>nothing</u> would be done about it because they're in a
> mental hospital. Um, with some patients that would be acceptable to me because they're,
> they're very ill, or, very brain damaged or whatever. But not necessarily all of them.
>
> (G: 580 – 586)

This account was supported by attributions relating to internal patient pathology ("because

they're in a mental hospital", "they're very ill" or "very brain damaged"). However, it was

stated that *not all* CB could be accounted for by such internal attributions, implying that some

was unacceptable. Minimising the possibility for justifying problematic behaviour was therefore also apparent. In addition, accounts relating to "forensic" characteristics (extract 14) and the potential for ascribing control (extracts 14, 15, 17 & 18) or responsibility (extracts 19 & 20) to patients might have reduced potential for making allowances.

3.3.2 Legitimising staff action.

Staff interventions could be considered as staff 'doing to' patients (Wilcox, Finlay & Edmonds, 2006). This interpretation potentially places staff in a position where their actions might necessitate defending. Participant B (extract 36) provided an account describing a reaction when new to the job ("from my outside thoughts") to a patient restraint.

Extract 36

> I tell you there's something else I found horrendous when I come to ...[*ward*] and that was a chap in a wheelchair that was, that was, I suppose really from my outside thoughts of, I've seen it after only being on...[*hospital*] for some time, it was like having a spastic in a wheelchair and you've got five people restraining him; a guy in a wheelchair and you've five people, I thought that was horrendous, I thought that was shocking, you know.
>
> *And, um, what was shocking about it?*
>
> Five, five people holding a guy down that can hardly, couldn't walk or anything, and he's
>
> *So, like, it was unnecessary?*
>
> It was necessary mate, he was really aggressive (*laughs*)   (B: 35, 817 – 830)

Participant B described witnessing the patient restraint as "horrendous" and "shocking". It was suggested that the actions of the staff were excessive ("it was like having a spastic in a wheelchair... five people holding a guy down that can hardly, couldn't walk or anything"). However, when asked if the intervention was deemed unnecessary, participant B argued that the actions of staff were required ("It was necessary mate"). This account seemed to illustrate the possible judgements of a person outside of the hospital whilst inferring that these

judgements would be misinformed as the appearance of the patient ("a spastic in a wheelchair") was misleading ("he was really aggressive").

Talk relating to internal notions of lack of patient control over (extract 16) or responsibility for (extracts 19 & 20) CB may have functioned to justify staff acquiring control over patients and taking responsibility. Conversely, talk attributing patient control and responsibility over problematic behaviour may also have acted to warrant staff lacking control. Where patients were constructed as having control yet persisting in exhibiting CB (extract 17) or they were considered to be responsible for their behaviour (extracts 19 & 20) staff might have been expected within their role to maintain control and responsibility. Participants could also be found to explicitly locate control and responsibility with staff due to patients' specific needs ("they're all here for a reason", extract 29) and notions of safety (extract 28). Here, staff interventions might be warranted as necessary for the patient's sake.

Participant accounts also seemed to legitimise inaction on the part of staff. Typically, such talk was associated with the idea that patient CB should not be taken personally by staff (extracts 8, 31 & 33). The construction of patient behaviour as non-personal to staff was often achieved by participants through drawing on patient brain function, non-ABI internal characteristics and hospital environment talk. Accordingly, if the CB was deemed to not be directed at a member of staff personally then retaliation might not be regarded as necessary.

3.3.3 Managing blame.

The allowances made for patients through attributions that justified displays of CB and for staff through attributions that legitimised their actions seemed to collectively open opportunities for participants to manage blame. This was accomplished in different ways depending on the attributions made about location. Aspects of participant talk were found to

imply that patients would not be expected to operate as other people would. For example, accounts relating to ABI (extracts 2-4) could have connotations of the brain not working as it should. Reference to reduced patient judgement (extracts 5 & 16) minimised the expectation that a patient would be even aware of a need to adapt their behaviour. Attributional talk relating to patient lack of control (extract 16), responsibility (extract 19) or changeable insight into their actions (extract 13) opened the possibility that patients would not be held accountable for something beyond their capacity. Accordingly, patients might be protected from blame. Participant accounts were also found to include the idea that CB could be understandable. For example, participants talked about problematic behaviours in relation to patients' reactions to the environment (extract 21), possessing insight into losses (extract 12) or lacking alternative options (extract 7). Furthermore, patient behaviour was associated with the actions of staff (extracts 22-24), including their inadequate knowledge (extracts 26 & 27), and thus minimising the construction of the patient as blameworthy.

Aspects of participant accounts also seemed to function to protect staff from blame. For example, talk relating CB to internal patient factors might suggest staff could not be accountable for something originating inside someone else. Accounts attributing CB to service factors, such as omitted role-modelling (extract 26) or undersupplied training (extract 27), might have suggested individual staff should not be blamed. Similarly, talk relating to a change in patient group (extract 27) and an inability to increase staff resources (extract 21) might have minimised the ascription of staff as blameworthy.

Nevertheless, not all attributional talk could be found to protect patients or staff from blame. Accounts relating patient control and responsibility with level of impairment (extracts 15 & 20) opened up the possibility for blaming patients who could be considered to possess a milder impairment. Furthermore, within accounts indicating that some patients deliberately displayed CB and were regarded as retaining some control (extract 17) or were deemed to be

responsible (extract 19), patients could be considered no longer protected from blame. Similarly, participant attributions could also be seen to construct staff as blameworthy. For instance, where staff were described as holding control over (extract 28) and responsibility for patients (extract 29) the occurrence of CB might be associated with a staff failure to identify and prevent it. To construct staff as lacking control or responsibility might have acted to reduce this blame. However, this might have also portrayed staff as ineffective. Participants could be found to manage this in their talk, for example participant G accounted for change (modification of patient CB through staff intervention) whilst maintaining that behaviour was internal to the patient by mixing internal and external talk (extract 37).

Extract 37

> I mean I remember there was a patient that I worked with, and he was always er (.) people were saying to him, he kept flicking his ash on the floor, but if they put him at the the table there and the ashtray there, and he's flicking his ash on the floor it looks like he's wilfully doing it. But because he's got, he had left-sided neglect, if you just changed it around and he'll do it. It's just little things like that, little things that if you learn about how their head injury might have affected them, (G: 13, 292 – 300)

Here, the patient's behaviour ("flicking his ash on the floor") was presented as caused by the combination of the patient's ABI ("he had left-sided neglect") and the external actions of staff ("they put him at the the table there and the ashtray there"). The suggested solution to the patient's problematic behaviour was an alteration in the staff actions ("if you just changed it around and he'll do it"). Yet, the existence of internalised patient attributions provided a means of deflecting blame if the CB continued. Therefore it could be said that this account constructed staff as effective in changing patient CB without negating notions of CB as internal to the patient.

The analysis will now be discussed in relation to the literature and its methodological limitations. Implications for clinical practice will be considered as well as possible areas for future explorations.

4. Discussion

4.1 Interpretation of Findings in Relation to the Literature

The current study was interested in the ways participants talked about patients who were described as ABI and deemed 'challenging'. Participants' accounts were considered to include attributions about location in relation to CB. Three central categories of talk were observed. In the first instance, attributions relating to CB as internal to and external from the patient were apparent. However, participants were also found to combine internally and externally located attributional talk. Specific internally located attributions were found surrounding notions of patients' brain dysfunction and non-ABI characteristics and relating to internal factors of control and responsibility. In addition, specific externally located attributions associated with the hospital environment, the actions of staff and their levels of knowledge and training were apparent, as well as notions of control and responsibility. Participants' talk was found to perform a range of actions. The main categories that became apparent through analysis were justifying patients' behaviours, legitimising the actions of staff and managing blame.

The position of the current study is that the making of attributions is something speakers perform (Potter & Wetherell, 1987; Willig, 2003). This was found to take place as participants constructed their accounts of CB. Reported attributions are not considered to unproblematically represent underlying mental processes that are discovered independently from those providing them and those seeking to retrieve them (Edwards & Potter, 1992). Hence, participant accounts are considered in terms of the actions they accomplished at the time of the interviews or focus group.

4.1.1 Justifying patient challenging behaviour and managing patient blame.

Patients engaging in behaviours deemed challenging has been found to represent a significant source of stress within families (McKinlay, Brooks, Bond, Martinage & Marshall, 1981; Oddy, Coughlan, Tyerman & Jenkins, 1985) and rehabilitation settings (Miller & Cruzat, 1981). Previous research has reported numerous negative staff emotions in relation to CB (Bird, 1999, Bromley & Emerson, 1995; Watts & Morgan, 1994; Whittington & Wykes, 1994). It has been suggested that this could lead to staff becoming defensive or punitive towards patients (Benson, Secker, Balfe, Lipsedge, Robinson & Walker, 2003). Furthermore, it has been suggested that staff might regard aggressive actions as a threat to self or a deliberate show of lack of respect (Jahoda & Wanless, 2005). Perhaps unsurprisingly, these patients may be unpopular and avoided (Miller & Cruzat, 1981), leading to fewer social interactions (Hastings, 1997; Hastings & Remington, 1994a). Patients might also be open to blame (Benson *et al.*, 2003; Wilcox *et al.*, 2006).

The construction of patients as blameworthy for exhibiting behaviour deemed as problematic was apparent within this study, for example within accounts relating to premeditation or patient control and responsibility. However, participants were also found to make allowances for patients, relating CB to the external environment or staff factors, and constructing some CB as both justified and understandable. In addition, locating the cause of CB internally, in part, constructed them as different from others. This 'difference' opened the possibility that patients might not be expected to operate as other people would. Often, it was implied that *anyone* would exhibit CB if they were in a situation similar to an ABI patient. However, in constructing patients' actions in this way participant talk may have acted to take away self agency and thus deny patients of control and responsibility. Consequently, although participants' accounts might have seemed to protect patients, it could be considered to simultaneously disempower them. Variation apparent in participants' accounts in relation to

CB was managed, in part, by associating descriptions of patients with constructions of 'impairment level', associating greater 'damage' with reduced blame. In their exploration of staff accounts regarding men and women with a LD and who exhibited CB, Wilcox *et al,.* (2006) identified a number of discourses, including an 'individual pathology discourse' and a 'context discourse'. Wilcox *et al.* (2006) suggest that these discourses protected patients from blame by constructing the patient as 'different' from other people and their behaviours as understandable. They suggested these non-blameworthy constructions may have enabled staff to maintain a relationship with challenging patients.

4.1.2 Legitimising staff action and managing staff blame.

'Intervention' might be regarded as 'doing to' patients (Wilcox *et al.*, 2006), although staff actions may be constructed in different ways as a form of social action. Within this study, participants' attributional talk was found to achieve, in part, a legitimising of staff actions. For example, talk relating to both patients' lack *and* possession of control and responsibility might have validated staff procuring control and responsibility. This was achieved by constructing patients as either deficient and in need of help or inappropriate and in need of correcting. Ultimately, staff intervention could be considered as warranted in the patients' best interest under the guise of 'rehabilitation'. This talk places staff in a powerful position within which they could 'legitimately do to' patients.

The function of the social environment, including the actions of staff, in reducing behaviours deemed inappropriate and enhancing behaviours regarded as adaptive has been well documented according to notions of operant conditioning (Skinner, 1974: Alderman, 2001; Hastings, 1997; Hastings & Remington, 1994b; Jahoda & Wanless, 2005; Wood, 1987; Wood & Worthington, 2001a; Wood & Worthington, 2001b). Benson *et al.* (2003) highlighted a 'moral code' established and maintained within professional discourses that staff

are expected to predict and hence prevent CB. Accordingly, talk about external factors in relation to CB might open up the possibility that these factors could be adapted in order to change patient behaviour. Not doing so may increase the potential for staff to be held accountable for the CB they encounter but fail to manage.

Inferences of staff being held blameworthy were apparent here. For instance, at times participants related staff actions with the outcome of CB incidents. Similarly, accounts describing CB as expected and therefore predictable implied staff should be proactive in managing it. Nevertheless, participants were also found to construct staff as *not* blameworthy on account of internal patient attributions, the external environment and service factors. These findings support Wilcox *et al.* (2006), who suggest that their 'individual pathology discourse' functioned to protect staff from blame and the construction of CB as unpredictable and independent of external triggers meant staff could not be accountable for not noticing or adapting situational triggers. Further, they propose that their 'context discourse' associated the actions of staff with wider service context and ideology.

4.1.3 Inconsistency between and within participant accounts.

Variation in research findings has been acknowledged in the attribution theory literature (Jahoda & Wanless, 2005; Todd & Watts, 2005). However, much of the research seems to be seeking consistency in findings, as demonstrated in the testing out of Weiner's (1980; 1985; 1986) models (see Fopma-Loy & Austin, 1997; Sharrock *et al.*, 1990). Certainly, psychology has been considered to traditionally seek single meaning in phenomena (Parker, 1997). The position of the current study contends that knowledge is derived from looking at phenomena from some perspective or another (Potter, 1997). Accordingly, one person's version of phenomena may be quite different from another's and variation or contradiction becomes expected. Within this study, participants were found to combine

attributions in different ways, sometimes contradictorily, and to use their talk to accomplish different actions. Similarly, Wilcox *et al.* (2006) identified the mixing of individual pathology and context discourses. It seems that in the present study the combinations of internal and external attributions opened up differing possibilities in order to support different versions of accounts and accomplish different actions. At times participants also made solely internal or external attributions. The consistencies also apparent in the accounts may have been the product of language sharing the same function, as it was put together in similar ways because participants were doing the same thing with it (Potter & Wetherell, 1987).

4.2 Methodological Limitations

Distinct methodologies might be considered to reflect data in differing ways. Nevertheless, each approach remains open to its own critique. In coming up with the findings they present, researchers themselves employ a process of construction, and thus any conclusions should be considered as interpretations (Ashworth, 2003; Burman, 1994). Some of the methodological limitations of the current study are therefore discussed.

It has been asserted that instead of questioning how much a person's account accurately or inaccurately represents phenomena, researchers should focus exclusively on the language constructed (Potter & Wetherell, 1987). The focus of the current study was on the ways in which staff attribute in relation to CB, and in particular an interest in the actions performed by talk within the research context. The SC GT method guided the activity of data interpretation, and the construction of a model allowed the presentation of an abstract description of the participants' accounts (Charmaz, 2006). The concerns of participants were considered as they arose, and aspects of the 'ABI' setting were found to be revealed in the accounts. These accounts provided the material to anchor the analysis (Charmaz, 2006). This is not to imply that there is no 'out there' reality. The question was not whether, for example,

CB existed in any one-off definable way, rather how participants constructed it and made it relevant at various points in their accounts. Language has been demonstrated here as having power as actions were accomplished through talk. For example, in order to open up or minimise potential for blame, participants made use of attributions of internal and external locations for CB. However, the ideas drawn on for this study that both language and knowledge are socially constructed rather than mapping any knowable reality (Gergen, 1985, 1994) have been critiqued as failing to theorise ways in which they are already grounded in and structured by external realities (Nightingale & Cromby, 2002). The current study considered language according to its action at the time it was produced. Yet, unnameable aspects of experience may be considered to be made sense of, ordered and accounted for retrospectively through language, and as such it has been suggested that a reality outside of the individual should be acknowledged (Frosh, 1999; Parker, 1997). Claiming everything is in language has therefore been criticised for evading reference to ideology, politics, power, embodiment and materiality (Cromby & Nightingale, 1999; Parker, 1997).

GT requires the coding and categorising of talk in order to sort data and initiate analytic interpretations (Charmaz, 2003; 2006; Strauss & Corbin, 1998). General categorisations may provide a way of making large amounts of data more manageable for the reader, although the meaning of an extract depends on the context in which it appears (Potter & Wetherell, 1987; 1995). Conclusions would accordingly be grounded in the utterances of the next speaker. Consequently, taking talk from its sequential context to form categories, as the current study has done, might carry the risk of losing the complex and often contradictory ways in which positions might be refuted, undermined or confirmed (Madill *et al.*, 2000). Furthermore, categories might be employed to look for consistency in accounts at the expense of variation (Morrow, 2005; Potter & Wetherell, 1987). Nevertheless, the SC GT methodology allowed the fundamental attributions and actions that participants performed

within their language to be categorised. Instances in talk that minimised the possibility for the actions portrayed in the categories were also presented. These categories allowed aspects of the data to be presented in relation to one another (Charmaz, 2006), although this was not to imply any directional or causal associations. The construction of the categories was supported with extracts of participant talk.

It is asserted that phenomena are constructed through language and one person's version may be quite different from another's (Gergen, 1985). Variation in data would therefore be anticipated as social realities are always under construction (Miller, 1997). The generalisability of conclusions onto different people or settings may therefore be limited. However, the generalisability of findings remains pursued by many (Silverman, 2000). The sample for this study might be considered fairly homogeneous as participants were all clinical staff working in an ABI CB setting. However, given that accounts are socially constructed, the assumption cannot be made that shared characteristics would denote generalisability within a sample or onto others. That said, the analysis does reflect something about how speakers might use language in this specific setting. For example, how participants used language seemed to be consequential, particularly for patients whose attributed location for CB might act to justify or blame them for the occurrence of CB. Additionally, this sample was restricted to the staff who agreed to participate, and consequently included a greater number of 'qualified' than 'unqualified' members of staff as well as more females to males. Participants were also limited to one hospital. A different combination of participants might have produced data in a different light. In addition, accounts may have been influenced by my prior relationship with the hospital, or the location of the interviews. This will be reflected upon further in Paper 3 (Stewart, 2007b). Nevertheless, collective social actions performed by participants' talk were apparent in this study. Perakyla (1997) discusses the concept of 'possibility' when considering the generalisability of studies based on data collected from a

small number of participants on one site. Accordingly, what the current study's SC GT methodology might demonstrate is the social actions that are possible through the use of language. The *possibility* of the ways in which attributions were made in relation to behaviour deemed problematic by speakers in this ABI setting could therefore be considered useful across different settings.

4.3 Implications for Clinical Practice

By grounding the analysis in participant accounts, the current study has pointed to ways in which attributional talk was produced. Participants made attributions about location in relation to CB as either internal or external, or combinations of each. What became apparent was that social actions were being performed through their attributions. Participants seemed to be managing notions of blame as well as justifying the behaviours of patients and legitimising those of staff. Occasions where these actions were minimised by participant accounts were also apparent. The current study therefore reflects the capacity of talk as more than mere description of inner experiences or outside observations of phenomena (Potter & Wetherell, 1987). In addition, the possibility of these constructions being apparent for other staff or other settings has been opened up.

The current study may have clear implications for individual members of staff and services, and consequently for patients, where interactional talk might be rarely considered beyond its apparent content. Firstly, these findings might be considered in the training and implementation of any staff based intervention for behaviours deemed to be 'challenging'. In particular, notions of blameworthiness need to be acknowledged. If a neurobehavioural intervention such as TOOTS (Wood, 1987) was taken as an example, training may focus on what to 'do' in response to a defined behaviour and why to do this according to notions of operant conditioning (Skinner, 1974). The current study would suggest that trainers might

consider how talk can be used to perform certain actions that have potential consequences for those speaking, listening and being referred to. Accordingly, within training staff might wish to explore the possibility of attributions being made regarding CB. In addition, they may consider the social activities they might be performing with this attributional talk. For example, if in a handover a member of staff was to attribute a behaviour internally to a patient as under their control, what consequences might that have for the ascription of blame regarding a subsequent incident of CB and what might that account do to the listener? Further, how might constructing an account in this way translate into the use of the TOOTS intervention in response to this incident? Secondly, the role if written text might be considered. For example, written reports or notes represent a permanent record of patient behaviours, potentially preserving dominant social constructions which are typically produced by the service and staff (Fine & Turner, 1997; Peter, 2000). Thirdly, the current study might be regarded in relation to reflective practice. To reflect might be considered to open variety in constructions, which might open variety in the social actions performed through language. Such reflective activity can be encouraged through a process of collaborative supervision (Fine & Turner, 1997). Similarly, time for peer support could facilitate a process of reflectivity within clinical teams. Lastly, the potential of psychological formulation should be considered, both in relation to an understanding of the patient's presentation and as a means for reflection and understanding of the attributions made by the staff.

The potential investments of speakers producing attributions in relation to CB need to be acknowledged and deliberated. Locating behaviours externally and/or internally to patients has been found to construct the exhibiting of CB in different ways. Different actions have become apparent as participants blamed, justified and legitimised with their language, but occurrences of these activities may remain obscured in speakers' accounts if they are not

actively sought out. Consideration of such possibilities might support staff and services to be

reflective about the uncontested assumptions that they make and maintain through their talk.

4.4 Areas for Future Exploration

Although by no means exclusively, three central areas for future exploration might be

considered. The first concerns the construction of CB by other groups of people. If the

apparent consistency in aspects of participants' accounts *is* deemed the effect of a shared

function (Potter & Wetherell, 1987), then it might be prudent to extend the study to that of

additional participants such as external observers or 'lay' outsiders, and in particular the

patients themselves. The aim would be to begin to open up the numerous functions different

people might achieve in their construction of patient behaviours in relation to ABI.

The second area relates to the wider systems of power that might be considered beyond

the context of language, as this could be bound up in the production and promotion of certain

versions of knowledge (Parker, 1997). Wilcox *et al.* (2006) suggest that the exploration of

dominant and counter discourses may illuminate the power issues that influence services. A

potential disparity in power is that of the staff-patient dichotomy, including the material

position of many patients as 'detained' within the hospital environment as well as 'done to'

through the implementation of interventions. In addition, patients may rarely be the ones who

determine what behaviour might be deemed 'challenging' or 'inappropriate' and what might

be regarded as 'adaptive'. Within this study, participants were found to often construct

patients as "different" by simultaneously categorising patients as abnormal in comparison to

'others' *and* as normal when compared to the 'ABI population'. Defining individuals as

abnormal may be a key step in the exercise of power by legitimising institutional control

(Peter, 2000). Wilcox *et al.* (2006) propose that their 'individual pathology discourse' was

utilised to explain patient CB, and consequently presented existing power inequalities between

staff and patients as fair and natural. The ascription of collective labels such as "staff" and "patients" could have strengthened the unquestioning of these assertions by drawing on connotations of the patient as defective and the staff as helper.

Lastly is the consideration of a more discursive route. The categories revealed in this study have indicated that speakers make attributions about the location of CB. In producing these attributions, social actions of justifying, legitimising and blaming were apparent. These categories emerged from analysing accounts produced in interview and focus group interactions. Further research might explore different types of conversation and interaction, such as within wardround, ward handover or the staff room. A discursive discourse analysis of naturally occurring conversation may allow exploration with a greater focus on the qualities of interactional language. Consequently, what one person's account might do to the next person who speaks could be explored (Potter & Wetherell, 1987; 1995). Furthermore, the contexts revealed in more naturally occurring data might produce further discursive devices and perform further social actions, as speakers account in different ways for the behaviour that they consider problematic.

4.5 Conclusion

'Attributions' have been considered in the Attribution Theory literature as cognitive processes occurring within a person that are unproblematically produced by participants and captured by researchers (Burr, 1995; Edwards & Potter, 1992; Potter & Wetherell, 1987). The notion of attribution has been demonstrated in this study to represent the social actions performed within people's language. Participants were found to make specific attributions in their accounts regarding patient behaviour they deemed as problematic within an ABI setting. These were grouped according to a number of internally and externally located categories and considered according to combinations of these groupings. This attributional talk both opened

up and minimised possibilities for the primary actions of justifying patient behaviours, legitimising staff actions and managing the potential for blame. The influential position of language was therefore apparent as participants demonstrated its power in the actions their accounts accomplished. The position of language produced in often taken-for-granted ways within clinical settings in relation to patients classified as displaying CB needs to be acknowledged. Such reflection needs to be integrated into training, intervention planning and supervision. In particular, this study has presented the possibility that the ways participants constructed themselves, patients and staff within the research interaction may be pertinent in other settings.

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Paper 3

Critical Appraisal

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Doctorate in Clinical Psychology

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1. Evolution of the Study

1.1 My Epistemological Journey

If I was asked to point to one aspect of the current study that has had the most profound impact on my learning then it would be the exploration of my epistemological standpoint. This journey has been ongoing throughout the study, and as it has developed then the direction of the study has evolved. As it might be considered inevitable, I find myself in a different place now than I was at the beginning of this study. This is by no means to suggest that I have reached any form of an end point, merely that when I look back to where I was in October 2004 it seems I have come a long way. The journey has been fraught with confusion, frustrations and anxieties as both the sheer complexity of epistemology *and* its utmost importance in every aspect of the research process has become increasingly apparent. Now, at the end of my write-up process, I feel the discomfort of grappling with my position has been invaluable. Nevertheless, I believe this journey will endure well past handing in my thesis.

1.2 The Choice of Methodology

The review of the published literature uncovered multiple studies utilising the cognitive concept of Attribution Theory, based on Weiner's (1980) 'cognitive (attribution) – emotion – action' model. This research had investigated staff's reported attributions relating to patient behaviours that were considered as challenging (CB). The context for most of this research was Learning Disability (Dagnan, Trower & Smith, 1998; Jones & Hastings, 2003; Tynan & Allen, 2002), although some studies had extended investigations to Mental Health (Sharrock, Day, Qazi & Brewin, 1990; Leggett and Silvester, 2003) and Older Adult patient populations (Fopma-Loy & Austin, 1997; Todd and Watts, 2005). As this literature base lacked Acquired Brain Injury (ABI) studies, the most obvious direction for my research

seemed to be to replicate aspects of these studies within an ABI setting, as this was my area of interest. This was certainly the direction that many advised me to pursue.

However, I felt that the application of attribution theory to an ABI population carried too many assumptions about what might be happening in relation to CB and what exactly could be uncovered from participant accounts. I also felt it missed an opportunity to explore what participants themselves might bring to a research interaction. A qualitative route was therefore considered because of its focus on the meanings of experiences, actions and events as interpreted and presented by participants (Henwood, 1998). In addition, it benefited from a focus on giving a voice to a small number of participants, rather than testing a preconceived hypothesis on a large sample (Turpin, Barley, Beail, Scaife, Slade, Smith, & Walsh, 1997). A Grounded Theory (GT) (Glaser & Strauss, 1967; Charmaz, 2006) methodology was selected. This was because of its focus on developing ideas from research grounded in the data, whilst it remained flexible enough to use from a number of epistemological standpoints (Charmaz, 2006).

1.3 Using a Literature Review Prior to Data Collection and Analysis

It has been argued that researchers should avoid conducting literature reviews prior to commencing GT data collection and analysis (Hickey, 1997; Lincoln & Guba, 1985; Strauss & Corbin, 1994). It is believed that by delaying the review the emergent theory will remain grounded in the data (Cutcliffe, 2000). However, it has also been argued that the literature review should precede data collection and analysis in order to identify current gaps in research and provide a clear rationale for research proposals (Hutchinson, 1993; Chiovitti & Piran, 2003). In addition, the researcher may be considered to always believe something about their topic and thus expanding their understanding of the multiple ways of viewing it might protect, to a degree, against bias (Morrow, 2005). Practically, within the requirements of the DClinPsy

(Coursework Guidelines & Assessment Regulations-Sept 2004), a thorough literature review and rationale for the proposed research is required and the ethics board requires studies to provide innovation and new learning. Indeed, to replicate research unnecessarily may be considered unethical.

My position was that I brought my own background and experiences to the study. For example I already possessed an interest in ABI patient populations and in particular the ways staff accounted for behaviours they deemed to be challenging. The key seems to be a transparent approach about this subjectivity as well as the acknowledgment of the influence of current literature on the direction of research and formulation of ideas. Reflection was endeavoured through the use of a research diary and the writing of memos, as well as supervision, peer debriefing and a qualitative methodologies group.

1.4 The Research Direction and Title

The original study title *"Care Staff Attributions for Challenging Behaviour in Acquired Brain Injury Populations: An Explorative Study"* was constructed at the research proposal stage following the review of the attribution theory literature. As the study progressed and analysis neared completion the title was revised to *"Attributing in Relation to Acquired Brain Injury Patient 'Challenging Behaviour': A Grounded Theory Analysis of Staff Accounts"*. The aim was to reflect firstly the idea of 'attributions' as something speakers *perform* in their talk (Potter & Wetherell, 1987), and secondly the idea that the 'data' produced in the interviews and focus group revealed *accounts* constructed as a form of social action (Burr, 1995; Edwards & Potter, 1992; Gergen, 1985; 1994; Potter & Wetherell, 1987). However, it was suggested to me that this title was fragmented and not as direct as it could be. I wondered about why I had created a title that was arguably 'wordy' and whether I felt a need to reflect a certain complexity in the title in order to give the study a first impression of credibility (Van

Maanen, 1988). In addition, on reflection this title might not necessarily have pointed the

reader to the ideas of participants' talk being considered as socially constructed accounts and

language performing social actions. The title was accordingly altered in order to represent

what I believe the study is: *Attributions Regarding 'Challenging Behaviour' within an*

Acquired Brain Injury Setting: A Grounded Theory Analysis.

2. Reflection on Data Collection

2.1 Participants

2.1.1 Access to participants.

Potential participants were approached because they shared the clinical experience of working with patients diagnosed with an ABI and considered to exhibit CB. However, the route by which they were contacted should be considered. Participants were contacted via the hospital's internal mail service using letters addressed according to their name, job title and ward. Although I used University of Leicester headed paper, approaching participants in this way was likely to generate assumptions about an interest in them as 'members of staff'. An inevitable link between myself and the hospital might have therefore been apparent. The way potential participants might have seen me could have already begun to be structured from this first contact. The influence of this on the interview or focus group process should not be neglected when considering the form and content of the accounts produced (Burman, 1994). Participants may distrust the stated purpose of the research or how the findings may be used (Charmaz, 2006). The potential position of power for the researcher and vulnerability for the participant became apparent during the data collection when a participant asked me questions about whom I represented as a researcher and why they had been approached to participate. It seemed that this participant suspected me of being part of a management conspiracy that had actively sought them out in order to gain information. Participants' introduction to the study as members of staff might have also generated more 'politically correct' responses to the questions posed to them, as they might have potentially constructed themselves in the research as 'staff' with certain connotations of 'professionalism'.

2.1.2 My prior relationship with the hospital.

Prior to beginning the DClinPsy, I worked at the hospital as an Assistant Psychologist.

It was from my observations whilst in this role that my ideas for this piece of research

developed. Returning to the hospital in order to conduct the study meant that I had previous

working relationships with many of the staff approached to participate and also retained

personal relationships with some. In addition, it was likely that many of the patients I had

worked with would still have been resident at the hospital. Researcher's prior knowledge of

their participants, and participants' knowledge of researchers, has been considered to facilitate

greater discussion and reflexive commentary (Burman, 1994). Although I had not worked

directly with some of the participants and had not encountered some at all in my previous role,

there was a sense of a shared history during the interviews and focus group. This may be

revealed in the data, in part, by reference to taken-for-granted terms such as "TOOTS" (time-

out-on-the-spot intervention) or expressions such as "prompter" (in reference to the person

providing patients with pre-defined prompts within an intervention programme). This became

particularly apparent to me during peer debriefing and coding sessions. For example, a

DClinPsy peer remarked that the term "prompter" made her think the participant was talking

about staff prompting the CB. Intriguingly, participants *did* refer in their accounts to staff

actions, such as delivering a prompt, as an antecedent to patient CB. I cannot know whether

participants would or would not have used terms such as TOOTS or prompter, or if they

would have been provided and received in such a taken-for-granted way if the interview was

conducted by someone without links with the hospital. However the possibilities remain

interesting. I feel that my prior relationship with the hospital and some of the participants

opened up discussion and facilitated an implicit feeling of a shared understanding behind their

accounts. However, this also might have also closed down potential for participants'

construction of alternative accounts within our interaction as a result of my reactions, or for potentially different interpretations of their talk as part of my analysis.

2.1.3 The interviews and focus group venue.

The interviews and focus group took place at the hospital. As with considering the way participants were contacted at the outset of the study and my previous associations with the hospital, the venue of the interviews and the focus group was likely to have an effect on participants' accounts. Participants were being asked to produce accounts of their clinical work within the same building where they carried out this work. Their role within this location might therefore be perceived as 'a member of staff' primarily and as an 'interviewee' secondly. I wondered whether this might alter their accounts in a way that would almost lose its honesty. However, I also considered the idea that all accounts are constructed in a way to express certain versions of phenomena in order to open up some possibilities and close down others (Gergen, 1985; 1994; Potter & Wetherell, 1987). Therefore, the talk produced by participants within their role of 'staff being interviewed' might have elicited *different* but equally important and interesting accounts, especially as it was within this capacity that I was interested in the participants. Nevertheless, the potential for a location away from the hospital building was open for participants as it is located on a larger site, however each participant declined this opportunity. Participants were granted permission by the Clinical Director to participate during work hours if they wished. However, the timing of the interviews was left to participants to determine so they had the option to attend outside of work time if they preferred. This may have allowed participants to take a step away from 'work'. The focus group timing, however, was arranged within the conventional working week and at a time near the nursing shift change in order to open it up to as many potential participants as possible.

Nevertheless, some staff who had consented to attend the focus group (additional to the eight stated in Paper 2) did decline to participate once the date and time were set.

2.2 The Development of the Interview Schedule and the Focus Group Vignette

The development of the interview and focus group schedule (Appendix 8) presented an interesting dilemma in this study. It was required to submit a detailed schedule of questions as part of the research proposal. However, this could be regarded as inconsistent with the 'emergent' nature GT methods seek (Charmaz, 2006). This dilemma might have been amplified by the realist nature of the literature pertaining to ABI and CB, and how this could be considered inconsistent with my position of considering accounts as social constructions. Maybe if the published research came from a similar epistemological standpoint to mine, using it to inform my schedule would have felt less problematic, even though the deductive nature of the process would have arguably remained. Nevertheless a schedule was considered useful in opening up possible areas for discussion and letting the participants know what the area of interest was. In order to open up the interaction to allow unanticipated talk to occur, participants were encouraged to expand into related topics. The schedule evolved with each interview as new areas of interest elicited by the preceding interviews were added. What was interesting was how the use of the schedule differed from interview to interview. I wondered if this, in part, might have been determined by the participants themselves. For example, my experience was that some participants necessitated only an initial question and a few comments throughout the interview whereas others seemed to produce shorter answers that required further questioning to elicit more ideas. The focus group was a different experience again, with participants talking amongst themselves and I felt less inclined, and at times even less able, to intervene in the discussion by providing encouragement or directing questions. Nevertheless, reduced interaction with the interviewer might be anticipated in focus groups

(Morgan, 1997). The schedule was used little in the focus group, and where it was utilised I felt it might lead the discussion away from the direction the participants were taking it. This may have reflected an alternative version of accounts or a differing agenda for participants. I also wondered if my reduced experience with focus groups, when compared to my interview experience, had an impact on the way the discussion progressed at times away from the schedule I had in mind. However, the accounts did appear to remain relatively close to those produced in the interviews.

The focus group vignette (Appendix 9) was created from the 'memorable incidents' produced by the interview participants. The aim was to focus the start of the group discussion at a shared point and provide an event to anchor accounts on if they wished. The incident chosen was one that was considered routine enough so as not to identify the patient or the participant who produced it, and to be relevant for all the wards. Interestingly, the group did not explicitly relate to the vignette often. However, aspects of the vignette seemed to be revealed in the talk. For example, participants did refer directly to the vignette as reflecting a regular phenomenon ("It's [*vignette incident*] a [*sic*] every day occurrence really, especially as, part is that we're short staffed" focus group I: 1, 6-7). However, other parts of their accounts could be associated indirectly with aspects of the vignette ("Our patients are <u>bored</u>. We're <u>not</u> providing the service which we know we can provide because we don't have the numbers of staff to <u>provide</u> that therapy, to <u>provide</u> that care." focus group J: 18, 406-408). I wondered if the group's focus on external service issues, such as resources, may have been a result of accounts drawing on shared staff issues. However, I also wondered if the use of this vignette might have had some impact on the content of the talk. The question remains of what might have happened within the group interaction if an alternative incident was presented.

2.3 What I brought to the Data Construction

I approached this study mindful of differing motives generated from the DClinPsy guidelines, my research and clinical interests and those of my supervisors, as well as the influence of my developing epistemological position. The data produced from the interviews and focus group could be regarded as an interactional co-construction between all those involved. It could be considered that the answers researchers receive will depend on the questions they ask (Burr, 1995; Charmaz, 2006). Participants' responses might therefore be considered as a process of managing my questions as they constructed themselves within our interaction. The questions that I asked participants may have consequently been reflected in their responses and subsequently in the categories constructed from the analysis. In addition, the way I responded was likely to have an effect on how their subsequent accounts were constructed. Moreover, according to GT methodology (Charmaz, 2006), previous interviews were actively used to inform the questions asked of participants. Therefore, past participants could also be considered part of the interaction. Participants could also be considered to enter into the research process with motives of their own and they may have not shared the research goals (Burman, 1994).

I also noted as the data collection progressed that my interviewing style seemed to be shifting. This may have been a product of the differences between the participants, or of a growing confidence on my part as I relaxed more into the role of interviewer. However, I also wondered about the influence of the psychodynamic clinical work I was engaging in. New to psychodynamic psychotherapy, I was learning about the idea that every word I produced within therapy could be considered as an 'intervention' (Brown & Pedder, 1991). The outcome of saying less in therapy had been a richer indication about where the patient took the session with less diversion from my interventions. Although Brown and Pedder's notions of intervention may be different from the SC notion of language as a form of social action

(Gergen, 1985; 1994) in that it seems to go beyond the language to notions of the unconscious, this experiential learning as a therapist was bound to have an impact on my practice as an interviewer. In addition, I wondered about the influence of the epistemological journey I was engaged in. As I learnt more about different social constructionist (SC) ideas and grappled with the notions that talk resulted from a complex interaction between speakers, replicated taken-for-granted ideas and performed actions (Gergen, 1985; 1994), I became increasing reflective about my own use of language. This was likely to have an impact on my interviewing style. Interestingly, the influence of this learning was also apparent in my use of language as a therapist.

It has been suggested that an interview may touch upon or even change both participant and researcher (Burr, 1997; Parker, 1994). A number of participants commented following the interviews that they would hope to be more reflective about their interactions with patients, especially when they found patient behaviours challenging. As I conducted the interviews and focus group, I too have become increasingly aware of the importance of reflexivity within my own practice with patients I find challenging, but also my role in encouraging reflexivity with the team within which I work.

3. Reflection on Data Analysis

3.1 What I brought to the Analysis

As much as it can be possible to know (Morrow, 2005), the influence of my preconceptions and values on the data collection and analysis process was acknowledged from the outset of the study. As has been discussed previously, I had clinical experience within the hospital prior to initiating the study. This was found to be revealed within the data, but was also apparent to me throughout the analysis process. For instance, discussions in supervision highlighted occasions where I had relied on my own interpretation of participants' talk based on my own experiences of working at the hospital. An example might be my initial use of the label "negative reinforcement" to represent participant ideas about patient behaviour being strengthened by staff responses (for example with the extract "Sometimes I think the behaviour ends up being quite spontaneous and and then it <u>gets</u> the result that they want and it becomes more embedded" E, 22, 507 – 509). This is not to suggest that the participant was not talking about operant conditioning notions of negative reinforcement, merely that this interpretation was not *grounded* in the data. An example of what could be seen in the extract was that participant E seemed to be using internally located (the behaviour being spontaneous, and the behaviour becoming more embedded) and externally located (getting the result) attributional talk.

3.2 The Construction of the Model

The process of constructing a model to represent my emerging analysis was thorny. I found the approach to depicting the data confusing, with different people inferring importance to contradictory model structures. For example, I initially produced a hierarchical representation of the data, with each level of the hierarchy illustrating higher- and lower-order

categories (Figure 1)[1]. Following presentation of this model at the qualitative methodologies

group I decided to construct a model to reflect a process within the data (Figure 2)[1]. However,

on reflection it became apparent that the use of a process model imposed directional

relationships between the categories. I therefore went back to my original hierarchical model

and began to re-construct a model that remained grounded in the data (Figure 3)[1]. At this

stage of the analysis the form of the categories was unclear. This phase seemed to be reflected

by the categories effectively 'floating'. From this model structure I was able to progress with

the analysis, re-visiting and re-categorising the data (Figure 4)[1]. It was at this stage of the

analysis that I began to consider the specific attributional talk that had been presented in

participant accounts and the actions performed by these attributions. I felt that depicting these

categories separately clarified the presentation of the analysis by representing both the

grounding of categories and the discursive view of language that had informed the SC GT

methodology. From this the "Participant Attributions in Relation to Challenging Behaviour"

model was constructed.

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[1] See Appendix 10 for examples of the evolving structure of the model

4. Reflection on Write-Up

4.1 Write-Up as Part of the Analysis

The importance of writing and re-writing in clarifying the analysis, sharpening the study conclusions and integrating findings with the literature is well documented (Becker, 1986; Charmaz, 1990, 2003; Potter & Wetherell, 1987; Willig, 2003). I found my write-up to far exceed the time I had anticipated it would take. Committing my codes and categories to paper along with my evolving ideas and discussions with supervisors and peers was challenging. However, as I was forced to be concise by the required word limit I found my analysis became tighter, more focused and better grounded.

4.2 My Write-Up Style

At the outset of this study I questioned how I might write it up at the end. I wondered how my evolving epistemological position and readings on GT would fit with the requirements of the DClinPsy thesis. From the literature it seemed that the undertaking of GT methodology was not agreed upon (Chiovitti & Piran, 2003; Cutcliffe, 2000) and, as Potter (1996) pointed out, to describe SC could be considered profoundly anti-constructionist. Yet it seemed that I was required to define an epistemological standpoint and the thinking behind it from the literature, to define the GT methodology and to describe how to 'do' a SC GT. Furthermore, this was expected within a strict word count. The route I took was to begin to write down what I understood from my readings and to try to form a picture of the alternative ways both SC and GT had been written about. What resulted was a lengthy and confusing essay, which arguably only touched on the extensive published literature. By writing and re-writing and then consolidating and summarising these chapters I began to gain a picture of my own position in relation to the literature. Although much of this writing did not remain in my

final paper, it informed the way I considered my data collection, analysis and ultimately the style of my write-up.

5. My Use of Supervision

5.1 Research Supervision

Formal supervision provided an invaluable source of discussion, reflection and support. This was utilised from the construction of the proposal through to data collection, analysis and write-up. With the idiosyncrasies of conducting research in mind, even when the 'same' methodology is employed, I decided to structure the use of my supervision in order to reduce the likelihood of receiving contradictory advice. For example, I met regularly with my primary field supervisor to discuss my epistemological ideas, the application of the methodology, the course of the data collection, the analysis and write-up, as well as to reflect on the each phase of the study. I worked with my neuropsychology field supervisor when accessing potential participants and conducting the data collection phase. Lastly, I liaised with my academic supervisor during the study planning and data collection and we had regular contact during the write-up. Nevertheless, the alternative perspectives of my supervisors that did become apparent opened up a dialogue surrounding the rationale for the choices I was making.

5.2 Peer Debriefing

During data collection and analysis I met weekly with a peer debriefer (DClinPsy colleague). We used this time to reflect on our experiences of interviewing, to act as a second coder of the transcripts and discuss our emerging ideas. Once we began to construct models to represent the developing categories we also used this time to explore these. In addition, this space promoted debate surrounding our epistemological development and methodological understanding. These meetings encouraged our reflective process and supported the consideration of alternative interpretations of the data. I found peer debriefing an invaluable support and source for exploration, even though it became apparent that many of our

uncertainties, questions and dilemmas could not in fact be clarified, answered or resolved. Maybe it was the feeling of not being 'the only one' that made these discomforts more manageable.

5.3 The Qualitative Methodologies Group

The qualitative methodologies group was attended by DClinPsy colleagues and a member of the university staff, meeting monthly during the final academic year. As with the research supervision and peer debriefing, the group provided an opportunity to discuss epistemological and methodological ideas, to access additional coders for the transcripts and provide support and encouragement. The group was generally very helpful, however there were times when collective anxieties were difficult to contain and it was a less helpful experience. Nevertheless, it offered the chance to bring together the readings and ideas of a number of colleagues in order to clarify concepts and ideas from the literature, consider alternatives and broaden our thinking.

6. Social Constructionism

Having read and re-read a number of different author's takes on notions of SC, discussed these ideas at length in various forums and considered them in relation to my evolving epistemological standpoint and the write-up of the current study, uncertainties nevertheless remain. Two key questions have related to the consideration of all social constructions as equal and the potential for co-construction beyond language.

6.1 Are All Social Constructions Equal?

Theories that seem to suggest that all points of view can be respected equally (Burr 1995; 1997; Gergen, 1985) may appear desirable. However, it has been argued that the fact phenomena can be relativised does not mean that all explanations or positions are equally valid or equally useless (Parker, 1997). Similarly, others claim that such a position is not possible as it could be argued that there is nothing to be criticised if all is considered equally valid (Kenwood, 1999). As a result, the accuracy of research undertaken from this position would not be assessable (Nightingale & Cromby, 1999). If all that is left is language, then potentially any analysis can only be a groundless construction. Nightingale & Cromby (1999) give the example: how might a claim that the moon is made of cheese be questioned if there is no 'objective' referent? Accordingly, a discursive critique of cognitive psychology has the potential of being undermined by maintaining all points of view are equally valid and it is impossible to choose between them. Nevertheless, some authors maintain that instead of questioning whether an account accurately or inaccurately represents the phenomena being considered, researchers should focus exclusively on the language being constructed (Potter & Wetherell, 1987).

6.2 Is Language the Only Social Construction?

The focus of research on language as a social construction (Potter & Wetherell, 1987) and the analysis of the way versions of events are constructed to support particular stories and challenge others (Edwards & Potter, 1992) has been referred to throughout this thesis. In Paper 2 (Stewart, 2007c) I talked about notions of CB as a way of conveying patient actions that seem to be problematic for the people talking about them and not as describing a static objectively observable phenomenon. However, it seems this notion of CB as a social construction can be taken further. An account of CB can be seen as constructed not only at the point it was produced in language, for example at the time of the interview or focus group, but the behaviours themselves can be considered as social constructions that are co-constructed at the time of their occurrence. Hacking (1999) talks about 'looping effects' as a way of describing interacting aspects of the social setting within which an idea is constructed. If notions of CB were considered in this matrix, it might include the *idea* of CB, the individual *people* falling under the idea, such as the patients or staff, the *interaction* between the idea of CB and these people, and the *social practices and institutions* involved in these interactions. According to Hacking's looping effect, as knowledge about CB becomes known to the people classified as 'challenging' or those working with the 'challenging', the way these individuals behave may change, which subsequently might 'loop' back to influence changes in the definitions and knowledge about CB. Consequently, it might be more than just the language that is co-constructed. The accounts provided by the participants in the current study might be considered as constructed beyond the apparent context of the interview or focus group, and the analysis could be considered within this potential interactional context.

7. A Final Thought: Paper 3 – Critical Appraisal

In writing up studies, what is produced is likely to reflect whoever wrote it as the information included is likely to be influenced by the person choosing it (Banister, 1994). It could be argued that the way a research account is written tells the tale the author chooses to present (Kvale, 1996; Van Maanen, 1988). The completed papers could therefore be considered as one 'version' of the research (Potter, 1997). The importance of taking a reflective stance in relation to every aspect of the research process has been well documented (Burman, 1994; Charmaz, 1990; Morrow, 2005) and has been referred to throughout this thesis. As I sit here and formalise the reflections I have been recording since I began writing my research diary in November 2004, I recognize what a substantial role it has held in my learning and the position of the study. However, given its utmost importance in qualitative research, I also wonder why there is so little space for this variety of reflection in the main research report. Maybe the importance of 'reflection' is made apparent in warranting its own paper, but I can't help wondering if its positioning as 'Paper 3' according to the DClinPsy requirements gives it an air of an after thought. For me, reflexivity has significantly guided my learning throughout.

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Appendix 1

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Appendix 2

Grounded Theory and Social Constructionism

Appendix 2

Grounded Theory and Social Constructionism

It is apparent that the nature and process of conducting a Grounded Theory (GT) study

is not uniformly agreed upon (Chiovitti & Piran, 2003; Cutcliffe, 2000). Therefore, some of

the key elements in the emergence of GT will be discussed. In addition, notions of Social

Constructionism (SC) will be introduced and discussed in relation to GT methodology.

2.1 The Emergence of Grounded Theory

Grounded theory is a label used to describe methods that emerged from two

sociologists working in the 1950s and 1960s: Barney G. Glaser and Anselm L. Strauss. It was

a radical discovery-orientated alternative to the sociological practice of the time, which was

considered to be becoming increasingly reliant on quantitative methods (Pidgeon, 1996). In

their book 'The Discovery of Grounded Theory' (1967) Glaser and Strauss discussed

systematic methodological strategies for studying phenomena and advocated developing

theory from research grounded in the data rather than using existing theory to deduce testable

hypotheses (Charmaz, 2001). The integration of a positivistic systematic technique to study

an external world with an interpretive focus arose from the joining of the two alternative

backgrounds; Glaser from a quantitative method background at Columbia University and

Strauss from a strong tradition in qualitative research from the University of Chicago (Strauss

& Corbin, 1998).

2.2 A Positivist or Interpretive Grounded Theory?

Glaser & Strauss' (1967) notion of theory being 'discovered from' data implies that

phenomena exist objectively and are captured by the researcher (Pidgeon, 1996). In its basic

state, GT seems to be following an inductive process in generating initial concepts. However, in interpreting, analysing and theorising, an existing repertoire becomes available. As such, induction may have given way to a certain extent to deduction (ten Have, 1999). Layder (1982) suggests knowledge and theory arise from an 'interplay' between prior knowledge and concepts revealed from the data. Arguably, there may be little sense in claiming that research can proceed from either testing prior theory alone or from a purely inductive process as analysis is inevitably constructed within preexisting conceptual frameworks (Henwood & Pidgeon, 2003; Layder, 1982; Pidgeon, 1996). For Charmaz (2003), the GT emphasis on systematic techniques to study the external world is considered to remain consistent with positivism and the interest in how people construct actions, meanings and intentions is in keeping with interpretive traditions. Therefore GT might bridge the gap between the two.

2.3 Social Constructionist Versions of Grounded Theory

Glaser and Strauss (1967) invited their readers to use GT strategies flexibly in their own way. Therefore, the basic GT guidelines can be used as a set of principles and practices from a number of epistemological standpoints. Although GT has been defined as realist in its nature by some (Van Maanen, 1988), many authors argue that GT can be used by those who subscribe to constructionist perspectives (Charmaz, 1995; 2006; Henwood & Pidgeon, 2003). SC developed as a response to, and critique of, traditional approaches in psychology (Harper & Spellman, 2006; Potter, 1996). It has been argued that to describe SC would be profoundly anti-constructionist as this would imply that it could be neutrally and objectively defined (Potter, 1996). However, there do seem to be a number of ideas that are arguably shared, making up a metaphorical 'family resemblance' (Burr, 1995). In order to gain some notion of SC for the purpose of the current paper, some of these resemblances will be highlighted.

Gergen (1985; 1994) discussed a number of assumptions which are believed to be implicit in most SC work. First, is a critical stance towards the taken-for-granted ways of understanding the world and the presumption that this may be unproblematically reflected in research. For SC, knowledge is seen as derived from looking at the world from some perspective or another, and our own versions of reality are seen as constructed between us (Burr, 1995; Potter, 1997). For some the focus of enquiry should not be concerned with arguments about whether or not phenomena exist, but with how people construct and utilise conceptualisations within interaction as factual (Potter, 1996; Potter & Wetherell, 1987). However, others write about the external availability of discursive recourses to people and the implications of these in terms of how they perceive and experience their world (Nightingale & Cromby, 2002; Parker, 1992; 1994); Second, is the view that knowledge is historically, socially and culturally specific (Gergen, 1985). Social processes are considered to maintain understandings across time. Instead of pursuing definitive truths, SC focuses on the emergence of current forms of taken-for-granted knowledge and how they are maintained or disregarded (Burr, 1995); Third, is the belief that the terms by which we account for the world are not fundamentally dependent on empiricist validity as measured by consistency in accounts (Gergen, 1985); Fourth, is the significance of language derived through its use in interaction and negotiation (Gergen, 1985). Traditionally, language has been considered as a means of expressing the person, independent of the words used to describe that which is being expressed; as a bag of labels used to describe states, objects and experiences (Burr, 1995, 1997). However, descriptions and explanations are not deemed neutral but represent forms of social action which serve to sustain certain viewpoints to the exclusion of others (Burr, 1995; Edwards & Potter, 1992; Potter & Wetherell, 1987).

SC is therefore interested in how people provide accounts of knowledge and focuses on the dynamics and processes of social interaction. Knowledge is therefore considered

something people 'do' together rather than something someone 'has' (Edwards & Potter, 1992; Gergen, 1985). Constructionist revisions of GT recognise that research cannot proceed either from testing prior theory or 'knowledge' *or* from pure inductive analysis of data. Here, the generation of theory is the result of a constant interplay between data, relationships with the respondent and the researcher's developing conceptualisations (Charmaz, 2006; Pidgeon, 1996). In particular, there is an emphasis upon exploration of multiple, partial and competing interpretations by utilising the constant comparison of data (Pidgeon, 1996). All accounts may be understood to be permeated with subjectivity and as such cannot be invalidated by conflicting with alternative perspectives (Madill *et al.*, 2000). However, by representing the perspectives of participants through basing findings in their actual accounts, a grounding for results is endeavoured (Tindall, 1994).

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Appendix 3

Approval letters from the hospital's Research Group,

the NHS Leicester, Northamptonshire and Rutland Research Ethics Committee 2

and

the University of Leicester Psychology Research Ethics Committee

8 March 2006

Inga Stewart
Trainee Clinical psychologist
Leicester partnership NHS Trust
Trust Headquarters
George Hine House
Gipsy Lane
Leicester
LE5 0TD

Dear Inga

Re: Care Staff Attributions for Challenging Behaviour I Acquired Brain Injury Populations: An Explorative Study

Thank you for providing the above research proposal and academic peer review. I can confirm that St Andrew's Group of Hospitals are willing to host this research project, subject, of course, to ethical approval by an appropriate Research Ethics Committee.

Please ensure that you let me know when ethical approval has been gained.

Yours sincerely

Geoff Dickens
Research Coordinator

19 July 2006

Mrs Inga R C Stewart
Trainee Clinical Psychologist
Leicester Partnership NHS Trust
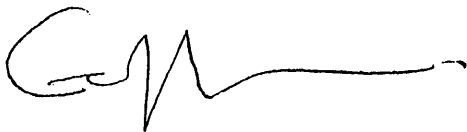George Hine House
Gipsy Lane
Leicester
LE5 0TD

Dear Inga

**Re: Care Staff Attributions for Challenging Behaviour in Acquired Brain Injury
         Populations: An Explorative Study**

Thank you for sending your confirmation of ethical approval.

I am writing to confirm that you may now proceed with your project as per the protocol.
Please send a copy of your report on completion.

Yours sincerely

Geoff Dickens
Research Coordinator

cc   Dr Nick Alderman

SPECIAL NOTE

THE FOLLOWING

IMAGE IS OF POOR

QUALITY DUE TO THE

ORIGINAL DOCUMENT.

THE BEST AVAILABLE

IMAGE HAS BEEN

ACHIEVED.

Leicestershire, Northamptonshire & Rutland Research Ethics Committee 2

Research Ethics Office
Derwent Shared Services
Laurie House
Colyear Street
DERBY
DE1 1LJ

Telephone: 01332 868842
Facsimile: 01332 868785

06 July 2006

Mrs Inga R C Stewart
Trainee Clinical Psychologist
Leicester Partnership NHS Trust
George Hine House
Gipsy Lane
Leicester
LE5 0TD

Dear Mrs Stewart

Full title of study:	**Care Staff Attributions for Challenging Behaviour in Acquired Brain Injury Populations: An Explorative Study**
REC reference number:	**06/Q2502/47**

Thank you for your letter of 04 July 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA. There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application	Version 2 Received 4.7.06	
Investigator CV	D/Version 1	28 February 2006
Protocol	Version 1.1	12 June 2006
Covering Letter	Dated 18.4.06	18 April 2006
Summary/Synopsis	Flow Chart of Protocol V1.0	10 March 2006

Peer Review	Done by Marilyn Christie D/Version 1	24 January 2006
Interview Schedules/Topic Guides	Version 1	10 March 2006
Letter of invitation to participant	(Focus Group) Version 1.0	10 March 2006
Letter of invitation to participant	(Interview) Version 1.0	10 March 2006
Participant Information Sheet: (Interview)	Version 1.1	12 June 2006
Participant Information Sheet: (Focus Group)	Version 1.1	12 June 2006
Participant Consent Form: (All)	Version 1.1	12 June 2006
Participant Consent Form	Consent to be Approached form Version 1.0	10 March 2006
Response to Request for Further Information	2 – to include signature pages	04 July 2006
Response to Request for Further Information	Emailed response	12 June 2006
Supervisor CV	Prof M.Wang D/Version 1	31 December 2005
Letter from host organisation	St Andrews Hospitals	08 March 2006
Literature Review	Version 1	10 March 2006

Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.
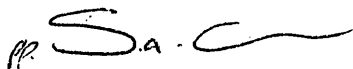
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q2502/47	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

pp ⌒）.ᴀ . ⌒

Chair

Email: sarah.gill@derwentsharedservices.nhs.uk

Enclosures: *Standard approval conditions*
                       (SL-AC2)

Copy to: University of Leicester
                      104 Regent Road, Leicester

From: Colman, Prof A.M. [amc@leicester.ac.uk]   Sent: Thu 29/03/2007 17:51
To: ircs1@leicester.ac.uk
Cc:
Subject: RE: PC_ethics2006 - Inga Stewart
Attachments:

Dear Inga

Your project (Care Staff Attributions for Challenging Behaviour in
Acquired Brain Injury Populations: An Explorative Study) has been
approved by the Psychology Research Ethics Committee.

This e-mail is the official document of ethical approval and should be
printed out and kept for your records or attached to the research report
if required - this includes all undergraduate and postgraduate research.

We wish you every success with your study.

Andrew M. Colman
Psychology Research Ethics Committee Chair

-----Original Message-----
From: www-data [mailto:webserver-admin@leicester.ac.uk]
Sent: 29 March 2007 17:20
To: amc@leicester.ac.uk
Subject: PC_ethics2006 - Inga Stewart

Proposer: PC_ethics2006 - Inga Stewart
email: ircs1@le.ac.uk
status: DClinPsy 2004-2007 cohort
supervisor: Prof. Mike Wang
title: Care Staff Attributions for Challenging Behaviour in Acquired
Brain Injury Populations: An Explorative Study
date: 29/03/07
preapproval: LMRC

Appendix 4

Letters of Invitation to Participants – Interview and Focus Group

University *of* Leicester

School of Psychology
Clinical Section

104 Regent Road
Leicester LE1 7LT · UK
Tel: + 44 (0) 116 223 1639
Fax: + 44 (0) 116 223 1650

Contact Tel:
(█)
Email:

Care Staff Attributions for Challenging Behaviour

in Acquired Brain Injury Populations:

An Explorative Study

August 2006

I am inviting you to take part in a research study. Firstly, if you are interested I need your consent to be approached. Having been approached if you wish to continue I will need your consent to participate.

Please find enclosed a copy of the research 'Information Sheet', which has information for you to decide whether or not to consent to be approached about talking part. Please read it carefully. If you have any questions or you would like any further information before you make your decision then please contact me.

There are two parts to this study; the first part is one-to-one interviews and the second part is a focus group. This letter refers to Part 1: Interview.

You do not have to be approached or take part in the research if you do not want to.

If you decide you may be interested in participating and you are happy for me to get in contact then please read, sign and date both copies of the 'Consent to be Approached' form. Please return one copy to "**Inga Stewart c/o █**, **Psychology, █**" using the internal mail service by **25th August 2006** and retain the second copy and information sheet for your reference.

Thank you for taking the time in considering my proposal.

Kind regards

Inga Stewart
Trainee Clinical Psychologist
University of Leicester DClinPsy

University *of*
Leicester

School of Psychology
Clinical Section

104 Regent Road
Leicester LE1 7LT · UK
Tel: + 44 (0) 116 223 1639
Fax: + 44 (0) 116 223 1650

Contact Tel:
( )
Email:

Care Staff Attributions for Challenging Behaviour

in Acquired Brain Injury Populations:

An Explorative Study

January 2007

I am inviting you to take part in a research study. Firstly, if you are interested I need your consent to be approached. Having been approached if you wish to continue I will need your consent to participate.

Please find enclosed a copy of the research 'Information Sheet', which has information for you to decide whether or not to consent to be approached about talking part. Please read it carefully. If you have any questions or you would like any further information before you make your decision then please contact me.

There are two parts to this study; the first part is one-to-one interviews and the second part is a focus group. This letter refers to Part 2: Focus Group.

You do not have to be approached or take part in the research if you do not want to.

If you decide you may be interested in participating and you are happy for me to get in contact then please read, sign and date the 'Consent to be Approached' form. Please return it to "**Inga Stewart, c/o** ▉▉▉▉▉▉▉▉, **Psychology,** ▉▉▉▉" using the internal mail service by **9th February 2007**. Please retain the information sheet for your reference.

The focus group is due to take place on **Wednesday 21st February at 10:30am**
in the ▉▉▉▉▉▉▉▉▉ room.

Thank you for taking the time in considering my proposal.

Kind regards

Inga Stewart
Trainee Clinical Psychologist
University of Leicester DClinPsy

Appendix 5

Participant Information Sheets – Interview and Focus Group

University *of*
Leicester

School of Psychology
Clinical Section

104 Regent Road
Leicester LE1 7LT · UK
Tel: + 44 (0) 116 223 1639
Fax: + 44 (0) 116 223 1650

I am inviting you to take part in a research study that I am undertaking as part of my training in Clinical Psychology. Before you decide to participate it is important for you to understand what it will involve. Please take time to read the following information carefully. Please contact me if there is anything that is not clear or if you would like any further information. Take time to decide whether or not you wish to participate. You do not have to make your final decision at this stage.

Title of Study

Care Staff Attributions for Challenging Behaviour in Acquired Brain Injury Populations: An Explorative Study

Researcher

Inga Stewart

Trainee Clinical Psychologist

Introduction

The experiences of staff in relation to challenging behaviour exhibited by patients with acquired brain injury (ABI) can be very different between different staff and between different patients. It seems that how staff feel about these incidents can have an impact on how they respond to patients. There are two parts to this study; the first part is one-to-one interviews and the second part is a focus group. This information sheet refers to Part 1: Interview.

What is the purpose of the study?

This study hopes to find out more about how staff feel about and understand incidents of challenging behaviour and how they feel this may obstruct or facilitate the way they work with ABI patients who exhibit challenging behaviour.

Why have I been chosen?

You have been invited to take part in this study because you have experience working with ABI patients who display challenging behaviour.

Do I have to take part?

No. It is entirely your choice whether or not you want to take part. Deciding not to participate or pulling out will not affect your role in the service in any way. I will ask you to sign a 'Consent to be Approached' form before coming to discuss the possibility of participating in the study, after which I will ask you to sign a 'Consent Form' to say that you want to take part. Even if you do decide to take part, you can pull out at any time.

What will happen to me if I take part?

You will be asked to sign a form saying that you want to take part. Then I will arrange to meet with you to discuss the possibility of participating further. If you agree to participate, you will be asked to sign a consent form. The first 12 respondents to agree to participate in the interviews will be included in the study. If you agree to participate in the study, it will involve a one-to-one conversation about a memorable incident of challenging behaviour and your overall experience of challenging behaviour in the ABI populations you have worked with, although there will be scope for us to move onto related topics if you feel this is appropriate. Please note there are no right or wrong answers.

A case vignette (a short outline of an event) will be put together based on your memorable incident. This will be used to facilitate our discussion. It may also be (anonymously) used to guide a focus group discussion. A copy of the case vignette will be available upon your request. If you wish details of the description to be altered to preserve anonymity, this can be done.

You have the right to end the interview at any point and to choose not to answer certain questions. You will be required to talk for no longer than one hour, although you are given the choice to stop the interview at any time or to talk for more than one hour if you wish to. With your consent the interview will be tape recorded and transcribed (typed up) and analysed afterwards.

Will my taking part in this study be kept confidential?

Yes. Utmost care will be taken in order to ensure your anonymity. The information will be kept in a locked cabinet in my office at ████████. Any information that is entered onto a computer will be entered in such a way that your name will not be able to be linked with the information. The computer will also be password protected meaning that only I will be able to access it. Your name and personal details will not be mentioned anywhere in the study in order to protect your identity.

The taped interview will be heard and transcribed only by me. In the event that another person transcribes your interview, they would be external to the service and would have no information on

your identity. They would not be permitted discuss the content of the interview with anyone. The recording will be destroyed after the transcription has been made in order to remove any identifying information you have provided.

In order to make sense of the interviews any papers written based on the findings will need to have a brief description of the participants. A copy of the interview transcript together with a copy of the description will be available upon your request. You will be given a pseudonym so your real name will not be used. If you wish details of the description to be altered to preserve anonymity, this can be done. As I may use extracts from you transcript, any information that might be used to identify you will be deleted.

If information is disclosed which refers to current or potential risk to participants or others confidence will have to be broken. This will be in line with █████ Hospital policy and procedure to follow in the event of such information being disclosed. If concerns were to arise the investigator would inform you at the time, and if action was to be taken discuss this with you.

What are the possible disadvantages and risks I should know about before I take part?
If you find that you feel upset in any way during the interview then I will stop and ask you whether or not you would like to take a break, or stop altogether. You will decide whether or not you want to continue with the interview. If you feel upset following the interview then you will have opportunity to contact me.

What are the possible benefits of taking part?
Your answers will help clinicians to understand more about the experiences of staff working with ABI patients with challenging behaviour and how this might impact on interventions implemented by staff. This could benefit the experiences of both staff and patients.

What happens if something goes wrong?
In the unlikely event that you are harmed by taking part in this study, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for legal action but you may have to pay for it. Regardless of this, if you wish to complain about any aspect of the way you have been treated or approached during the study you may. You will have to follow the complaints procedure for your service and it will be handled according to the formal and correct procedures.

What will happen to the results of the study?

The results will be written up as a thesis which will be submitted to the University of Leicester as part of their requirements to enable me to gain a Doctorate in Clinical Psychology. They may also be published in a medical journal. You can get a summary of the results if you would like them once the study is completed.

Who is organising and funding the research?

I will be organising the research with the assistance of the Clinical Neuropsychologist. Nobody will receive any money if you choose to be part of the study. The University of Leicester are funding any costs associated with the research.

Who has reviewed the study?

This study has been reviewed and approved by a University initial review panel, my University academic supervisor, a formal peer reviewer, the ██████ Research Committee and the Leicestershire Medical Research Ethics Committee.

Conclusion

If you wish to participate, please could you read and sign both copies of the attached 'Consent to be Approached' form. Please return one copy of the form to me using the internal mail service ("Inga Stewart, Psychology, ██████"). Please retain the second copy and this information sheet for your reference. Once I have received your signed 'Consent to be Approached' form I will organise a time to meet you and discuss the possibility of participating further. At the end of our meeting I will ask you to sign a form saying whether or not you want to take part in this study. This does not commit you to take part in this research, you are only giving consent to be approached. You can change your mind and withdraw at any time. Withdrawal or refusal to participate will not effect your conditions of employment.

Thank you for considering whether or not you would like to take part in this study. I would be very pleased if you could help.

Contact Details

Inga Stewart   ██████ Contact Tel: ████████ (███)

Trainee Clinical Psychologist   ██████ Email: ████████

University of Leicester   ██████ Internal Mail: *"Inga Stewart,*

104 Regent Road   *Psychology,* ██████"

Leicester, LE1 7RH

University of Leicester

School of Psychology
Clinical Section

104 Regent Road
Leicester LE1 7LT · UK
Tel: + 44 (0) 116 223 1639
Fax: + 44 (0) 116 223 1650

I am inviting you to take part in a research study that I am undertaking as part of my training in Clinical Psychology. Before you decide to participate it is important for you to understand what it will involve. Please take time to read the following information carefully. Please contact me if there is anything that is not clear or if you would like any further information. Take time to decide whether or not you wish to participate. You do not have to make your final decision at this stage.

Title of Study

Care Staff Attributions for Challenging Behaviour in Acquired Brain Injury Populations:
An Explorative Study

Researcher

Inga Stewart

Trainee Clinical Psychologist

Introduction

The experiences of staff in relation to challenging behaviour exhibited by patients with acquired brain injury (ABI) can be very different between different staff and between different patients. It seems that how staff feel about these incidents can have an impact on how they respond to patients. There are two parts to this study; the first part is one-to-one interviews and the second part is a focus group. This information sheet refers to Part 2: Focus Group.

What is the purpose of the study?

This study hopes to find out more about how staff feel about and understand incidents of challenging behaviour and how they feel this may obstruct or facilitate the way they work with ABI patients who exhibit challenging behaviour.

Why have I been chosen?

You have been invited to take part in this study because you have experience working with ABI patients who display challenging behaviour.

Do I have to take part?

No. It is entirely your choice whether or not you want to take part. Deciding not to participate or pulling out will not affect your role in the service in any way. I will ask you to sign a 'Consent to be Approached' form before coming to discuss the possibility of participating in the study, after which I will ask you to sign a 'Consent Form' to say that you want to take part. Even if you do decide to take part, you can pull out at any time.

What will happen to me if I take part?

You will be asked to sign a form saying that you want to take part. Then I will arrange to meet with you to discuss the possibility of participating further. If you agree to participate, you will be asked to sign a consent form. The first 8 respondents to agree to participate in the focus group will be included in the study. If you agree to participate in the study, it will involve a group discussion with other ███████ about your experiences of challenging behaviour in the ABI populations you have worked with. Please note there are no right or wrong answers.

You have the right to leave the discussion at any point and to choose not to answer certain questions. You will be required to participate for no longer than one and a half hours, although you are given the choice to leave the discussion at any time. With your consent the discussion will be tape recorded and transcribed (typed up) and analysed afterwards, and written notes will be made.

Will my taking part in this study be kept confidential?

Yes. Utmost care will be taken in order to ensure your anonymity. The information will be kept in a locked cabinet in my office at ███████. Any information that is entered onto a computer will be entered in such a way that your name will not be able to be linked with the information. The computer will also be password protected meaning that only I will be able to access it. Your name and personal details will not be mentioned anywhere in the study in order to protect your identity.

'Ground rules' will be established at the beginning of the group regarding confidentiality. Agreeing these ground rules will mean that you, and the other participants, will not be permitted to discuss the content of the focus group discussion outside of the group.

The taped interview will be heard and transcribed only by me. In the event that another person transcribes your interview, they would be external to the service and would have no information on your identity. They would not be permitted discuss the content of the interview with anyone. The recording will be destroyed after the transcription has been made in order to remove any identifying information you have provided.

In order to make sense of the interviews any papers written based on the findings will need to have a brief description of the participants. A copy of the interview transcript together with a copy of the description will be available upon your request. You will be given a pseudonym so your real name will not be used. If you wish details of the description to be altered to preserve anonymity, this can be done. As I may use extracts from you transcript, any information that might be used to identify you will be deleted.

If information is disclosed which refers to current or potential risk to participants or others confidence will have to be broken. This will be in line with ▮▮▮▮▮ Hospital policy and procedure to follow in the event of such information being disclosed. If concerns were to arise the investigator would inform you at the time, and if action was to be taken discuss this with you.

What are the possible disadvantages and risks I should know about before I take part?
If you find that you feel upset in any way during the discussion then I will stop and ask you whether or not you would like to take a break, or stop altogether. You will decide whether or not you want to continue with the discussion. If you feel upset following the focus group then you will have opportunity to contact me.

What are the possible benefits of taking part?
Your answers will help clinicians to understand more about the experiences of staff working with ABI patients with challenging behaviour and how this might impact on interventions implemented by staff. This could benefit the experiences of both staff and patients.

What happens if something goes wrong?
In the unlikely event that you are harmed by taking part in this study, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for legal action but you may have to pay for it. Regardless of this, if you wish to complain about any aspect of the way you have been treated or approached during the study you may. You will have to follow the complaints procedure for your service and it will be handled according to the formal and correct procedures.

What will happen to the results of the study?
The results will be written up as a thesis which will be submitted to the University of Leicester as part of their requirements to enable me to gain a Doctorate in Clinical Psychology. They may also be published in a medical journal. You can get a summary of the results if you would like them once the study is completed.

Who is organising and funding the research?

I will be organising the research with the assistance of the Clinical Neuropsychologist. Nobody will receive any money if you choose to be part of the study. The University of Leicester are funding any costs associated with the research.

Who has reviewed the study?

This study has been reviewed and approved by a University initial review panel, my University academic supervisor, a formal peer reviewer, the ███████ Research Committee and the Leicestershire Medical Research Ethics Committee.

Conclusion

If you wish to participate, please could you read and sign both copies of the attached 'Consent to be Approached' form. Please return one copy of the form to me using the internal mail service ("Inga Stewart, Psychology, ██████"). Please retain the second copy and this information sheet for your reference. Once I have received your signed 'Consent to be Approached' form I will organise a time to meet you and discuss the possibility of participating further. At the end of our meeting I will ask you to sign a form saying whether or not you want to take part in this study. This does not commit you to take part in this research, you are only giving consent to be approached. You can change your mind and withdraw at any time. Withdrawal or refusal to participate will not effect your conditions of employment.

Thank you for considering whether or not you would like to take part in this study. I would be very pleased if you could help.

Contact Details

Inga Stewart
Trainee Clinical Psychologist
University of Leicester
104 Regent Road
Leicester, LE1 7RH

███ Contact Tel: ██████████ (███)
███ Email: ████████████
███ Internal Mail: *"Inga Stewart,*
                     Psychology, ██████"

Appendix 6

Research Participant Consent to be Approached form

University of Leicester

Please ensure that you have read and understood the attached 'Information Sheet' before you make a decision about being approached to take part in this research.

Title of Study

Care Staff Attributions for Challenging Behaviour in Acquired Brain Injury Populations:
An Explorative Study

Researcher

Inga Stewart

Trainee Clinical Psychologist

Researchers briefing and undertaking

I am happy to answer any general questions you have about the research study.

As a Trainee Clinical Psychologist I agree to abide by the British Psychological Society's Code of Conduct and Ethical Guidelines for Research with Human Participants.

Signed: _____   Date:_____

      Inga Stewart

Participant's briefing and undertaking

I have agreed to be approached to take part in this study on the basis of the information made available to me by Inga Stewart.

I understand the purpose of the study and give my informed consent to be approached. I understand that signing and returning this form does not commit me to take part in the research, and if I do choose to partake I will be asked to give my consent to participate. I understand that I can change my mind and withdraw at any point and that withdrawal or refusal to participate will not effect my conditions of employment.

Signed: _____   Date:_____

Name (PLEASE PRINT): _____

Ward: _____

Appendix 7

Research Participant Briefing and Consent Agreement form

University of Leicester

School of Psychology
Clinical Section

104 Regent Road
Leicester LE1 7LT UK
Tel: + 44 (0) 116 223 1639
Fax: + 44 (0) 116 223 1650

Title of Study

Care Staff Attributions for Challenging Behaviour in Acquired Brain Injury Populations:

An Explorative Study

Researcher

Inga Stewart
Trainee Clinical Psychologist

Signing this form does not commit you to complete the study.
You remain free to leave the study without having any reason for doing so.

I have read the information sheet	yes/no
I have had the opportunity to ask questions and discuss this study	yes/no
I have had all my questions answered to my satisfaction	yes/no
I understand the nature of confidentiality with regard to this study	yes/no
I have received enough information about the study	yes/no
I understand that I am free to withdraw consent	
- at any time	yes/no
- without having to give a reason	yes/no
- without my employment or legal rights being affected	yes/no
I would like to receive a copy of my transcript	yes/no
I would like to receive a summary of the results of this study	yes/no
I give my consent to take part in this study	yes/no

Signed: _____   Date:_____

Name (PLEASE PRINT): _____

Signed: _____   Date:_____

      Inga Stewart

Confidentiality and data protection
Data will be kept in a locked cabinet in the principal investigator's office. Electronic data will be kept on a password protected computer and will be coded so that it cannot be linked to your name. This project complies with the requirements of the Data Protection Act.

Appendix 8

Interview and Focus Group Schedule

Title of Study

Care Staff Attributions for Challenging Behaviour in Acquired Brain Injury Populations:

An Explorative Study

Researcher

Inga Stewart

Trainee Clinical Psychologist

These questions should be regarded as a *starting point* to open possible areas of discussion relating to care staff experiences and ideas regarding 'challenging behaviour' in ABI populations.

- What terms or phrases could you use to describe your idea of 'challenging behaviour'?
- Please could you describe an incident of challenging behaviour that was memorable to you, and explain why it might have been memorable.
- With your idea of 'challenging behaviour' in mind, how might it relate to the ABI population that you work with?
- Why might you think some ABI patients exhibit challenging behaviour?
- Where, if at all, do you think staff might fit in with patient challenging behaviour?
- What terms or phrases could you use to describe the notion of 'control'?
- With this in mind, who, if anyone, could been seen to have control over a patient's challenging behaviour?
- What terms or phrases could you use to describe the concept of 'responsibility'?
- With this in mind, what responsibility, if any, do you think the individual patient might have in their challenging behaviour?
- What responsibility, if any, do you think staff could have in a patient's challenging behaviour?
- I wonder if a patient can change their behaviour? How might that therefore make you feel when you are working with them?
- I wonder if your actions as a member of staff could influence the actions of patients? Why do you think this may be?
- What are your thoughts about the notion that: your feelings about why a patient exhibits challenging behaviour may affect your experience of the behaviour? With your thoughts in mind, why do you think this could be?
- Please could you describe some of the 'interventions' for ABI patient challenging behaviour?
- What things do you believe could help you to implement interventions for challenging behaviour?
- What things do you think might make it harder to implement these interventions?

The interviewee should be encouraged to expand onto related topics where they feel it is appropriate.

Appendix 9


Focus Group Vignette

Case Vignette

Peter had wanted to go out in the grounds for some fresh air after lunch but the staff had been unable to facilitate it due to low staffing levels. Peter began to shout and demand that he was taken out. After explaining that there was currently not enough staff on the ward, staff withdrew attention from this behaviour. These demands continued throughout the afternoon as he moved from shouting at one member of staff to another. Other patients on the ward began to complain to staff about Peter's shouting. Peter then picked up a near by chair and threw it across the floor hitting an empty chair.
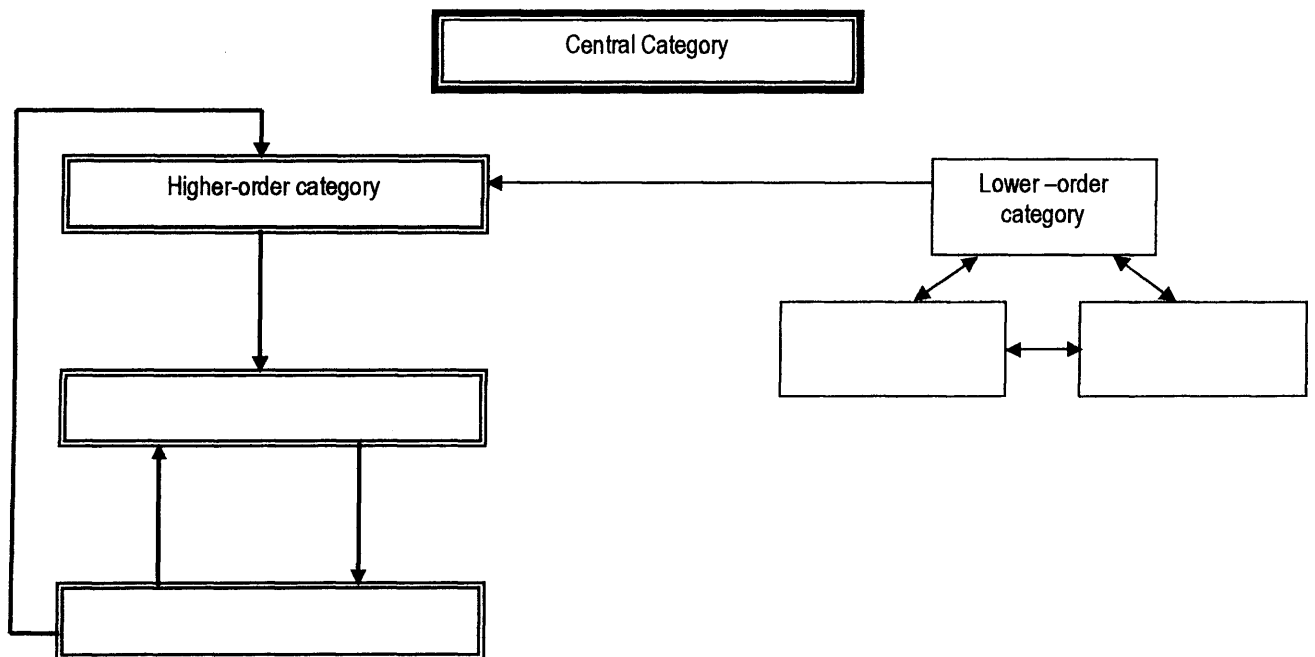
Appendix 10

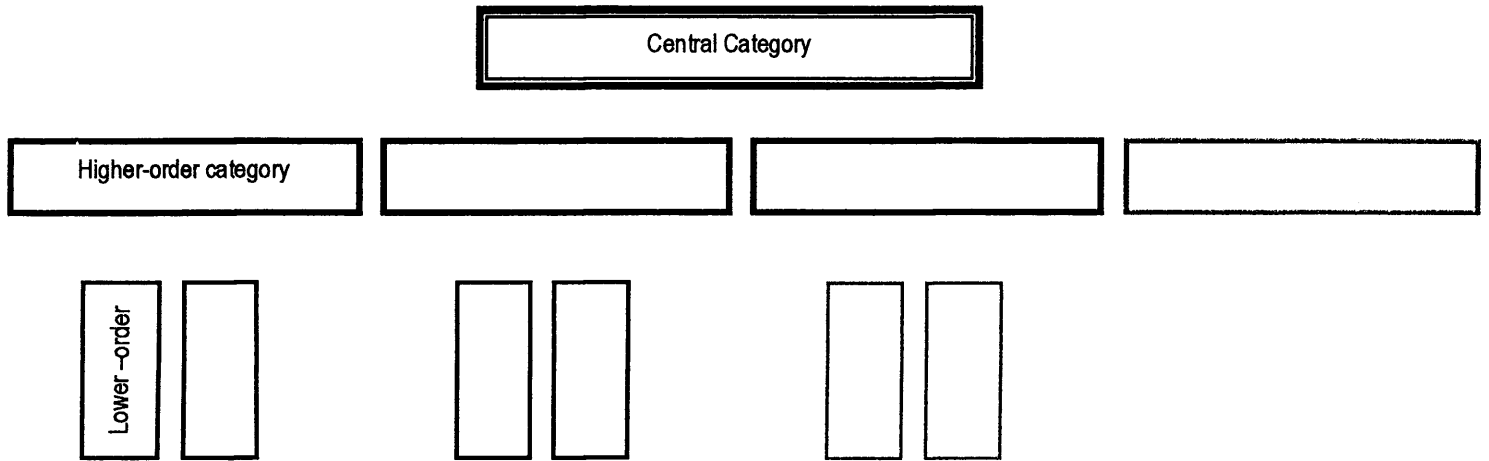## Examples of the Evolving Structure of the Model

Appendix 10

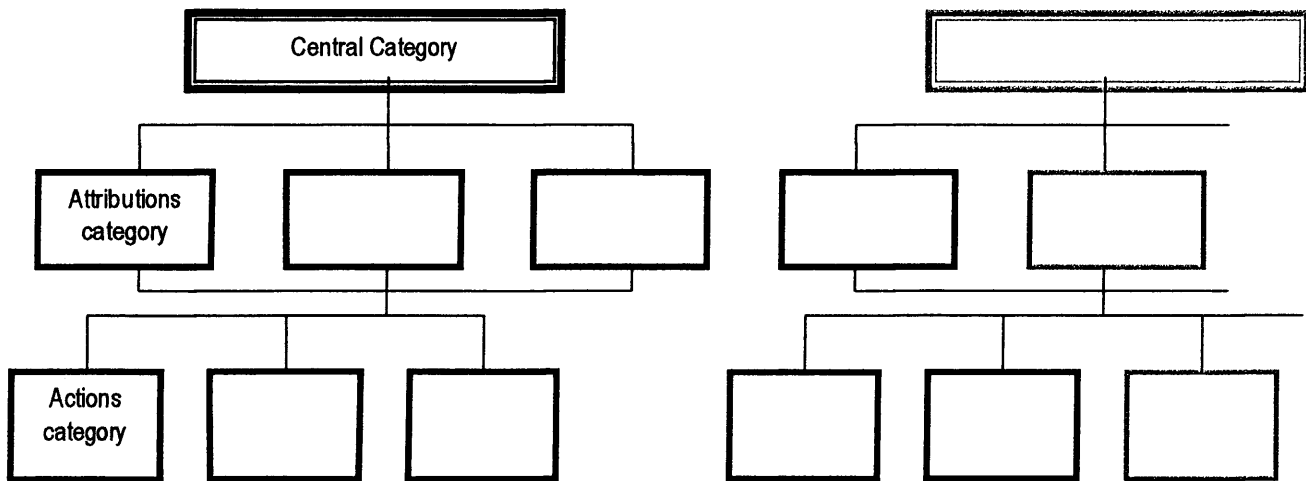## Examples of the Evolving Structure of the Model
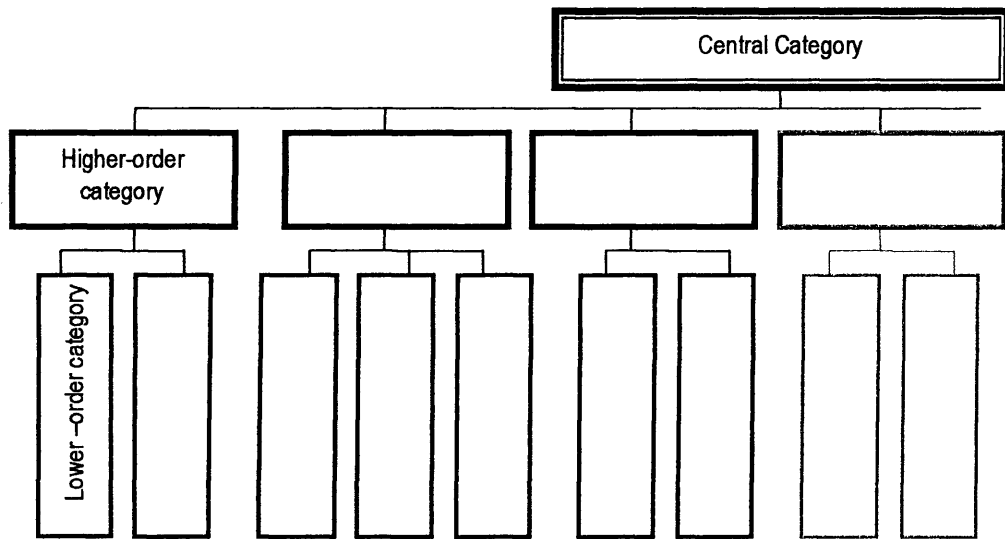
Figure 1 Example of Early Hierarchical Model Structure

Figure 2 Example of Early Process Model Structure

Figure 3 Example of Model Re-Structure Following Reflection

Figure 4 Example of Model Evolution as 'Attributions' and 'Actions' were Depicted Separately