Staff Attributions and Management of Violent Incidents in Hostels for Homeless People

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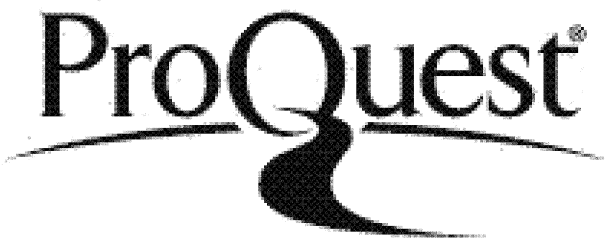

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ABSTRACT

Staff often have to deal with, explain and manage violent incidents in direct access hostels for homeless people. It may be hypothesised that staff's attributions and preferred management strategies would vary according to their attitudes and whether they believed the violent person had schizophrenia. The present study examines the attributions and preferred management strategies of 59 hostel workers in response to a hypothetical vignette of a violent incident. Half of the participants were told that the individual described had schizophrenia. Agreement with attributional statements was assessed using Likert scales, and later grouped according to the internal temporary, internal enduring and external dimensions. Management strategies were grouped as punitive, talking/caring and medical. Attitudes towards homeless people and people with schizophrenia were assessed using social distance scales and the Public Attitudes Towards Homelessness Scale. The Just World Scale was also administered.

Staff reported internal temporary, internal enduring and external attributions for the incident. The results indicated that staff made fewer internal enduring attributions about the behaviour of a homeless person with schizophrenia than a homeless person without a diagnosis, otherwise, they made quite similar attributions. Staff rated psychiatric strategies as more useful in managing the behaviour of a person with schizophrenia. Staff were found to have positive attitudes towards homeless people and people with schizophrenia. External attributions, positive attitudes and talking/caring management strategies were associated. The findings are discussed in the context of theories of attribution, balance and helping behaviour. They are also compared with other studies of attributions, attitudes and violence. The clinical implications of the current study are explored. Finally, directions for future research are suggested.

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CHAPTER ONE

INTRODUCTION

1. INTRODUCTION

A recent report into the stabbing of a voluntary care worker in Oxford has highlighted the issue of violence in hostels for the homeless and mentally ill (Davies, Lingham, Prior and Sims, 1995, the Newby Report). A CD-ROM search through The Times, Guardian and Independent demonstrates the media interest and the catalogue of incidents that hostel workers deal with. Interviews with hostel staff show aggression and violence to be a daily occurrence and area of concern (preliminary interviews). However, a Psych-lit search reveals a striking absence of academic research in this area. "Although violence is a serious and painful side of homeless life, it has not been addressed as a primary focus of investigation in published literature on this population" (North, Smith & Spitznagel, 1994, p.97).

The current study begins to redress the balance. It investigates the attributions and management of violent incidents by staff in hostels for the homeless. It is timely and important for current service provision. The literature on homelessness, violence and attribution is reviewed in the introduction. Definitional issues are covered here. Epidemiological information about homelessness and its relationships with mental health are outlined. The literature on violence and its explanation and management is then reviewed. Attribution theory is critically discussed, along with other social cognition factors, such as the categorisation of people into groups using schemas and labelling, and it is related to measures of social distance from people in less favourable categories. Some of the methods used in the areas of attribution, violence and homelessness are critically evaluated. Ethical issues that a research project such as this might raise are explored later, in the method section.

1.1 Homeless Literature

"In Great Britain 1-2 million people may be homeless" (Scott, 1993, p. 314). In Leicester, 942 out of 113,000 households applied to the council as homeless under Part II of the 1985 Housing Act; 274 were accepted as homeless and 130 lived in hostels in the first quarter of 1994 (Department of Environment, 1994). There are currently nine hostels in Leicester which accept people on direct access (see Appendix 1). Scott (1993) reviews the current epidemiological literature on homelessness. Most homeless people are single, middle-aged men, however the mean age of hostel residents is falling and there are

increasing numbers of women, and significant numbers of young people whose homelessnes is often causally related to sexual abuse (Hendessi, 1992). Whilst few homeless people currently have any paid employment, most have had in the past. Over half live in a single city for over a year.

It is well known that "hostels are having to care for long term severely affected psychiatric patients discharged into the community" (Marshall, 1989, p.706). Marshall (1989) found 48/146 residents of hostels in Oxford were disabled by mental illness. In her review, Scott (1993) suggests 50 per cent of the total homeless population may have some form of mental disorder. Fisher *et al.* (1986, in Scott, 1993) estimate that twice as many homeless than non-homeless people have psychiatric problems. Again, a significant number have difficulties with alcohol and drug use although figures vary from 9-63 per cent (Scott, 1993). It is with these groups that clinical psychologists might be expected to have most input, although few authorities employ them to work in this specific area. Generally, the services provided for homeless people who have mental health problems is poor and Singh, Meltzer, Holbrey, Meddings & Shepherd (1992) found people of no fixed abode to receive significantly less follow up care even when diagnosis, health authority and reason for discharge was controlled for: "despite the clear evidence of psychiatric symptoms before and during admission this appears not to positively influence the history and they receive very little planned input from services at discharge and follow-up" (Singh, *et al.*, 1992, p.11). Bachrach (1984), over 10 years ago, urged that services be improved for the homeless mentally ill. Today, this goal has not been met and forms part of Trust strategic plans (e.g. Leicester Mental Health Services Trust, Andrews, 1996).

1.1.1 *Violence in Hostels*

Most research on the homeless has been epidemiological. There has been only one study relating attributions and homelessness: the relationship between perceived loss of control over the shelter environment and giving up on finding a home or employment (Burn, 1992). There has been some limited research looking at violence in hostels. Hogg and Marshall (1992) found that 14/46 of their subjects in an Oxford hostel had had current or recent problems of violence to self or others. North, Smith and Spitznagel (1994), in a study of 900 homeless people in America, found over 10 per cent of subjects had been mugged, assaulted or raped in the past six months, and half reported engaging in aggressive behaviour as adults.

Newspaper reports testify to the violence in hostels: "Housing support worker killed by resident of Christian fellowship hostel in Guildford" (Times, 12:04:94), "Youth charged with murdering mother in hostel for the homeless" (Times, 05:01:95). Media reports should be viewed with some scepticism due to the obvious sensationalist and biased reporting that sells newspapers. They often give an unbalanced and subjective report. Nevertheless, they do show that violence in hostels is an issue of media interest and perhaps popular interest and do illustrate the occurence of such events which ought to be investigated more systematically by researchers.

Staff working in direct access hostels in Cambridge, interviewed by the author, reported daily aggressive incidents that they had to deal with, including shouting, swearing, damage to property, and assaults on themselves and other residents (see Appendix 2). Statistics produced by Leicester City Council show that three to five attacks against staff in five hostels are recorded each month: this is an underestimate since staff claim only to record more serious violence (Leicester City Council). This demonstrates that it is an issue of importance to some staff. Therefore, homeless people suffer from violence but there is also a considerable amount of violence in homelessness hostels and staff have to manage this. It is an area that requires further investigation.

1.1.2 *Methodological Issues*

There are a number of problems with the literature on the homeless, in addition to its narrow epidemiological focus. Definitions of homelessness vary. The Alcohol Drug Abuse and Mental Health Administration (1983) states that a homeless person is "anyone who lacks adequate shelter, resources and community ties" (in Scott, 1993, p.314). The British government uses the term roofless which excludes most homeless people who do not actually sleep rough, whilst the NHS uses the term NFA (no fixed abode) which in Cambridge includes all people in hostels, B&B's and other people's floors (Singh *et al.*, 1992). Different studies have looked at different groups of homeless people. Marshall's (1989, 1995) studies have concentrated on those living in hostels but these people could be significantly different from those sleeping on the streets or in friends' houses: it might be postulated that more women and children stay with friends. It is methodologically difficult to sample people other than those in hostels, although Roth *et al.* (1985, in Susser, Conover and Struening, 1990) did so using key informants to locate them. Nevertheless a problem with representativeness remains. Again, the usual census style approach may oversample the longterm homeless as opposed to the transient. Susser *et al.*

(1990) suggest a major problem has been the lack of adequate control groups, particularly as multiple problems seem more common amongst the homeless population. However, some of these definitional problems are avoided in the current study which focuses on direct access hostels only, and does not claim to be relevant or generalisable to the homeless population as a whole.

Studies have also been criticised for their operationalisation of mental illness. Susser *et al.* (1990) note the reliance on clinicians' diagnoses, pointing out that behaviours such as urinating in the street could be due to mental health problems or being homeless itself. Based on the ideas raised by Susser *et al.* (1990), it could be suggested that diagnosis by lay interviewers could overcome difficulties in knowledge about homeless issues. However, such interviewers are less knowledgeable about psychiatry and this could result, for example, in mis-diagnosis of psychotic people as schizophrenic when it might be temporarily drug induced. Standardised scales have been used such as the General Health Questionnaire (GHQ), but summary scores do not lend themselves to diagnosis and may be complicated by life events. Case notes may provide information on past diagnoses, however, diagnoses may change over time, and may be influenced by extraneous considerations, for example, in the over-diagnosis of NFA people as "personality disordered" and therefore not treatable. The current study does not look at the actual diagnoses of people living in hostels, but rather, the way staff might potentially discriminate between people if they are offered different diagnoses. It is more interested in staff's use of labels and schemas rather than how these might be initiated.

Since the homeless literature is mostly epidemiological and does not broach the issue of attributions for violent incidents in hostels, it is necessary to turn to the more general literatures on violence and on attributions.

1.2 Violence in Health Settings

Whilst there is only limited research on violence and homelessness, there is a burgeoning literature on violence and mental health and an acknowledgement of its importance. Wykes (1994) notes that 1/200 health service staff suffered major injury and 1/10 needed first aid following a violent attack during the study year. Perkins (1991, in Wykes, 1994) found 53 per cent of clinical psychologists had been assaulted during their career. "Serious patient violence may be rare, but minor acts of violence ... are an every day part of

psychiatric life" (Crichton, 1995b, p.80) and British health service staff are three times more likely to suffer injury compared with industrial workers (Crichton, 1995a). Since untrained staff are more likely to suffer aggression, it is probable that hostel staff, who are usually untrained, would also experience more. It is also likely that hostel staff with more training and experience will suffer less aggression.

McDonnell, McEvoy and Dearden (1994) discuss ways of managing violent situations in caring environments. They suggest defusing incidents by using mood matching, calm, surprise or assertiveness; restraint using C&R (control and restraint), or seclusion; and self-defence, but note the many problems, particularly, ethical, with these. Greaves (1994) discusses more organisational ways of managing violence, particularly through policy making and training. Drinkwater (1982, cited by Whittington, 1994) uses a more psychological framework, looking at antecedents and consequences to violence. She notes that violence occurs more often when a client is angered by intrusive procedures such as being given an injection or being excluded from a room, and also by being ignored when violence may initiate interaction.

Crichton (1995a) has looked at the response of nursing staff to patient violence using vignettes in a controlled way. He found that staff rated time out, p.r.n. (pro re nata / when required) medication, relaxation, talking about the incident and making it clear that behaviour was unacceptable as most helpful in managing violent behaviour; and calling the police, seclusion, imposing sanctions and carrying on as if nothing had happened to be least helpful. Untrained staff were significantly more likely to prefer more coercive methods of control, such as seclusion than were trained staff ($p<0.001$). Management strategies were also associated with diagnosis. Schizophrenia was, not surprisingly, associated with rating medication as more helpful, whereas punitive sanctions were more associated with personality disorders. Crichton (1995a) also looked briefly at staff's attributions for violent incidents. Using a simple question asking "how much do you feel mental disorder is responsible for what happened and how much is due to J's free choice and lack of control?" he found the most common response to be a mixture, however, diagnosis of schizophrenia was more associated with seeing mental disorder as causally responsible, and personality disorder with choice and lack of control ($p<0.001$). This related to treatment of choice. However, he did not ask about alternative attributions, such as situational factors and nor did he relate it to the wider attribution literature.

Crichton's (1995a) study benefits from a clear, well controlled vignette design and from the large number (N=576) of participants. However, vignettes might be criticised as they look, not at subjects' actual responses to real incidents, but their intentional responses to fictional ones. Although Crichton's scenario is a common one, this form of research can suffer from using hypothetical incidents removed from those actually experienced by staff. Finally, although the study is very thorough in addressing management strategies, it is less clearly related to work on explanation and attribution and makes only a limited attempt to analyse this. Attributions for violence are discussed more fully later.

The current research addresses some of the issues arising from this as regards staff working in direct access hostels for the homeless: their attributions for violent incidents and their ensuing management. In order to explore more fully the attributions for violence it is necessary to look at attribution theory and related theories and research.

1.3 Attributions

1.3.1 *Attribution Theory*

A framework of attribution theory is used as the basis for the research. This is a major field of study in psychology and those aspects that most closely relate to the current project are now reviewed.

"Attribution theory is about people's conscious reflections on their own actions and the actions of other people, and the explanations which are contrived to account for these actions" (Totman, 1982, p.45).

Attribution theory is the study of how people try to find appropriate causal explanations for one another's behaviour and for other events in the environment. It was developed by Heider (1958) who assumed that people are motivated to perceive their social environment as predictable and controllable. People make sense of theirs and others' actions in terms of situational and dispositional attributes. Attributions may be categorised along the dimensions of internal/external, stable/unstable and global/specific. "Fundamental to the question of why someone behaves as he or she does is whether the locus of causality is in the person (internal) or in the environment (external) or both" (Fiske & Taylor, 1991, p.25). Antaki and Brewin (1982) argue this dichotomy should be

expanded to separate characterological internal attributions which might confer blame for stable unchanging traits from behavioural or temporary internal ones which are modifiable and controllable. There is a difference between seeing someone as causally responsible when it is due to an internal stable factor such as personality, and something they can change, such as effort.

If an attribution is internal and identified with a specific person who is believed to have foreseen the consequence, to be operating under free choice and to not be justified by the situation, an attribution of responsibility may be made. Attributions of blame worthiness are reserved for causes for which the agent may be punished, including in the crimino-legal and mental health settings, and arguably, in staffed hostels. Attributions of blame pre-suppose ones of causality and responsibility and centre on intentionality (McGraw, 1987, in Fiske and Taylor, 1991). However, Shaver and Drown (1986, in Fiske & Taylor, 1991) found research studies to use the terms blame and responsibilty interchangeably. The literature can thus be confusing.

Jones and Davis (1965) elaborate notions of personal causality and its relation to perceptions of intentionality in their theory of correspondence. They state that a dispositional attribution is correspondent to the extent that it explains the observed action. People assume intentionality, that others try to achieve a desired action, and so the result of their action provides clues as to the cause. Common, expected results are less informative than non-common, distinctive ones. For example, in an experiment by Jones, Davis and Gergen (1961, in Jones and Davis, 1965), subjects observed stooges being interviewed for a job: when they showed characteristics which would hinder their chances of success, subjects made more confident dispositional attributions. Kelley (1967, in Fiske & Taylor, 1991) suggested that people act as statisticians, observing the covariation of events in an analysis of variance. Attributions covary according to distinctiveness (is it only John that does it?), consistency over time (how often when John is there?) and consensus (does John do it to others or just Amy?).

"There is a pervasive tendency for actors to attribute their actions to situational requirements, whereas observers tend to attribute the same actions to stable personal dispositions" (Jones & Nisbett, 1971, in Eiser, 1978, p.251). Eiser (1978) cites an experiment by Jones and Harris (1967) whereby even where an opinion is shown to be expressed under force, it is still attributed to the person and not to situational factors. He argues that dispositional attributions about someone's responsibility for good and bad

events also affects our more general attitudes to them. However, there is also a bias to explain negative outcomes in terms of situational factors, and positive ones in terms of dispositional factors (Tillman and Carver, 1980, in Fiske and Taylor, 1991).

Brewin and Antaki (1987) further refine the concept of attribution. They argue that most research has been too willing to accept that explanatory statements or ratings are simple expressions of belief in causal relationships. They identify other functions: labelling, moral evaluation and self-presentation. Thus, help giving would be mediated by pity and anger due to perceived controllability of causes. Black people may be imbued with such salient personality characteristics that these would override other explanations, and stereotypes might influence both initial descriptions and later attributions for behaviour.

1.3.2 *Schemas and Labelling*

Attribution theory assumes that people make attributions which can then be categorised. However, as Heider (1958) argues, people do not directly perceive these causes but do so through their context, the manner in which they are perceived, attributes of the object and of the perceiver. Kelley (1972, in Critchlow, 1985) theorises that when observers do not have enough information to make inferences, they rely on causal schemata, or general beliefs about cause and effect developed through life. If an act is seen as having multiple sufficient causes, each of which is plausible and sufficient to explain the act, an observer can choose any of these explanations. For example, alcohol may be focused upon as the primary cause of a violent incident, attributing responsibility to intoxication, rather than to the individual or other factors (Critchlow, 1985). It is a subjective process, affected by stereotypes and past experiences.

Attributions are not context free, but are affected by knowledge and schemas: people think through what they know about a specific domain (Hilton and Slugoski, 1986, in Fiske and Taylor, 1991). Schemas are "people's cognitive structures that represent knowledge about a concept or stimulus" (Fiske & Taylor, 1991, p.139). They are theory driven, rather than data driven, processes through which prior knowledge may be organised and simplified into categories (Fiske and Taylor, 1991). They allow greater sense of understanding, prediction and control over the world. They affect what is perceived, remembered and inferred.

Through categorisation people classify and identify individuals with larger groups and use schemas of these groups to infer properties about the individual. People belong to many categories, visible ones being most salient. These schemas and stereotypes then inform decisions about attributions. For example, Felman-Summers and Kiesler (1974, in Aronson, 1995) found undergraduate men to attribute a female physician's success more to an easier path and not to her competence, using sexist stereotypes on gender differences. Again, it is implicit in policies such as stop and search, where police rely on stereotypes of black people as criminals and explain their whereabouts using such schemas. "In an ambiguous situation, people tend to make attributions consistent with their beliefs or prejudices" (Aronson, 1995, p.305). Hostel staff may be expected to have schemas about homeless people, schizophrenia and violence.

Labelling theory states that "social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labelling them as outsiders" (Becker, 1966, in Cochrane, 1983, p.148). It may be argued that labels are pragmatic and enable the identification of shared needs and specialist treatment. However, it is important to recognise the relationships between labelling, power and imposed language: "categorisation often seems to be sufficient for discrimination" (Gardner and Hopkinson, 1996, p.136). The effect of labelling is illustrated by Rosenhan's (1973) classic study where stooges were treated according to a label, or schema for mental illness, rather than their actual health. Behaviours such as writing were labelled as psychotic, in line with the predominant schema, although this may have been affected by their initially acting as if they were schizophrenic. Conversely, Lindsay (1982) has shown labelling may be less important than objective differences. Both categorical labelling and the current situation may play a part in determining attributions.

1.3.3 *Social Distance and Attitudes towards Homeless People and People with Schizophrenia*

People have schemas that separate their own from other groups. Tajfel's (1981) social identity theory suggests people are motivated to see themselves and their groups as different from, and better than, other groups in order to enhance their self-esteem. Social distance from outgroups and negative attitudes to them would improve self-esteem. Perceiving oneself as similar to a victim or denigrated group increases one's own feelings of vulnerability and thus may be defended against by increasing social and psychological distance (Pyszczynski, Greenberg, Solomon, Cather, Gat and Sideris, 1995). Thus, people

might distance themselves from people with schizophrenia and homeless people. Miles (1987) demonstrated that the public do have negative schemas of mentally ill people as easily recognisable, potentially dangerous and unpredictable. Farina (1973, in Cockerham, 1981) found subjects who claimed a break in job record to be due to admission to a mental hospital to be rated as less friendly and less likely to be offered the job than those who explained it in terms of travel. Warner (1985) suggests that stigma reduces job and housing prospects and, in turn, recovery prospects.

There has been a wealth of studies of public attitudes to mental illness, particularly as it is an important variable in the successful implementation of community care policies. Commonly, a methodology involving vignettes and social distance measures has been utilised. Levey and Howells (1995) found a majority of participants rated a person in a vignette, behaving as if experiencing schizophrenia, as different from themselves. Brockington, Hall, Levings and Murphy (1993) examined the attitudes of residents in two Midlands areas, using vignettes and measures of social distance. They found an absence of fear, generally positive attitudes, but with a substantial minority holding intolerant attitudes. Positive attitudes were associated with higher education, higher social class, and younger age, excepting the under 25 age group who were less positive. It is possible that social desirability factors interact with attitudinal measures. Trute, Tefft and Segall (1989), in a study of public attitudes to mentally ill people in Canada, found a slight tendency to negative attitudes and social distance, contrary to expectations that attitudes may have become more positive. They found that rejection of the mentally ill in social situations, such as falling in love, was linked to prior experience, age and perceived dangerousness. Rejection in social responsibility contracts, such as employment or housing, was related to education.

Eker and Arkar (1991) studied the attitudes of Turkish nurses towards mentally ill people depicted in vignettes using measures of social distance, such as asking if they would "sit beside him on a city bus". They found more negative attitudes, social distance and expectations of physical and emotional burden in the vignette of a person with 'paranoid schizophrenia' than 'neurosis' or 'normal'. More positive attitudes were associated with younger age and higher education. This paralleled their findings with university students (Eker, 1989), although the nurses showed less social distance, perhaps indicating people with more positive attitudes are more likely to enter such professions or that increased knowledge and experience improve attitudes. These factors differ for hostel workers, who, whilst having much contact with people with mental health problems, have not

specifically chosen to work with them, but with homeless people, and have little related training.

Homeless people are also stigmatised. Guzewicz and Takooshian (1992) summarise the results of American surveys as finding a recent backlash against homeless people in the 1980s, changing from sympathy to resentment. Nevertheless, Toro and McDonell (1992) found subjects in their telephone survey to be supportive and well informed. This difference may have been due to methodology, but also due to phenomena described by Somerman (1993) whereby people may express sympathy but be rejecting of hostels in their neighbourhood. Measures of social distance might elucidate this. Guzewicz and Takooshian (1992), using the PATH scale of attitudes towards homeless people, found a wide range of responses and overall a slight tendency towards more positive attitudes. There are no published studies of attitudes towards homeless people in Britain, although ad hoc media reports and statements made by the Prime Minister about people on the streets might lead to an impression of negative attitudes. People might create social distance between themselves and people who were homeless or had schizophrenia to promote their own self-esteem.

People are also motivated to see the world as a meaningful, controllable place where good things happen to good people and bad to bad (Lerner, 1970, in Rubin and Peplau, 1975). The defensive need to ward off threats to the self and view the world as predictable means it is more psychologically comfortable to believe people deserve their situation. Rubin and Peplau (1973, in Rubin and Peplau, 1975) found high scores on the Just World Scale relate to attitudes towards those perceived by some as negative outgroups, such as blacks. Guzewicz and Takooshian (1992) report that sympathetic responses to homeless people, as measured by the PATH, are related to lower belief in a just world. It may be related to negative attitudes to homeless people and people with schizophrenia and affect attributions for incidents.

Heider's (1958) balance theory might explain these findings and provides the basic framework for all consistency theories. It states that the relationship between cognitive elements, such as attitudes, objects and people should be mutually congruent and form an ordered whole. Elements are seen as forming triads which can be balanced or unbalanced. A balanced whole is when the sum of values between elements is positive, for example, if the perceiver has a positive relationship with another person and both of them dislike x. However, if p and o have a positive relationship but disagree about x, there is imbalance

and one of the relations is liable to change. Heider implies that balanced structures are more stable, and that individuals are motivated to achieve it. If not, tension ensues. Attitudes and attributions might be affected by these principles. Mills, Jellison and Kennedy (1976) found people's attributions for their emotional states on election information could be predicted using the model. It would also predict that if someone had a positive attitude to homeless people and they did something negative, this would be attributed to situational factors, whereas, if a negative attitude were held, it would be attributed to dispositional factors internal to the individual.

1.3.4 *Attributions and Violence*

A number of studies have examined attributions for violence. "Aggression is considered as a special kind of interaction whose features are socially defined" (Vala, Monteiro & Leyens, 1988, p.231). Vala, Monteiro and Leyens (1988) explored perceptions of violence as a function of observer's ideology and violent actor's group membership, using vignette methodology and offering potential explanations to choose from. They found radical left wing subjects made more external attributions to delinquent actors than police actors. Conservative subjects did not show significantly different attributions. Radical subjects showed more tolerance of delinquents than policemen whilst conservatives showed the reverse. For conservatives, they also found a significant correlation ($p<0.05$) between type of attribution and severity of sanctions deemed appropriate: more internal attributions were associated with more violence, more responsibility and more severe punishment. Additionally, they found that, overall, more external than internal attributions were provided to explain the violent act, raising queries over the fundamental attribution error. Therefore, it could be expected that actors' membership of other groups, such as people with schizophrenia or who are homeless, and subjects' attitudes towards them may also affect attributions and management.

Home (1994) examined police officers' and social workers' attributions of responsibility and assessment of seriousness of wife abuse situations using vignettes. She found police to be more likely than social workers to attribute responsibility to the woman, and prior violence or abuse to increase men's responsibility. Women police and social workers saw men as more responsible than men did. Home notes the link between attributions and management: "judgements about attribution of responsibility and the gravity of a domestic violence incident may play an important role in shaping workers' intervention decisions" (Home, 1994, p.68). She suggests that in order to improve the treatment of women

survivors by police, they should be given more training on domestic violence, including sensitisation. Further research is needed to show the effects of such training, but it might equally be important with other groups or types of incident.

"The relationship between alcohol abuse and interpersonal violence is well established" (Aramburu & Critchlow Leigh, 1991, p.31). Critchlow (1985) found blame for socially disapproved acts was placed on the alcohol rather than the actor and alcohol took precedence over other attributions. This decreased responsibility did not also relate to changes in punishment for perpetrators. Leigh and Aramburu (1994) found both victims and perpetrators to be seen as more responsible if they had been drinking. They also found unexpected violence to be attributed to more non-dispositional causes and for more situational attributions to be made if more information was available.

1.3.5 *Attitudes, Attributions and Management Strategies*

Attitudes and attributions affect management strategies. Attitudes relate to the care and interventions used by staff with people in longstay psychiatric services (Conning and Rowland, 1992). Marteau and Riordan (1992) investigated the influence of staff's causal attributions for illness and their attitudes. They gave staff vignettes of patients who had followed/ignored health advice such as not smoking for lung cancer. Staff blamed people who ignored advice more for their illness and held more negative attitudes towards them. They suggest this might affect the care patients receive. Brewin (1984) found if pre-clinical students believed people were more to blame for their illness they were less willing to consider medication. Attitudes towards homeless people, particularly regarding responsibility for their predicament, could explain why people of No Fixed Abode receive poorer standards of care. Attitudes towards them might also affect attributions for violent incidents and consequential management of such situations.

Schemas may also affect attributions of responsibility. Howells (1984), using vignette methodology, found a mentally ill offender was perceived as less responsible, less deserving of blame, deserving less punishment and more in need of treatment than a non-mentally ill person. Howells, McEwan, Jones and Mathews (1983) conclude that people make allowances for people with mental health problems, consistent with hypotheses of mitigation rather than double deviance. They also found people suggested more medical and therapeutic treatment rather than punishment. Similarly, Critchlow (1985) found people discounted attributions of blame if they thought the aggressor had been drinking.

This may be explained in terms of Kelley's (1972, in Critchlow, 1985) discounting principle whereby, in the absence of enough information, causal schemata would be used to develop attributions and one salient schema would be chosen at the expense of others. In the current study, two salient schemas are given: homelessness and schizophrenia: it might be hypothesised that the label of schizophrenia would discount attributions of responsibility.

Meyer and Mulherin (1980) found willingness to help another person was influenced by attribution of controllability of the cause. They were more willing to lend money to a hypothetical person in a vignette, if they believed the other person's shortage of money was out of their control. With nursing staff, Crichton (1995a) found aggressive behaviour was attributed more to illness in a person with schizophrenia and responded to with more medical interventions compared with people with personality disorder whom they viewed as more in control of the behaviour and to whom they responded to by punishing. Therefore, it might be anticipated that hostel staff's attributions for behaviour would affect their favoured management strategies.

1.3.6 *Attributions and Schizophrenia*

Barrowclough, Johnston and Tarrier (1994) have studied the importance of attributions and relapse in schizophrenia. They related it to the concept of Expressed Emotion and used attributions spontaneously given during the Camberwell Family Interview. They found high EE relatives made more attributions than did low EE ones. Those relatives with high criticism suggested more causes internal to the patient and characterological, and hostile relatives perceived the causes to be controllable by and personal to the patient. Emotionally overinvolved relatives made more external and universal attributions outside the patient's locus of control. Low EE relatives saw it as a more legitimate illness and did not blame them. Hostile relatives might try to coerce the patient to change and behave normally, causing stress and relapse of positive symptoms, whilst overinvolved ones might take control away from them and do things for them, encouraging withdrawal and negative symptoms. "Attribution variables were better predictors of patient relapse at nine months follow-up than were EE measures" (Barrowclough, Johnstone & Tarrier, 1994, p.67). Similarly, Brewin, MacCarthy, Duda and Vaughn (1991) found attributions to affect relapse in schizophrenia and for this to link with Expressed Emotion. Molvaer, Hantzi and Papadatos (1992) looked at clients attributions about their own schizophrenia and found attributions of personal inadequacy to relate to decreased optimism about their

future mental health. Such results may seem to contradict those of the physical health literature (e.g. Brewin, 1988), however, it is internal behavioural attributions, personal responsibility without blame, which seems to predict good outcome as these are controllable, whereas less controllable characterological factors predict poorer outcome, as do attributions of an external nature again over which the person has little control.

1.3.7 *The Relationship between Attitudes, Attributions and Behaviour*

"Some people may be buying the assumption that people always behave in line with their attributions... that's not really true. There are many occasions where there is slippage between the way in which people explain reality and how they respond to that reality" (Jones,1978, in Harvey, Ickes & Kidd, 1978, p.377). There is little published work on the relationship of attributions and behaviour. Snyder (1976) found there was an association between self-perception of the causes of one's own behaviour and actual causation. The extensive literature on attitudes and behaviour may be enlightening, but shows a complex picture. LaPiere's (1934, in Wicker, 1969) classic study found only 1/250 restaurants actually refused to serve a Chinese couple whereas 90 per cent said they would refuse. Wicker (1969) summarises his review stating, "it is considerably more likely that attitudes will be unrelated or only slightly related to overt behaviours than that attitudes will be closely related to actions"(p.178). However, more recently, Fishbein and Ajzen (1975, in Ajzen, 1988) have developed a model whereby attitudes and planned behaviour states derived from a trilogy of affect, cognition and intention do predict actual behaviour, and the specificity of the attitude and behaviour is consistent. Rabkin *et al.* (1984, in Hall, Brockington, Levings and Murphy, 1993) concluded that attitudes remain the most reliable precursors of behaviour. It is probable that there would be a relationship between the stated attributions and management strategies of hostel staff and their actual behaviour, but that this would not be sufficient to make predictions. The study should not be interpreted as going beyond the hypothetical vignette situation.

In summary, the attribution literature suggests explanations for events can be explored along dimensions of external, internal characterological and internal behavioural. People use schemas to simplify their world, and to categorise in and outgroups. Negative schemas and stereotypes exist for people who are homeless and who have schizophrenia. In order to enhance self esteem people may create social and psychological distance between themselves and other negatively valued groups. Balance theory explains how attitudes and schemas may influence attributions. The staff's attributions may affect later outcome

through their effect on the management of incidents and through their influence on users' own attributions. It is important to investigate staff's attributions of violent incidents in hostels. Clinical psychologists might be able to work on the attributions and attitudes of staff and affect the ways they manage incidents. There is no research as yet looking at this. However, there is much related work on violence, attributions and homelessness. Additionally NHS Trusts and hostel workers view this as an important issue, in need of greater consideration.

1.4 Methodological Issues

1.4.1 *Research Design*

The study aimed to compare participants' attributions for violent behaviour and management strategies regarding people who were homeless and people who were homeless and had a diagnosis of schizophrenia. Two options of experimental design are appropriate: between subjects and within subjects designs. A within subjects design whereby the same people are given both versions of the questionnaire is more efficient in that fewer subjects need to be sought, and subjects and conditions are not confounded. However, order effects might interfere with the study as the first version of the questionnaire might affect responses to the second. A between subjects design, whereby different people received different versions of the questionnaire might be regarded as safer, as there would be no such contamination. Possible differences between the groups are controllable by matching along likely confounding variables.

Self-administer survey formats may decrease response rates and thus reliability. On the other hand, they are more time efficient than interviews, and lessen the effect that the researcher has on participants. Reactivity can also be reduced by care over language used, for example, not including any swear words in vignettes, which, whilst part of the situation in hostels, might affect responses.

1.4.2 *Attribution Measurement*

Some of the central variables in the study are attributions for a violent incident. Attributions have been measured using closed and open questions and discourse analysis. Closed questions have the advantage of being standard across subjects and, used as rating

scales, can be assumed to have interval properties, enabling the use of parametric tests, a psychometric advantage (Hewstone, 1989). However, they limit responses to those suggested by the researcher which might be different from those normally made, querying validity. As Kelley and Michaela (1980, in Hewstone, 1989, p.38) have stated, "the central irony of attribution research is that while its central concepts concern the causal distinctions made by common people, these have been little investigated."

Open ended questions do allow subjects to generate their own causes, but Turnquist, Harvey and Anderson (1988) argue that subtle differences in procedure may produce contradictory findings, for example, "why?" and "why me?" have very different connotations. Responses must be coded into categories, through use of factor analysis or nominal categories based on theoretical models. Elig and Freize (1979, in Peterson, Semmel, von Baeyer, Abramson, Metalsky and Seligman, 1982) also suggest they are less reliable than fixed-formats. They might have greater face validity but poorer reliability. Nevertheless some psychometric difficulties may be overcome by asking subjects to rate their self-generated attributions along rating scales as in the Attributional Style Questionnaire (Peterson *et al.*, 1982).

Stratton, Heard, Hanks, Munton, Brewin and Davidson (1986) describe a way of extracting and coding causal beliefs in natural discourse with adequate reliability. Brewin *et al.* (1991) used this in their study of attributions and expressed emotion, coding from transcripts of the Camberwell Family Interview. This method is useful as it relates more to actual beliefs held rather than artificial constructs. However, it relies on researchers later coding them using their own categories, which could be subjective and different from subjects'. Brewin *et al.* (1991) report Kappa coefficients of .35 - .76 for reliability which are not very high. The system is good at finding general themes and exploring causal distinctions. However, it does not lend itself to statistical comparisons.

In the present study, a series of closed rating scales to facilitate later coding, statistical analysis and increase reliability, was chosen.

1.4.3 *Other Measures*

There are many aspects of attitudes which could be assessed. Trute, Tefft and Segall (1989) argue that the most critical concern is the degree to which individuals accept the participation of outgroups in their social relationships, measured through social distance.

Problematically, there is no standard rating of what constitutes social distance from people with mental health problems, homeless people or other groups. Pyszczynski *et al.* (1995) measured it by giving participants personality profiles of a target person, and then asking them to rate themselves along the same personality dimensions. More commonly, social distance scales have been utilised whereby participants are asked to rate their willingness to interact with a member of the target group in a number of different ways, such as living next door or falling in love with them. This is the methodology adopted by Levey and Howells (1995) and is adopted in the current study.

Attitudes and attributions may be unstable, contextual and not generalise to actual situations. People may also be biased towards giving the most socially desirable response. This might be decreased by their response after reading a vignette, which through individualising, may reduce such pressures. Levey and Howells (1995) suggest that asking directly about violent offending gives different results as a conceptual framework is provided and certain aspects are made salient. They argue that use of vignettes is a more fruitful methodology. Again, use of the Just World Scale, which is correlated with social distance and attitude scales, but is less obviously associated with socially desired responses may counter self serving biases. Hall (1993) *et al.* argue that their measurement, in response to vignettes, does reflect predicted behavioural responses, and that this is superior to other more cognitive and emotional responses obtained through attitude questionnaires alone. The current study assesses attributions, proposed management strategies and attitudes following the presentation of a vignette.

1.5 Summary

Violence in direct access hostels is an important area of research, with limited literature. A study is proposed looking at the attributions of staff for such incidents and their management. The literatures of attribution, violence and homelessness have been drawn on. Such a study will have implications for the service. It should show the types of attributions made by staff and how these differ if someone has a diagnosis of schizophrenia. If, as is hypothesised, staff attribute violence more to illness and manage it more leniently if someone has schizophrenia, this has important service implications. Clinicians, managers, workers and users may then decide whether this difference is a useful one because it is less punishing, or whether it is unhelpful because it decreases the

user's responsibility. Clinical psychologists might help inform discussion on this and could be involved in training to affect attributions and management strategies.

In conclusion, this research project is timely, it fills a gap in the research literature and has implications for hostel management. Hostel workers interviewed were keen that it be done.

1.6 Aims and Hypotheses

Based on the above theoretical background and on the expressed needs of staff working in hostels for homeless people a research project was defined with the following aims:

1. **To investigate staff's attributions for violence in direct access hostels for homeless people.**

a. Do they make different attributions if told the person has schizophrenia?

hyp1.i staff will make more illness attributions, less characteroløgical and equally few situational attributions for violence by people with a label of schizophrenia compared with other homeless people.

hyp1.ii. staff will see other homeless people's behaviour as more controllable, more to blame, more internal temporary, less internal enduring and equally external.

b. Do people with different attitudes make different attributions?

hyp1.iii. staff with negative attitudes will make more internal enduring attributions, than staff with positive attitudes, who will make more internal temporary and external attributions.

hyp 1.iv. staff with positive attitudes will judge violent behaviour as more justifiable.

hyp 1.v. staff with negative attitudes will judge the individual as more to blame and more in control.

Note: The categorisation of attributional statements and management strategies is discussed more fully in the Method section.

2. **To investigate the management of violent behaviour.**

a. Do staff manage the behaviour differently if they are told the person has schizophrenia?

hyp 2.i. staff will be less likely to use punitive strategies (call the police, ban from the hostel, use time out or sanctions); and will use more medical strategies (p.r.n. medication, call health professionals) and more talking/caring responses (counsel, be understanding, ask what's wrong) if they are told the person has schizophrenia.

b. Do attitudes towards homeless people and people with schizophrenia affect management of aggression?

hyp 2.ii. staff with negative attitudes will favour more punitive strategies and those with positive attitudes will favour more talking/caring strategies.

3. **To investigate the association between attributions for violent behaviour and management strategies.**

hyp 3.i. if staff attribute violence more to factors internal temporary, controllable and blame, they will favour more punitive management strategies.

hyp 3.ii. if they attribute violence more to external factors they will favour more talking/caring strategies.

hyp 3.iii. if they attribute violence more to internal enduring factors, they will favour more medical strategies.

hyp 3.iv. if they attribute violence more to mental health problems, they will favour more psychiatric and medical strategies.

4. **To investigate the association between demographic variables and attributions, attitudes and management strategies.**

hyp 4.i. Women will make more external and fewer internal attributions and prefer more non-punitive management strategies than men.

hyp 4ii. Trained staff will make fewer internal attributions

hyp 4.iii. Age, years in job and numbers on shift will also affect attributions, attitudes and management strategies

CHAPTER TWO

METHOD

2. METHOD

2.1 Participants

The 59 participants in the study were all staff working in direct access hostels, which accommodate homeless people without prior referral, in Leicester. There were nine hostels in this industrial Midlands city at the time of the study, serving a population of 279,791 (Hanks, 1986, 1981 census) with a throughput of 130 homeless people each quarter (Department of Environment, 1994). A response rate of 83 per cent (59/71) of all such hostel workers in Leicester was achieved. Three people did not complete the demographic section of the questionnaire, due to previous negative experiences with research. Of those who gave personal details, 29 (51.8 per cent) were women and 27 (48.2 per cent) were men. Their ages ranged from 21 to 48 years with a mean of 35.8 (SD=9.0).

For some analyses, participants were split into two groups depending upon the vignette they received. There were no demographic differences between these groups.

2.2 Measures

A three part questionnaire was developed for the study. The first part consisted of a vignette and questions about attributions for the incident described and preferred management strategies. The second part comprised questions to elicit attitudes about homelessness and mental illness, using social distance scales and the Public Attitudes towards Homelessness Scale (PATH). It also included the Just World Scale to assess more general attitudes and ways of viewing the world. Finally, in part three, questions were asked about more demographic information. A copy of the questionnaire is available as Appendix 3.

2.2.1 *Part One: Measurement of Attributions and Management Strategies*

No current instruments were available to measure attributions of violent incidents or preferred management strategies for violence in hostels for homeless people. Attributions were assessed using the vignette methodology developed by Starr (1955, in Levey & Howells, 1995) and widely used in research on attitudes to mental illness. Some

researchers (e.g. Crichton, 1995a) have used video vignettes, however there is little evidence that these are preferable, and Leigh and Aramburu (1994) found a written version to be rated as more realistic than a video one ($p<0.001$).

The vignettes and questions were developed using the procedure discussed by Home (1994), involving literature review, interviews and pilot studies. Firstly, theoretical perspectives and constructs, such as the internal/external dimensions of attribution theory, were established from a literature review. This informed the basic structure of this section in relation to the hypotheses, and, specifically the more theoretically oriented questions (no's 17-23). Initial information about possible management strategies was obtained from Crichton (1995a). Secondly, semi-structured interviews, with six staff and three residents, in hostels for homeless people in Cambridge, enabled common scenarios involving violence and its management in hostels to be identified. The interviews are described more fully in Appendix 2.

A vignette was produced based on the typical aspects of these real incidents. It told of a young man who had had a bad day, involving feeling unwell, losing money and arguing with his girlfriend. On returning to the hostel, staff confronted him about the tidiness of his bed area. Background details were deliberately ambiguous to enable a variety of different explanations for the incident. Two versions of the vignette were produced, differing only in that the one concerned a "28 year old man" and the other a "28 year old man with schizophrenia". The interviews also elicited spontaneous explanations for aggressive incidents and management strategies commonly employed in dealing with them. These attributional statements and management strategies were then phrased as a series of statements, along Likert-type scales, anchored by bi-polar adjectives. Participants rated the importance of different explanations and the usefulness of proposed management strategies along dimensions of importance and usefulness respectively. They were coded by the researcher on a scale of 1-7.

Examples of the final attributional statements included:

"he's a violent man	*very important*	[——————————]	*un-important*
it was noisy	*very important*	[——————————]	*un-important"*

Statements about management strategies included:

"phone a mental health professional
eg. psychiatrist, CPN *very helpful* [——————————] *very unhelpful*
ban him from the hostel *very helpful* [——————————] *very unhelpful"*

Face validity was assessed by consulting three other hostel workers and four professionals in the field during the drafting of the questionnaire. They read the questionnaire and discussed it with the researcher. Construct validity (i.e. whether the attributional statements referred to the proposed dimensions) was measured by asking 25 Trainee Clinical Psychologists and 10 unqualified staff, from mental health projects unrelated to the study, to classify each statement according to the internal enduring, internal temporary, and the external dimensions. A number of items were found to be ambiguous (i.e. to be interpretable as referring to both internal and external dimensions), necessitating revision and further validation checks. Of the items in the final questionnaire, 15 out of 16 items fulfilled the construct validation criteria of over 80 per cent agreement as to attribution category as rated by non-psychologists, and 10 out of 16 by psychologists (plus three which fulfilled the internal/external criteria only). This compares with Vala, Monteiro and Leyens (1988) who obtained 100 per cent agreement by three judges. However, they reduced their number of causes from over 200 to 30 which best fitted the model and there were only three, unspecified, judges. It was necessary to balance construct validity related to the attributional model and face validity based on the actual elicited explanations of hostel staff in interview. It may be a criticism of attribution theory that some items did not fit the model, for example, "he didn't understand the request" could have been classified as external if respondents focused on the clarity of the request, as internal temporary or as internal enduring if they focused on the individual's current state or intelligence.

Factor analyses of the attributions and of the management strategies supported the validity of the questionnaire. Using principal components analysis, the scree test and a varimax orthogonal rotation, four attribution factors were extracted: external (e.g. it was noisy), internal temporary (e.g. he's been drinking), internal enduring/malevolent (e.g. he's a violent man) and other (e.g. he was provoked by the staff member). Six factors were extracted for management strategies: medical (e.g. admit to psychiatric hospital), punitive (e.g. call the police), tough caring treatment (e.g. impose a sanction, counsel him), talking/caring (e.g. ask what's wrong), ignore, caring 2 (be understanding). Fuller details

are provided in Appendix 4. These were consistent with the researcher's expectations and with participants' ratings.

Test-retest reliability was assessed by giving the questionnaire to 10 hostel workers twice, with a week's interval. Demographic data was analysed separately and showed no variance. Of the remainder of the questionnaire, there was 71 per cent concordance between the two administrations, and 93 per cent concordance$^{+/-}$1. There was 100 per cent reliability in the PATH scale, but this was related to limited variance. Otherwise, no overall pattern was found: changes were in both positive and negative directions, and changes were not associated with specific variables. The test-retest reliability of questions devised specifically for this study was the same as for the published measures detailed below (71 and 70 per cent respectively).

Spearman's correlation coefficients were computed to more thoroughly assess the test-retest reliability of the attribution and management strategy questions. Of the attributional items, nine had correlation coefficients >0.90 and 17 were >0.70, accounting for over 50 per cent of the variance. Of the remaining six items, two were <0.60. The first item ("he is a chaotic person") may have correlated poorly (0.39) as participants were learning to use the questionnaire or due to the ambiguity of the statement. Item 20 ("to what extent was the behaviour controllable by him?") also correlated poorly (0.24). Of the items regarding management strategies, 15 items correlated >0.90 and 16 >0.80. One item correlated less well, item 36 ("give p.r.n./emergency medication") (0.67), this may have been due to workers' lack of understanding as to the meaning of this item. Overall, test-retest correlations vared from 0.24-1.00, and 83 per cent (33/40) had adequate correlation coefficients (>0.70).

Inter-rater reliability was assessed by two independent raters coding and entering the data from ten questionnaires. Inter-rater reliability was found to be 98 per cent. Differences may be attributed to scores on the seven-point scales which fell on the line between two points.

To summarise, following exploratory interviews, a series of closed rating scales was devised to facilitate later coding and statistical analysis and increase reliability. A 40 item section was produced with responses scored on a Likert scale of 1-7. The items may be divided into those eliciting attributions based on the interviews (1-16), and theoretical literature (17-23) and those eliciting preferred management strategies (24-40).

2.2.2 *Part Two: Attitudinal Measures*

Social Distance

Social distance from people who are homeless, and from people with schizophrenia was measured using a social distance scale. Social distance has been widely used in research into attitudes towards mental illness (eg. Eker, 1989). Measures have become outdated and so have been refined by Levey and Howells (1995) who additionally used a question on perceived difference to tap psychological distance. The present study used Levey and Howells' scale of social and psychological distance from people with schizophrenia. It is a seven point Likert scale, where higher scores indicate greater distance. It was modified for the section on attitudes towards homeless people by replacing the label "schizophrenia" with "homeless". It has face validity and has the advantage of being a published scale. There is no published normative data. Test-retest reliability coefficients were conducted as part of the current study. Good correlation coefficients were found (social distance from people with schizophrenia, r=.88, from homeless people, r=.93; psychological distance from people with schizophrenia, r=.90, from homeless people, r=.58). It would be possible to compare results with separate data bases from other studies.

Examples of social distance scale items include:

"People who are homeless are similar to me

strongly agree [——————————————] *strongly disagree*

I can imagine making friends with someone who is homeless

strongly agree [——————————————] *strongly disagree*"

Public Attitudes Towards Homelessness Scale

Attitudes towards homelessness were measured using Guzewicz and Takooshian's (1992) scale of public attitudes toward homelessness (PATH). The five item PATH was based on a survey of 222 members of the general public in America. It was found to correlate moderately with other attitudinal scales e.g. the McDonald's Poverty Scale (r=0.49) and significantly, but low, with the Just World Scale (r=-.24). It has good construct validity: those most sympathetic to the homeless scored lower in authoritarian personality and in belief in a just world. It also has high reliability (.74) and demonstrated a high test-retest

correlation (r=1.00) in the current study. Guzewicz and Takooshian (1992) found a mean score of 12.9, with scores ranging from 3-20 on the 20 point scale (where 20=most positive) and a standard deviation of 3.9, showing wide variation of attitudes, with slightly more people holding positive attitudes. There is no published research using the PATH scale in the UK, but neither has an alternative scale been used.

Examples of PATH items include:

"Society is responsible for people being homeless.

strongly agree [——————————————] *strongly disagree*

Many homeless people have themselves to blame

strongly agree [——————————————] *strongly disagree"*

Just World Scale

More general attitudes to outgroups and ways of viewing the world were measured using Rubin and Peplau's Just World Scale (1975). It has the advantage over the other measures used in that it less obviously relates to attitudes of respondents, which might be viewed as positive or negative by the researcher or managers, and thus may be less affected by self-serving biases. It has also been widely used in other research. The original study of 180 people (Rubin and Peplau, 1975) found a mean score of 3.08 (where 6=most belief in a just world), and high internal consistency (KR-20=0.8), showing that the diverse questions do tap general beliefs. Construct validity has been demonstrated by Hanback (1974, in Rubin and Peplau, 1975) who found that student nurses scoring high on the Just World Scale evaluated a woman in a car accident less favourably if they were told she was responsible and more favourably if not responsible, compared with people who scored low on the scale. Again, Rubin and Peplau (1975) report that high scorers resented the losers of the national draft lottery in America more than low scorers on the scale. Test-retest reliability, assessed as part of the current study, was found to be just adequate (r=.68).

Examples from the Just World Scale include:

"I've found that a person rarely deserves the reputation s/he has

strongly agree [——————————————] *strongly disagree*

Basically the world is a just place

strongly agree [——————————————] *strongly disagree"*

2.2.3 *Part Three: Demographic and Other Information*

Demographic data such as age and gender were elicited. Questions were asked about training and length of time in the job as it was felt this might relate to attributions, preferred management strategies and attitudes. Questions were also asked about perceived levels of support from colleagues, managers and outside agencies, and the usefulness of different forms of support, such as training, supervision and consultancy. These again might influence other variables, but were also included due to a request by service managers to investigate this.

In summary, the questionnaire included a vignette and questions to elicit attributions and preferred management strategies designed by the author; attitudinal measures of social distance to people with schizophrenia and homeless people, and the PATH; the Just World scale; and demographic information.

2.3 Pilot Study

A pilot study was conducted which necessitated a number of changes to the final questionnaire. Questionnaires were mailed to staff in three direct access hostels in London. A low response rate of 40 per cent led to changes in procedure to improve this, from mail questionnaire to visiting hostels. Two questions were also altered to facilitate understanding and clarity. Otherwise, the study was found to be appropriate. The pilot study is described more fully in Appendix 5.

Data collected during the pilot study were not included in the final analysis.

2.4 Procedure

Participants were recruited from the nine Direct Access hostels in Leicester (see Appendix 1). Managers were first approached, information about the hostels was obtained and ways of best accessing the workers discussed. Staff meetings or handovers were attended in order that the study be briefly explained and self-administered questionnaires were distributed. This facilitated the answering of any queries raised by staff and provided support to people distressed by thinking about violence. In each hostel, the two forms of

the vignette were distributed through random allocation to produce two equal groups. Self addressed envelopes were provided so that subjects might return questionnaires anonymously by post, or give them to the researcher, in person, in sealed envelopes. After completion, participants were debriefed as to the aims and hypotheses of the research.

Feedback sessions have been arranged in each hostel (in each City) plus an extra one for managers.

2.4.1 *Ethical Issues*

Elmes, Kantowitz and Roediger (1992) outline some of the main ethical concerns in research as informed consent, confidentiality, debriefing, deception, opportunities to withdraw and long-term consequences. To some extent, the ethical issues are fewer in this study than they might have been if patients had been used. Staff were informed about the study and were able to ask questions about it before taking part: they may be assumed to have the ability to consent thereafter to the project. Questionnaires did not include identifying information, and the option of omitting to complete the demographic information was discussed. Results were analysed by group rather than individual to ensure confidentiality. The results are to be fed back, in Leicester, Cambridge and London by holding meetings at community centres, to present the research, to which all participants and interested parties are invited.

Prior to contacting any participants, approval was sought and obtained from the ethical committee at the University (see Appendix 6). Since the study did not involve patients, it was not necessary to seek approval from the health authority ethics committee. Approval was obtained from an informal hostel managers ethical committee.

2.5 Statistical Analysis

Strictly speaking, most of the measures, including those relating to attributions, management strategies and attitudes, are ordinal variables. They are categorised and can be ordered in terms of 'more' and 'less'. To be interval variables the differences between categories would need to be identical. This is not the case with the variables in the study: it is not possible to say that a difference between 1 and 3 on the attribution scale is the same as that between 4 and 6. The variables of age, length of time in job and number of

staff per shift are interval. The qualifications and gender variables are obviously categorical ones.

"Most of the multiple-item measures created by researchers are treated by them as though they are interval variables because these measures permit a large number of categories to be stipulated" (Bryman and Cramer, 1990, p.65). Bryman and Cramer (1990) report a trend towards a more liberal treatment of such scales as having the qualities of interval variables. This enables the use of more powerful statistical procedures, and involves few errors. The issue is controversial: Gravetter and Wallnau (1988) argue that unless the criteria are strictly met, parametric tests should not be attempted.

The criteria for use of parametric tests is that the measurement used must be interval or ratio scale; there is a normal distribution of responses in the population from which the sample is drawn; and if two groups are studied, the variance of scores within the groups must be similar, there is homogeneity of variance (Bryman and Cramer, 1990). Callanan (1993) argues that the condition of interval or ratio variables is often side-stepped, in clinical psychology research, to enable parametric testing of ordinal data, and the criteria of normal distribution is assumed, therefore the condition of homogeneity of data is that which must be assured.

In practice, most researchers investigating attributions using Likert-type scales have treated their data as interval and have used parametric tests (eg. Howells, 1984 on attributions for responsibility and blame; Guzewicz and Takooshian, 1992, using the PATH; Brockington *et al.*, 1993, on social distance).

The data in this study are of an ordinal type that might be treated as interval. It is possible to assume that responses in the general population would be normally distributed. Preliminary statistical exploration showed homogeneity of variance, between the two groups with the two vignettes, using Levene's F-Test for Equality of Variances. Three items didnot show this homogeneity, the standard deviations being different: this was corrected statistically using SPSS and a separate estimate of variance was used. Therefore, parametric tests were used for the analysis of data in this study, although some purists would have used non-parametric tests.

Frequency measures were used. To analyse the differences between the two groups, with the different vignettes, where differences could have been in either direction, independent

two-tailed *t*-tests were used, e.g. to compare the attributions made by the group with the vignette of a man with schizophrenia with the other vignette. To analyse the association between two variables designated as interval (according to the above discussion), such as attitudes and attributions, Pearson's Product Moment Correlation Coefficients (Pearson's *r*) were utilised. Where appropriate, significant differences between groups were planned to be controlled for statistically, in actuality this was not necessary as these differences were not evident.

Analysis was conducted using SPSS for windows (SPSS Inc., 1993).

CHAPTER THREE

RESULTS

3. RESULTS

3.1 Demographics

People's experience of working in hostels varied from one month to 17 years (M=4.5, SD=5.5). Most people (58.9 per cent) stated that they did not have any relevant qualifications. Four people (7.3 per cent) reported having nursing qualifications, three had social work training and three had NVQ qualifications. The mean number of people working each shift was reported as 2.1 (SD=0.5), ranging from 1 to 3.5 per shift.

3.2 Attributions

Aim 1 **To investigate staff's attributions for violence in direct access hostels for homeless people.**

a. **Do they make different attributions if told the violent person has schizophrenia?**

hyp1.i staff will make more illness attributions, less characterological and equally few situational attributions for violence by people with a label of schizophrenia compared with other homeless people.

hyp1.ii. staff will see other homeless people's behaviour as more controllable, more to blame, more internal temporary, less internal enduring and equally external.

Staff rated "he is angry" (M=6.34), "his argument with his girlfriend" (M=5.46) and "he is a violent man" (M=5.4) as the most important explanations for John's behaviour, using the Likert scale of 1-7. They rated "he didn't understand the request" (M=4.42), "he was trying to get his own way" (M=4.15) and "he is a chaotic person" (M=3.91) as the least important explanations. People given the vignette with a man with schizophrenia rated the most important attributions as "he is angry", "he is a violent man" and "he is mentally ill", and the least important as "he is a chaotic person". The others rated as most important "he is angry", "his argument with his girlfriend" and "he lost money", and the least important as "he didn't understand the request". Table 3.1 shows the mean ratings for suggested attributional statements explaining the behaviour.

Table 3.1. Staff ratings of attributional statements and comparisons between the groups who received the vignette stating the man had schizophrenia or not.

	Total *M* (SD)	schizo vignette *N*=29 *M* (SD)	not schizo *N*=30 *M* (SD)	*t* (d.f.)
he is angry	6.34 (1.23)	5.97 (1.59)	6.80 (0.48)	-2.70 (32.98)**
the argument with his girlfriend	5.46 (1.67)	5.31 (1.65)	5.60 (1.71)	-0.66 (57)
he is a violent man	5.40 (1.83)	5.38 (1.55)	5.42 (2.14)	-0.09 (53)
his headache	5.37 (1.67)	5.31 (1.49)	5.43 (1.85)	-0.28 (57)
he lost money	5.21 (1.83)	4.93 (1.72)	5.47 (1.93)	-1.12 (56)
he is an unstable man	5.07 (2.03)	4.83 (1.77)	5.33 (2.27)	-0.93 (54)
he is mentally ill	5.05 (2.08)	5.35 (1.78)	4.74 (2.36)	1.09 (54)
he's been using drugs	4.88 (2.22)	4.72 (2.17)	5.07 (2.34)	-0.58 (54)
he was provoked by the staff member	4.80 (1.88)	4.90 (1.66)	4.69 (2.13)	0.40 (54)
he's been drinking	4.78 (2.14)	4.45 (1.99)	5.14 (2.30)	-1.22 (56)
it was noisy	4.74 (1.89)	4.32 (1.81)	5.14 (1.90)	-1.66 (55)'
he is physically ill	4.73 (1.92)	4.45 (1.80)	5.04 (2.03)	-1.15 (54)
he was seeking attention	4.42 (1.94)	4.57 (1.57)	4.26 (2.28)	0.59 (46)
he didn't understand the request	4.42 (2.25)	5.07 (1.89)	3.75 (2.43)	2.29 (55)*
he was trying to get own way	4.15 (2.04)	4.43 (1.85)	3.84 (2.23)	1.05 (51)
he is a chaotic person	3.91 (2.01)	3.86 (1.94)	3.96 (2.12)	-0.19 (55)

	Total *M* (SD)	schizo *M* (SD)	not schiz *M* (SD)	*t* (d.f.)
internal enduring	5.87 (1.56)	5.32 (1.83)	6.44 (0.97)	-2.83 (41.5)**
internal temporary	5.53 (1.38)	5.82 (1.28)	5.64 (1.50)	0.48 (54)
external	5.06 (1.79)	4.96 (1.64)	5.16 (1.97)	-0.39 (51)
controllable by him	5.16 (1.39)	4.93 (1.46)	5.38 (1.29)	-1.23 (55)
he was to blame	5.02 (1.41)	5.14 (1.43)	4.90 (1.40)	0.65 (56)
it was predictable	4.95 (1.81)	5.04 (1.84)	4.86 (1.81)	0.36 (55)
it was justifiable	3.19 (1.59)	3.32 (1.72)	3.07 (1.48)	0.60 (56)

*p<.05, **p<.01, 'p<.10 (clinically, not statistically significant)

Pooled estimates of variance were used for *t*-tests, except for "he is angry" and "internal enduring" where the heterogeneity of variance using Levene's F test dictated a more cautious separate estimate of variance.

Staff explained the man's behaviour in terms of it being due in part to factors personal to him and enduring (M=5.87); factors personal to him and temporary (M=5.53); and external factors (M=5.06). They also viewed it as controllable by him (M=5.16); and saw him as to blame (M=5.02). They gave medium ratings as to whether it was predictable or justifiable. On the whole, staff rated all potential explanations as more, rather than less, important.

Table 3.1 also shows the differences in attributions by staff given the two vignettes. Staff did attribute the person without the label of schizophrenia's behaviour more to factors internal and enduring (M=6.44) compared with the schizophrenic's (M=5.32) (p< .01).

However, few significant differences in specific attributional statements were observed between the group with the schizophrenia vignette compared with the other. Staff explained the violent incident as more due to the man not understanding the request in the schizophrenia vignette (M=5.07) compared with the other one (M=3.75) (p<.05) and less due to him being angry (M=5.97 compared with M=6.8) (p<.01).

No significant differences were found when the two groups were compared using factor scores ('external' attributions, 'internal temporary', 'internal enduring/malevolent' or 'other' attributions).

Therefore, staff did not generally make different attributions if told the violent person had schizophrenia. They did not make more illness attributions or less internal temporary ones for violence by people they were told had schizophrenia compared with other homeless people. They did see it as less internal enduring and equally external. They did not see other homeless people's behaviour as more controllable, more to blame or more internal temporary. Generally the hypotheses were not borne out. Staff gave similar attributions whether they were told the man had schizophrenia or not.

3.3 Attitudes

Aim 1

b. **Do people with different attitudes make different attributions?**

hyp1.iii. staff with negative attitudes will make more internal enduring attributions, than staff with positive attitudes, who will make more internal temporary and external attributions.

hyp 1.iv. staff with positive attitudes will judge the aggressive behaviour as more justifiable.

hyp 1.v. staff with negative attitudes will judge the individual as more to blame and more in control.

Most staff demonstrated positive attitudes to homeless people and to people with schizophrenia. Staff showed positive attitudes to homeless people as measured by PATH 0-20 point scale (M=15.27, SD=4.08). This compares with scores for the average population in America (M=12.84, SD=3.89) (Guzewicz and Takooshian, 1992).

The mean individual item score on the Just World Scale was 3.05 (SD=0.55), in line with Rubin and Peplau (1975)'s mean score of 3.08, indicating a slight tendency to reject the notion that the world is a just place.

Staff reported less social distance from homeless people (M=2.44, SD=1.08) than from people with schizophrenia (M=3.17, SD=1.36) (t (56) =-4.88, p<.001). Similarly they reported less psychological distance from homeless people (M=2.55, SD=2.05) than people with schizophrenia (M=3.91, SD=2.19) (t (55) =-5.16, p<.001).

Table 3.2 shows the attitudinal measures in more detail. Most of the attitudinal measures were correlated with each other as is shown in Table 3.2b. They were not correlated with the Just World scores.

Table 3.2. Attitude Scores (in the format used in the literature)

attitudinal measure	mean (SD)	range	
PATH	15.27 (4.08)	4 - 20	total score (scale 0-20) 0=negative, 20=positive
soc.dis.NFA	2.45 (1.06)	1 - 5.25	mean score (scale 1-7) 1=least distance, i.e.: positive
soc.dis.sch	3.17 (1.36)	1 - 6.5	mean score (scale 1-7)
psy.dis.NFA	2.58 (2.03)	1 - 7	actual score (scale 1-7)
Psy.dis.sch	3.91 (2.19)	1 - 7	actual score (scale 1-7)
Just World	3.05 (0.55)	1.85 - 4.35	mean score (scale 1-6) high scores indicate belief in a just world

Table 3.2b. Correlations of Attitude Measures

	PATH	soc.dis.NFA	soc.dis.sch	psy.dis.NFA	psy.dis.sch	Just World
PATH	-	-.35**	-.35**	-.14	-.14	-.18
soc.dis.NFA		-	.60***	.52***	.34**	.19
soc.dis.sch			-	.41**	.63***	.17
psy.dis.NFA				-	.57***	.09
psy.dis.sch					-	.19
Just World						-

*p<.05, **p<.01, ***p<.001

key:

PATH	Public Attitudes to Homelessness Scale
soc.dis.NFA	social distance from homeless people
soc.dis.sch	social distance from people with schizophrenia
psy.dis.NFA	psychological distance from homeless people
psy.dis.sch	psychological distance from people with schizophrenia
Just world	Just World Scale

Correlations were computed of attitudes and attributions for the violent incident. Table 3.3 details the correlations of all attitudinal and attributional measures, and their levels of significance. Significant correlations were observed between social distance from homeless people and explaining the incident in terms of the man being angry ($p<.05$) although the association was weak ($r=-.28$), lower social distance linked with being more likely to explain it in terms of his being angry. More social distance from homeless people and from people with schizophrenia was significantly correlated with explaining the incident more in terms of him being a chaotic person (an internal enduring attribution) ($r=.38$ and $r=.38$, p's$<.01$). Increased social distance from schizophrenia was also associated with explaining the incident in terms of the man trying to get his own way ($r=.33$, $p<.01$). PATH scores indicating more positive attitudes to homeless people were significantly correlated with increased agreement with the attributions of "he is angry" (internal temporary)($r=.30$, $p<.05$), "his headache" ($r=.32$, $p<.01$) and "the argument with his girlfriend" ($r=.25$, $p<.05$) (both external attributions).

More positive attitudes as measured by the PATH correlated with making more external attributions for the incident ($r=.28$, $p<.05$). There were no significant correlations between attitudinal variables and direct measures of internal temporary and enduring attributions. There were no significant correlations between attitudes and agreement with statements regarding the man being more to blame or in control, or the incident being more justifible.

Analysis of factor scores showed the 'internal enduring/malevolent' factor to correlate with social distance from schizophrenia ($r=.29$, $p<.05$) and PATH ($r=-.36$, $p<.01$); and 'external' with PATH ($r=.30$, $p<.05$). The other factor scores were correlated at a clinically relevant, but statistically non-significant level ($p<.10$). Thus, factor scores showed a relationship between positive attitudes and making more external and fewer internal enduring attributions.

Therefore, there was evidence to support the hypotheses that people with more positive attitudes would make more external attributions. There was mixed evidence about the hypotheses that staff with positive attitudes would make less internal enduring attributions and more internal temporary and external attributions. The hypotheses that staff with negative attitudes would judge the individual as more to blame and more in control than staff with positive attitudes who would judge it as more justifiable or predictable were not supported.

Table 3.3. Relationship between agreement with attributional statements and attitudes for all participants

	social distance schizo *r*	social distance homeless *r*	psychol distance schizo *r*	psychol distance homeless *r*	belief in a just world *r*	PATH *r*
he is angry	-.09	-.28*	.13	.01	-.17	.30*
he is a chaotic person	.38**	.38**	.21	.06	.20	-.21
he didn't understand the request	-.16	-.01	-.16	.12	-.18	-.01
he's been drinking	.12	-.06	.14	.10	.15	-.10
he's been using drugs	.22	-.12	.28*	.08	.23	-.05
he is an unstable man	.13	.01	.05	.10	.10	-.20
he's mentally ill	.07	-.12	-.08	-.12	.14	.17
he's physically ill	.13	-.01	-.00	-.06	.00	.12
he lost money	.08	-.10	-.03	.01	.14	.21
he's a violent man	.21	.08	.24	.14	.12	-.13
it was noisy	.04	-.12	-.08	-.23	.08	.14
he was trying to get his own way	.33**	.16	.17	.27	.02	-.20
he was provoked by a staff member	-.14	-.11	.12	.19	-.22	.13
he was seeking attention	.01	-.01	-.03	.10	-.02	-.19
his headache	.03	-.13	-.03	-.14	.11	.32**
the argument with his girlfriend	.08	-.04	-.06	-.15	.18	.25*

	social distance schizo *r*	social distance homeless *r*	psychol distance schizo *r*	psychol distance homeless *r*	belief in a just world *r*	PATH *r*
internal enduring	.08	.06	.06	.07	.21	.06
internal temporary	-.23'	-.15	-.05	-.22	-.09	.24'
external	-.10	.04	-.04	.01	-.12	.28*
controllable by him	.15	.12	-.12	.05	.03	-.02
he was to blame	.19	-.02	.10	.22'	.15	.06
it was predictable	.03	.09	.23'	-.08	-.12	.12
it was justifiable	-.17	-.00	-.19	.08	.10	-.02

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

3.4 Management Strategies

Aim 2 **To investigate the management of violent behaviour**

a. **Do staff manage behaviour differently if they are told the person has schizophrenia?**

hyp 2.i. staff will be less likely to use punitive strategies (call the police, ban from the hostel, use time out or sanctions); and will use more medical strategies (medication, call health professionals) and more talking responses (counsel, be understanding, ask what's wrong) if they are told the person has schizophrenia.

Staff rated the most useful ways of managing the behaviour as being to "feedback he's angry" (*M*=5.95), "look after him" (*M*=5.10) and "calmly ask him to leave" (*M*=5.09). They rated the least useful ones as "carry on as if nothing happened" (*M*=2.05), "ban him from the hostel" (*M*=2.15) and "call the police" (*M*=2.27).

Table 3.4. Staff ratings of the usefulness of management strategies and comparisons between the groups who received the vignette stating the man had schizophrenia or not.

		schizo	not schizo	
	M (SD)	*M* (SD)	*M* (SD)	*t* (d.f.)
feedback he's angry	5.95 (1.50)	6.17 (1.04)	5.73 (1.84)	1.13 (57)
look after him	5.10 (1.82)	5.04 (1.69)	5.17 (1.97)	-.27 (56)
calmly ask to leave	5.09 (2.14)	4.72 (1.72)	3.07 (1.48)	.60 (56)
counsel him	4.49 (1.96)	4.41 (1.82)	4.57 (2.11)	-.30 (57)
phone mental health prof	3.61 (2.16)	4.35 (2.11)	2.90 (1.99)	2.71 (57)**
time out	3.40 (1.93)	3.89 (1.81)	2.89 (1.95)	1.98 (53)*
p.r.n. medication	3.31 (2.19)	4.21 (2.51)	3.20 (2.54)	1.53 (57)'
phone health prof	3.09 (2.12)	3.58 (2.02)	2.66 (2.14)	1.64 (53)'
evacuate others	2.78 (2.01)	2.66 (2.01)	2.90 (1.97)	-.46 (57)
admit psych hospital	2.46 (1.85)	2.93 (1.96)	2.00 (1.64)	1.98 (57)*
impose a sanction	2.28 (1.92)	2.39 (1.99)	2.17 (1.88)	.45 (56)
call the police	2.27 (1.82)	2.14 (1.60)	2.40 (2.03)	-.55 (57)
ban from hostel	2.15 (1.75)	2.28 (1.62)	2.03 (1.88)	.53 (57)
carry on as if nothing	2.05 (1.59)	2.11 (1.77)	2.00 (1.44)	.25 (56)

*$p<.05$, **$p<.01$, '$p<.10$

From Table 3.4 it can be seen that there are significant associations between staff being told that the violent person has schizophrenia and their rated usefulness of phoning a mental health professional; using time out and admitting to a psychiatric hospital (all *p*'s <0.05). Differences were also observed at a statistically non-significant, but clinically interesting, level for p.r.n. medication and phoning a health professional ($p<.10$).

Analysis of factor scores showed that there was a significant difference in the way staff suggested they would manage the behaviour. Staff who were told the man had schizophrenia scored much higher on the factor 'medical management' ($M=.44$, SD=1.04) compared with those who were not told he had schizophrenia ($M=-.25$, SD=.86) ($p<.01$). There were no other significant differences in factor scores.

Therefore, there was some evidence to support the hypothesis that staff would manage the behaviour differently if they thought he had schizophrenia. Staff would be more likely to use psychiatric or medical strategies. There was no evidence to support the hypotheses that staff would also use fewer punitive strategies or more talking responses.

Aim 2

b. **Do attitudes towards homeless people and people with schizophrenia affect management of aggression?**

hyp 2.ii. staff with negative attitudes will favour more punitive strategies and those with positive attitudes will favour more talking/caring strategies.

Significant correlations were observed: "calmly ask him to leave" correlated positively with PATH; "call the police" positively with psychological distance from homeless people; "ban him" positively with Just World; "ask what's wrong" negatively with psychological distance from homeless people, social distance from schizophrenia and positively with PATH; "time out" and "give p.r.n." positively with psychological distance from homeless people (all *p*'s$<.05$). Table 3.5 shows the correlation matrix for attitudes and management strategies.

Additionally, the factor 'medical management' was positively correlated with social distance from schizophrenia ($r=.11$, $p<.05$); 'tough treatment' with PATH ($r=.34$, $p<.01$);

and 'ignore' with psychological distance from schizophrenia (r=.3, p<.05) and homelessness (r=.35, p<.01).

In each of these cases the more positive attitudes were associated with less punitive and more talking responses. The tougher and more medical forms of treatment were associated with less positive attitudes. However the r values in each case were quite low, indicating only small correlations. Most items were not correlated. Thus, there is some evidence as to the effect of attitudes on management strategies, but overall it is inconclusive.

Table 3.5. Pearson's r for Attitudes and Management strategies

	social distance schizo *r*	social distance homeless *r*	psychol distance schizo *r*	psychol distance homeless *r*	belief in a just world *r*	PATH *r*
calmly ask him to leave	-.17	-.23	-.09	-.14	-.04	.30*
call the police	.08	.10	.04	.23*	.19	.08
feedback you know he's angry	-.14	-.14	-.07	-.08	-.19	-.03
be understanding	-.03	-.06	-.11	-.05	-.19	-.03
counsel him	-.06	-.18	.01	-.17	-.19	.09
phone a health professional	.18	.24	.00	.12	.13	-.10
phone a mental health professional	.02	.14	-.13	-.02	-.02	-.02
ban him from the hostel	.13	.17	-.03	.16	.26*	-.08
get him admitted to a psychiatric hospital	.18	.14	-.01	.15	.14	-.12
look after him	-.12	-.19	.19	.08	-.16	.07
evacuate other people	.08	.17	.17	.22	.14	.07
ask him what's wrong	-.31*	-.22	-.13	-.25*	-.12	.27*
give p.r.n. medication	.06	.11	.20	.30**	-.02	.06
short period of time out	.14	.13	.16	.28*	.14	-.04
carry on as if nothing happened	-.05	-.16	.11	.13	-.23	.04
impose a sanction	-.06	.12	-.04	.01	-.15	.10

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

Aim 3 **To investigate the association between attributions for violent behaviour and management strategies.**

hyp 3.i. if staff attribute violence more to factors internal temporary, controllable and blame, they will favour more punitive management strategies.
hyp 3.ii. if they attribute the violence more to external factors they will favour more talking/caring strategies.
hyp 3.iii. if they attribute the violence more to internal enduring factors, they will favour more medical strategies.
hyp 3.iv. if they attribute the violence more to mental health problems, they will favour more psychiatric and medical strategies.

Table 3.6 shows the significant correlations between attributions for the behaviour and proposed management strategies. Complete details are given in Appendix 7. The majority of correlations were with psychiatric and medical attributions. They were more likely to see phoning a mental health professional as useful if they attributed the behaviour to him being mentally ill, a violent man, trying to get his own way, and attention seeking; and less likely if it was due to him being angry or using drugs. Similarly, they were more likely to view an admission to psychiatric hospital as useful if they attributed the behaviour to him being mentally ill, being a violent man, trying to get his own way, seeking attention and it being predictable; and less likely if it was due to drug use. Some more talking/caring strategies such as being understanding and looking after him were associated with the external attribution of him being provoked and with the behaviour being more predictable and justifiable. Few other significant correlations were observed.

Of the general attributional statements, external attributions were positively correlated with asking what's wrong and giving p.r.n. Internal enduring attributions were positively correlated with imposing sanctions. Internal temporary attributions were not correlated with management strategies. Predictability and justifiability were positively associated with medical psychiatric strategies, e.g. phoning a mental health professional, and with caring strategies, e.g. look after him and be understanding.

Table 3.6. Significant correlations between attributions for behaviour and management strategies (given in full in Appendix 7).

	phone health professional	phone mental health prof	ban him	get him admitted to psych hospital	look after him
he's a chaotic person	.29*				
he is angry		-.29*	-.26*	-.38**	.28*
he didn't understand	.33**				
he's been using drugs		-.32**			
he's mentally ill	.41**	.32**		.32**	
he's a violent man		.27*	.31*	.35**	
he was trying to get his own way	.36**	.34**	.27*	.42**	
he was provoked					.34**
he was seeking attention		.40**		.38**	
was he to blame			.28*		
was it predictable		.44***		.32**	.32**
was it justifiable		.27*			

	ask what's wrong	give p.r.n. medication	carry on as if nothing happened	impose a sanction
he's physically ill				.36**
he's a violent man				.28*
he was provoked			.28*	
he was seeking attention		.29*		
enduring				-.26*
external	.27*	.46***		

	calmly ask him to leave	be understanding
he's an unstable man	-.30*	
was it justifiable		.25*

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

Analysis of factor scores revealed positive significant correlations between 'internal enduring/malevolent' attributions and 'medical' strategies (r=.61, p<.001) and clinically relevantly with 'punitive' strategies (r=.27, p<.10). The miscellaneous attributional factor was also positively correlated with ignoring (r=.33, p<.05) and tough caring treatment strategies (r=.30, p<.05).

Therefore, there was no evidence to support the hypothesis that attributing the behaviour to factors internal temporary, controllable and blame would be associated with more punitive management strategies. External attributions did associate with more talking/caring strategies, although the evidence was not conclusive for all variables. Some specific internal enduring attributions and the 'internal enduring/malevolent' factor were associated with mental health strategies, the general attributional statement of this was negatively associated with sanctions. The hypothesis that attributions related to mental health would be associated with psychiatric and medical management strategies was supported.

Aim 4 **To investigate the association between demographic variables and attributions, attitudes and management strategies.**

hyp 4.i. Women will make more external and fewer internal attributions and prefer more non-punitive management strategies than men.
hyp 4ii. Trained staff will make fewer internal attributions.
hyp 4.iii. Age, years in job and numbers on shift will also affect attributions, attitudes and management strategies.

Women explained the incident more in terms of the man's headache (M=5.79, SD=1.40) compared with men (M= 4.74, SD=1.79) (t (54) =2.46, p<.05) and less in terms of his trying to get his own way (M=3.36, SD=1.73 compared with M=4.76, SD=2.3) (t (46.1) =-2.55, p<.01).

Women believed that to calmly ask him to leave and to carry on as if nothing had happened were more useful than men did (M=5.79, SD=1.61 compared with M=4.44, SD=2.38) (t (45.3) =2.50, p<.05) (M=2.50, SD=1.97 compared with M=1.59, SD=0.93) (t (38.8) =2.19, p<.05, respectively). There were no other gender differences.

There was no relationship between gender and designation to the vignettes, therefore it was not necessary to control for this in the analyses.

People who had relevant qualifications for their job saw the man as less to blame (M=4.55, SD=1.50) than those without them (M=5.33, SD=1.27) (t (53) =-2.10, p<.05). Qualified people also rated the strategy counsel him as more useful (M=3.91, SD=2.07, compared with M=5.03, SD=1.76) (t (54) =-2.18, p<.05), and ban him as less useful (M=1.70, SD=1.49, compared with M=2.58, SD=1.89) (t (53.08) =-1.95, p<.05).

Therefore there was some limited evidence to support the hypotheses that trained staff would have less internal attributions for the behaviour, since blame presupposes an internal attribution. They also preferred less punitive management strategies.

Pearson's r correlations showed older staff to agree more with the attributions "he didn't understand the request" (r=.28, p<.05), "he was trying to get his own way" (r=.28, p<.05) and "it was justifiable" (r=.32, p<.05), and younger people with ones about the argument with his girlfriend (r=-.30, p<.05). Older people saw the man as less to blame (r=-.36, p<.01) and as more justifiable (r=.32, p<.05). Older people also showed less belief in a just world than did younger ones (r=-.31, p<.05).

Older people rated the management strategy of being understanding as more useful than did younger people (r=.33, p<.01). This was linked with people who had been in the job longer also rating this as more useful (r=.49, p<.001). Age and length of time working in homeless hostels were significantly correlated (p<.05). They also rated phoning a health professional as more useful (r=.31, p<.05). Numbers of people on shift was negatively correlated with viewing phoning a mental health professional as useful (r=-.27, p<.05).

Therefore, age and length of time in hostel employment was related inconclusively to some attributions and management strategies.

3.5 Other Analyses

Most hostel workers reported feeling supported in their work, rating towards the most positive end of the seven point Likert scale. They felt particularly supported by their colleagues (M=6.2, SD=1.4), but significantly less supported by outside agencies (M=3.2, SD=1.8) (t (58) =13.19, p<.001). They felt fairly supported by their managers (M=5.6, SD=2.0): this was significantly less than by colleagues (t (57) =2.56, p<.01) but more than by outside agencies (t (57) =7.54, p<.001). In response to questions about what they would find helpful to improve this, staff were positive about all suggestions: training (M=6.4, SD=1.0), consultancy (M=6.0, SD=1.4), de-briefing (M=6.1, SD=1.4) and supervision (M=5.8, SD=1.8).

Feeling supported in their work related to attributions and management strategies. Staff who felt more supported by colleagues attributed the violence less to the man seeking attention (r=-.28*); or to it being noisy (r=-.30*). Staff who felt more supported by their management attributed it less to seeking attention (r=-.27*); or the man being a chaotic person (r=-.32**); and viewed it as less predictable (r=-.33**). They were more likely to rate calling mental health professionals as useful (r=-.27*). Those who felt supported by outside agencies attributed the behaviour less to the noise (r=-.35**); and they rated p.r.n. medication as more useful (r=.30*). Thus, support was related to making fewer internal attributions and finding psychiatric strategies more useful.

CHAPTER FOUR

DISCUSSION

4. DISCUSSION

A summary of the main findings of the current research is presented. The results are then related to the broader literature on attributions, attitudes and management strategies outlined in the introduction. Both empirical and theoretical links are considered. Next, a methodological critique of the present study is presented, focusing on Type I and II errors, floor and ceiling effects, generalisability and difficulties measuring and categorising attributions. Consideration is made of the relative merits of the approach adopted in this study and comparisons are made with other studies. The clinical applications of the current research are considered in some detail, in particular, the relevance of training, discussion of strategies to deal with violence in individual hostels, the input of mental health services in homeless hostels and the role psychologists could play. Finally, directions for future research are suggested.

4.1 Summary of Findings

Staff reported internal enduring, internal temporary and external attributions as important reasons for the violent incident described in the vignette. They did not generally make different attributions for the violent incident if told the person had schizophrenia, although there were some statistically significant differences on individual variables, including some evidence for them making less internal enduring attributions about the man with schizophrenia. Staff held quite positive attitudes to homeless people and people with schizophrenia. More positive attitudes were associated with more external attributions. Attitudes were not associated with other attributional measures.

Staff reported preferring different management strategies depending on whether they were told the man had schizophrenia. They preferred more psychiatric and medical strategies if told the person had schizophrenia, but there was no evidence that they would also prefer more talking responses and less punitive ones. External attributions were correlated with more talking/caring management strategies. Attributions related to mental health were correlated with psychiatric and medical strategies. There was no evidence that attributing the behaviour to factors internal temporary, controllable and blame were associated with more punitive management strategies.

There were some gender differences on individual items, but no overall patterns. There was some evidence that trained staff used less blame or internal attributions for the

aggressive behaviour and preferred less punitive management strategies. Age and length of time working in the hostels were inconclusively related to some attributional variables and management strategies.

In general, staff felt supported in their work by colleagues and managers, but unsupported by outside agencies. They rated all suggestions as to how to improve their support as useful (i.e. training, de-briefing, consultancy and supervision).

4.2 Attributions

Staff used a mixture of attributions to explain the violent incident. This is consistent with Crichton's (1995a) findings that nursing staff also used a mixture of attributions to explain a violent incident in a vignette. Although Crichton's study is to be commended for its large sample of 576 nurses, the current study is more rigorous in its measurement of attributions and relates more closely with the attributional model. Vala, Monteiro and Leyens (1988) found people generally made more external attributions for aggression, contrary to the fundamental attribution error which predicts that observers would attribute others' behaviour to internal factors (Ross, 1977). The mixed results of the current study could be the result of the competing psychological factors of the fundamental attribution error and of a bias to explain negative outcomes in terms of situational factors, seeing people as generally good (Tillman and Carver, 1980, in Fiske and Taylor, 1991). Alternatively, the results may be due to methodological problems with the current study as will be discussed later.

The current study found some differences in the way staff attributed the violent incident depending on whether they were told the person in the vignette had schizophrenia or not. Staff attributed the behaviour to less internal enduring factors if they were told the man in the vignette had schizophrenia. Similarly, Crichton (1995a) found staff attributed a person with schizophrenia's behaviour less to internal factors. This might be due to stereotypes and perceptions of people with schizophrenia and might begin to explain why Howells (1984) found mentally ill offenders to be perceived as less responsible or less deserving of blame than other offenders. Such perceptions of responsibility and blame depend on a priori internal attributions rather than external ones. It might also be that people make more internal enduring attributions for homeless people and that a label of schizophrenia overrides this. In the current study, two salient labels were available: that of schizophrenia

and of homelessness. In general, there were fewer than expected significant differences observed in the current study, between the ways staff attributed the violence depending on the version of the vignette they received. This may be because both homeless people and people with schizophrenia are negatively stereotyped, and schemas of them may overlap. It would be interesting to follow up the study by investigating the four way interactions of people with no labels, people with a label of homelessness or of schizophrenia only, and of people with both labels. Thus the effect of the two labels could be better disentangled and the importance of each assessed.

The current study adds to the wealth of literature on the saliency of alcohol as an attribution for violence (e.g. Critchlow, 1985). Alcohol was viewed as an important reason for the violent behaviour despite very ambiguous information as to whether the man had been drinking. Interestingly, "he's been using drugs" was rated within the most important half of attributions, despite there being no indication at all within the vignette that he had been using drugs. Such findings support the theoretical notion of schemas: that when an action may have multiple causes or is ambiguous, causes based on past stereotypes and schemas are utilised (Kelley, 1972, in Critchlow, 1985). A common stereotype of homeless people is that they have alcohol or drug problems (Toro and McDonell, 1992). This would seem to be a schema used, to some extent, by the hostel staff participating. The saliency of alcohol as an attribution for violence might be extended to other consciousness altering substances such as drugs. Perhaps in 1996, drugs are a more salient feature than alcohol, which has been traditionally researched by psychologists. No statistical analysis was conducted to test this. Nevertheless, it warrants further attention. A Psych-lit search revealed no published studies investigating the association between drugs and attributions for behaviour.

Surprisingly, no significant differences were observed between the two groups over whether or not they attributed the incident more to the man being mentally ill. Whether staff were told the person had schizophrenia or not, they rated the attribution "he is mentally ill" as fairly important. It might be that part of staff's schemas for homeless people is that they might be experiencing mental health problems and thus, they would not need to be reminded of this for it to be a salient construct. This would be consistent with the epidemiological literature that half of homeless people may be experiencing some form of mental disorder (Scott, 1993) and with informal estimates that significant numbers of people in the Leicester hostels have mental health difficulties (interviews with hostel managers). However, such a hypothesis must be reconciled with the fact that staff did,

conversely, suggest more psychiatric management strategies if told the person had schizophrenia. Perhaps there is some evidence for implicit, non-verbalised attributions based on mental health in this situation.

4.3 Attitudes

As there are no published studies in UK about social distance and attitudes towards homeless people, this study begins to fill this gap. Participants showed positive attitudes towards homeless people. They showed low levels of social and psychological distance from homeless people. The PATH score of the sample (M=15.27, SD=4.08) might be compared with that of the general population in America (M=12.84, SD=3.89) (Guzewicz and Takooshian, 1992). Although it is not possible to compare them statistically, the attitudes of the current sample appear to be more positive. This is as would be hoped amongst staff working with homeless people. It is unknown whether staff had positive attitudes towards homeless people prior to working in hostels, or whether contact with homeless people made them more tolerant.

The participants in the current study showed low levels of social and psychological distance from people with schizophrenia (M=3.2, SD=1.7 and M=2.6, SD=2.0). The findings are consistent with those of Brockington *et al.* (1993) that people have predominantly positive attitudes to people with mental health problems. This might be contrasted with the findings of Levey and Howells (1995) who, using the same scale as the current study, found nursing students and the general public to rate a person with schizophrenia as different from themselves, showing high levels of social and psychological distance (M=5.7, SD=1.3 and M=6.2, SD=1.2 respectively). Although it is not strictly possible to compare these studies, it would appear that the findings of Levey and Howells and of the current study differ. This difference may be due to the different vignettes employed. It may be that the vignette employed by Levey and Howells is genuinely of someone more different from the participants than that of the current study. It may be that hostel staff genuinely have quite different attitudes from nurses, perhaps because they are a highly selected group who have chosen to work in such hostels. Extraneous variables may also have interfered with the findings, for example, participants may have been aware of positive or negative media coverage at the time of either study.

The mean individual item score on the Just World Scale was 3.05 (SD=0.55), in line with Rubin and Peplau's (1975) mean score of 3.08, indicating a slight tendency to reject the notion that the world is a just place. This is what would be expected of people with positive attitudes to outgroups. Staff may also view it as consistent with the experiences of the users with whom they work, as they may believe that few deserve the situations they are in: the world may not be fair for them. Unexpectedly, the Just World Scale did not correlate with the other attitudinal measures. Other studies have found such associations, although they have been weak and not very significant (Guzewicz and Takooshian, 1992). It demonstrates that the Just World Scale, whilst related to other attitudinal measures, taps different aspects of people's ways of viewing the world.

Unexpectedly, older age of staff was found to relate to decreased belief in a just world; making more external attributions; seeing the person as less to blame; and favouring more talking/caring management strategies. This might appear contrary to Brockington *et al.* (1993) who found positive attitudes were associated with younger age. A closer examination of the literature might explain this apparent anomaly. Whilst Brockington *et al.* did find an overall link with age, this did not apply to the younger respondents in their survey, under 25 years, who, in fact showed the least benevolent attitudes, perhaps supporting the popularist conception of "Thatcher's children". The respondents in the present survey were of a younger average age (i.e. 36 years) and did not include anyone over the age of 48 years. Brockington *et al.*'s (1993) sample included people over 65 years and these people had the most negative attitudes. Additionally, the association between age and experience working in the hostels might affect attitudes, attributions and management strategies. Neither Levey and Howells (1995) nor Crichton (1995a) report any age related differences on attitudes, attributions or management strategies.

Social identity theory (Tajfel, 1981) might have predicted that workers would have had more negative attitudes towards potential outgroups such as homeless people and people with schizophrenia in order to enhance their self esteem. Yet it seems that physical proximity through choice is related to more positive attitudes. Trute, Tefft and Segall (1989) found attitudes towards mentally ill people to be more positive amongst members of the public who had prior experience. Similarly, Eker and Arkar (1991) found Turkish nurses to show less social distance than students towards people with mental health problems. The contact hypothesis (Amir, 1969) would predict that increased contact with outgroups under favourable conditions (e.g. with shared superordinate goals) would lead to more positive attitudes. Undergraduates' attitudes towards mental patients have been

found to improve following contact through shared tasks (Desforges, Lord, Ramsey, and Mason, 1991).

It is possible that the staff identified themselves with the users of their service and that they were not seen as an outgroup but part of the group to which staff also belong, hence the social distance findings. This is hinted at by Gardner and Hopkinson (1996). Users and workers might be seen to belong to the same group, in the present study, of people involved with homelessness and mental health. Since it is more psychologically beneficial to view ingroups as positive, it would be expected that people who were homeless or had mental health problems would be viewed positively. Depending on whether homeless people and people with mental health problems were viewed as an ingroup or outgroup, they might be viewed as positive or negative to enhance self esteem

Attitudinal scores may have been influenced by social desirability norms. To an extent this may have been lessened due to the anonymity and confidentiality promised to participants. Nevertheless, these factors may have remained pertinent as the researcher did meet the participants who were able to ask questions or discuss their feelings after completing the questionnaire. Again, previous experiences of some of the participants with another study, in which confidential information was divulged to their employer, may have rendered them overly cautious about presenting a positive image. Brockington *et al.* (1993) present similar concerns about their study of social distance and suggest the use of a lie scale.

Positive attitudes were found to relate to more external attributions. Heider's (1958) balance theory would predict and explain this. A consistent balanced whole would be one where the sum of the elements of a triad were positive. Thus, positive attitudes to the individual would be associated with more external, less blaming, attributions for the negative violent event. More internal attributions might be predicted to explain a more positive event. Conversely, people with negative attitudes would be expected to make more internal attributions for such negative events. The current study is the first study to investigate this within the sphere of homeless hostels, and it complements the vast literature supporting balance theory.

4.4 Attitudes, Attributions and Management Strategies

The preferred management strategies of hostel workers in the present study were broadly similar to those found by Crichton (1995a) amongst nursing staff. In both studies carrying on as if nothing had happened and calling the police were seen as unhelpful; and talking or using counselling type strategies were seen as helpful. Time out and p.r.n. medication were seen as quite helpful by Crichton's sample and by hostel staff who received the schizophrenia vignette. Thus, similar strategies for managing violent behaviour are preferred by both nursing staff and by hostel workers.

Again, in both studies, trained staff reported preferring less punitive and more counselling type strategies than untrained staff who reported a higher preference for such strategies as banning the person described in the vignette from the hostel (in the current study) and using sanctions (in Crichton's study).Therefore, despite the inconclusiveness of the current study's findings, the combined results of Crichton (1995a) and this study would indicate that trained staff make less blaming attributions and prefer less punitive and more talking/caring management strategies than untrained staff. This demonstrates the potential benefits of employing staff who have received some form of training.

Staff given the schizophrenia vignette rated psychiatric management strategies (e.g. phoning a mental health professional or getting the person admitted to hospital) as more helpful. This is as would be hoped and expected. Hostel staff are not specifically trained to deal with mental health problems, and systems exist in Leicester whereby they might begin to access statutory support to manage such people (Andrews, 1996). There was a negative relationship between attributions due to drugs and preference for phoning a mental health professional. This could be due to methodological artefacts, but also due to the differentiated services within Leicester whereby there is a drugs and alcohol service separate from the other mental health services.

Interestingly, there were strong positive correlations between attributions that "he was trying to get his own way" and "he was seeking attention" and a number of preferred management strategies such as phoning mental health professionals or admitting to hospital. These attributions were also associated with preferring to ban the person from the hostel. People preferred mental health strategies both if they viewed the man as mentally ill or exhibiting difficult or challenging behaviour. These attributions were not associated with each other. It might be that users viewed in this way are thought to have

personality disorders which staff believe ought to be treated by psychiatric services. They might hope that such users, who are difficult to understand or manage, could be managed by other people as they feel less able or willing to do so.

The schema of someone with mental health problems does seem to mitigate in favour of more medical and psychiatric treatment strategies, in line with Crichton (1995a) and Howells (1984). However, in contrast to Crichton (1995a) and Howells (1984) there is no evidence that this also mitigates against punishment. This might be due to the strong stereotype of homelessness which might overlap with that of schizophrenia. The schema of homelessness, including elements connected with mental health problems, might be particularly salient for hostel staff. Schemas of schizophrenia seem only partially to operate. Perhaps this is more in line with Howells' (1984) hypothesis of double deviancy rather than of mitigation. It might also be that few differences were observed in terms of preference for punishment because management strategies of a punishing nature were not generally viewed as useful by workers (i.e. a floor effect).

In a medical setting, Brewin (1984) found medical students' internal and blaming attributions for patients' illnesses were associated with decreased willingness to prescribe treatment. Mannetti and Pierro (1991) suggest nurses who see AIDS patients as more personally responsible may provide less adequate care. They did not find an association between this and attitudes, proposing that this might be due to the incompatibility of negative attitudes and the role of health care worker. Marteau and Riordan (1992) did find attributions of blame to relate to negative attitudes. The findings of the present study, that external attributions related to more positive talking/caring strategies and positive attitudes, and that some internal attributions related to imposing sanctions, would be consistent with these findings. Thus the theoretical model of helping behaviour (Weiner, 1980) applied to medical settings by Brewin (1984) could tentatively be applied to hostel settings.

4.5 Homelessness

Most of the literature on homelessness is epidemiological (e.g. see Scott, 1993). The current study is exciting in that it moves away from this and investigates psychological phenomena in homeless hostels. It is the first study in the UK to assess attitudes towards homeless people. Comparisons with Guzewicz and Takooshian's (1992) study of attitudes

in America have already been made. It is the first study to investigate the attributions or management strategies preferred by staff working in hostels for homeless people. It is important in that it raises the profile of homelessness as an area in need of research within the wider psychological literature.

4.6 Methodological Issues

4.6.1 *Difficulties Drawing Conclusions about Hypotheses*

The results might appear quite inconclusive. Most hypotheses amalgamated several attributions or management strategies and it may have been preferable to have treated them separately. For most hypotheses, there was evidence to support some parts, but overall they were neither proved nor disproved. A methodological critique is now presented. Firstly, problems with the statistical analysis and form of data are discussed. Difficulties in measuring and categorising attributions are then considered. The relative merits of a qualitative and quantitative approach are compared. Finally, the applicability of strict adherence to the attributional model is discussed.

4.6.2 *Type I and Type II errors*

It may have been that some results were shown to be significant by chance. A number of variables were analysed separately to test some of the hypotheses. Thus, the series of *t*-tests employed may have led to Type I errors: whereby results appear significant when they are not, due to chance alone (Bryman and Cramer, 1990). This would have been most problematic for Aim Three where a large number of correlations were computed to investigate the association between attributions and management strategies: 12 correlations would have been expected to reach a significance level of $p<.05$ by chance alone: 33 were found. Harris (1986) suggests this difficulty can be remedied by using a more stringent significance level. Two would have been expected to reach a level of $p<.01$ by chance alone: 18 were found (see results page 42). It is unlikely that the other aims would have been affected by Type I errors, since less than one analysis per aim, and fewer per hypothesis, would have been expected to be significant at $p<.05$ by chance alone. Therefore, it is unlikely that Type I errors particularly affected the conclusions drawn about hypotheses.

Some hypotheses were tested in several ways, such as by investigating relationships with external attributions both by looking at specific statements which might be classified as external (e.g. "it was noisy") and at a variable asking straightforwardly if it was due to reasons external to the individual in the vignette. On the one hand this may have led to Type I errors as discussed above, yet conversely, it might have been more rigorous than simply asking whether it was external. Crichton (1995) simply asked: "How much do you feel mental disorder is responsible for what happened and how much is due to T's free choice and lack of control (p.19). Critchlow (1985) asked: "Was he the cause of the incident?" (p.264). Thus, the current research used a more rigorous, but complex approach than some published studies. A process of triangulating spontaneous attributions, forced choices within the attributional model and responses to real life incidents would have been a very rigorous way of investigating the attributions made.

The relatively small sample size of 59 may have contributed to Type II errors, leading to some relationships which were important not appearing to be significant. Thus, if a study with a larger sample had been carried out, more confident conclusions could have been made about whether specific relationships were significant or not. Nevertheless, a sample of 59 might have been deemed appropriate in size since other studies measuring similar aspects had similar sample sizes. For example, Marteau and Riordan (1992) investigating the influence of staff's attributions for illness on attitudes towards patients studied 40 nurses and 8 doctors. Crichton (1995a) studied 576 nurses, however since he used 32 different vignettes, the average number of participants in each condition was 18: less than the 29 in the present study.

4.6.3 *Floor and Ceiling Effects*

Staff's responses tended to cluster together, often at one extreme, for any particular item, with little variation. Most statements were rated as being more, rather than less, important, raising questions as to acquiescence. For example, all staff showed positive attitudes towards homeless people and to people with schizophrenia; most staff agreed with the statement "he is angry", with little variation. On some particular items, there may have been floor or ceiling effects, thus obscuring the results and hypothesis testing. It is difficult to make confident assumptions about the existence or lack of association between attitudes and certain attributions when there may be ceiling effects for attitudes and floor or ceiling effects for the attributions.

4.6.4 *Wider Theoretical Issues in Interpreting the Results*

The difficulty in interpreting the results may not have been due to artefacts, but have been representative of the topic investigated. There might be real differences between, for example, those internal attributions which were found to relate to attitudes and those which did not, e.g. between "he is a chaotic person" which did relate to attitudes and "he didn't understand the request" which did not. Similarly, there might be differences between some of the management strategies designated as being punitive, such as "call the police" and "ban him" that renders it less useful to consider hypotheses about them as a group, rather than separately. It is also possible that other variables, not investigated in this study, have had a real effect on the data, again rendering the results more difficult to summarise in relation to the hypotheses. The literature does not suggest any obvious omissions from the present study. However, the management style and existing policies on violence in individual hostels may have influenced attributions and management strategies; recruitment policies might have influenced attitudes.

The results should have been clearer to interpret had the questionnaire been more rigorously developed. It may have enabled clusters of variables to have illustrated the internal/external dimensions, or a more definitive result from the factor analysis. Thus the number of variables could have been reduced through combination, facilitating clearer results. Difficulties measuring and categorising attributions are considered next.

4.6.5 *Measurement and Categorisation of Attributions*

The measurement of attributions and management strategies was based on interviews with hostel staff and used their statements as a basis for later questionnaire development. This was the methodology adopted by Home (1994) and had the dual benefits of providing a Likert rating scale which was standard for all participants, thereby enabling statistical analysis, and being based on the actual attributions of staff, thereby increasing validity.

The methodology used could be criticised for its limited investigation of hostel workers' actual attributions and stated management strategies. Semi-structured interviews with six staff did elicit spontaneous attributions and strategies, however this was not conducted in a qualitative way to identify categories, themes and concepts. The current study imposed upon the interviews at an early stage the attributional categories derived from the literature, rather than considering connections with existing theory afterwards as is argued

by Turner (1981). The study followed a quantitative methodology, hence resulting in these problems. It may have been preferable to have focused the entire study on discovering how staff talk about violent incidents and, from this, gain insight into their attributions and management strategies used.

A qualitative study may have been preferable in order to move from the data of actual experience to theory rather than testing prior theory (Henwood and Pidgeon, 1992). The current study attempted to use real attributional statements, identified from semi-structured interviews, to test empirical hypotheses. On the other hand "the truth value of qualitative investigation generally resides in the discovery of human phenomena or experiences as they are lived and perceived by subjects, rather than in the verification of a priori conceptions of those experiences... truth is subject-oriented rather than researcher-defined" (Sandelowski, 1986, p.30). Having identified the ways in which staff explained violent incidents using qualitative methodology, spontaneous attributions could have been categorised using the coding system derived by Stratton *et al.* (1986) to code causal beliefs in natural discourse. Thus, a more detailed preliminary stage may have led to a clearer understanding of the actual attributions and management strategies used by hostel workers. These may or may not have fitted more with the attributional categories suggested in the literature. This could have led onto a more quantitative study testing the specific hypotheses posed in this research at a later date.

The method used led to the production of a series of attributional statements which were difficult to relate with one another in the analysis. Additional, more general, attributional statements derived from the theoretical literature complemented them. This may have rendered interpretation of the results confusing. There was some evidence for theoretical validity and generally good reliability. But, some of the statements, using interviewees' own words, were quite ambiguous (e.g. "he is a chaotic person") leading to potential confusion in understanding and completing items on the questionnaire as evidenced by the poorer test-retest reliability of such items. Factor analysis and validity checks showed a minority of variables did not fit the attributional model. For example, "he didn't understand the request" could be internal temporary or enduring if located within the individual, or external if seen as a communication problem on the part of the person making the request, resulting in people categorising some of them differently during the validation exercise (see Method, page 23).

Although the potential problem with the theoretical fit of the attributional statements is a criticism of the current research, it could also be argued that validity is best conceptualised by the degree to which participants view the findings as fitting with, being meaningful and applicable to, their experience (Sandelowski, 1996). To have altered those statements which did not fit the theoretical model would have increased the theoretical validity at the expense of the validity of fit for the participants themselves. Perhaps the model is most relevant for attributions that fit an "ideal type" and can be placed within the dimensions used. Nevertheless, had the statements fitted the model more closely, the results may have been more clear.

Difficulties categorising variables might have been due to problems with the attributional model itself as not all explanations people use can be categorised into the discrete categories of internal enduring, internal temporary and external. Different people may have different ways of organising their cognitive schemas. Care should be taken in assuming people share the same attributional constructs. Following a more theoretically driven procedure would have simplified this problem. Gudjonsson (1984) reduced the number of statements originally made by participants to include those which best fitted the theoretical model and had the best statistical properties, validity and reliability. Vala, Monteiro and Leyens (1988) reduced the number of statements from 305 given in response to open ended questions in a pilot study to 30 which best linked with the internal/external classification. Researcher invented statements based solely on the theoretical literature would also have enabled more rigorous theoretically oriented attributional statements to be derived. Major, Mueller and Hildebrandt (1985) asked women about attributions for their pregnancy using Likert scales invented by the researchers and based on the theory rather than actual statements. However, this would have resulted in other difficulties (e.g. perceived validity) and met with the criticism of much attributional research that it does not address the real attributions of common people (Kelley and Michaela, 1980, in Hewstone, 1989). The present study did attempt to conduct a rigorous study comparing attributions and preferred management strategies based on actual, rather than contrived, statements by the sample studied.

4.6.6 *Response Rate and Generalisability*

The response rate of 83 per cent was high and therefore represented the majority of all direct access hostel workers in Leicester. There may have been differences between respondents and non-respondents, for example, non-respondents may have had more

negative attitudes, been less confident about ways of managing the behaviour or been more stressed at work and hence not able to spend time completing the questionnaire. Again, the sample may not have been representative of the total hostel staff population as it was confined to staff working in Leicester and these may differ from those in other areas. Nevertheless, the good response rate from both City Council and Voluntary Sector hostels, in both the city centre and suburbs should have ensured a fairly representative sample. The measures used had good test-retest reliability. It might therefore be possible to extrapolate from the present study to direct access hostel workers in general.

In summary, the study was methodologically sound in that it had high test-retest reliability; good validity data; and there was a good response rate. It also attempted to follow rigorous quantitative procedures to test a number of hypotheses about staff's attributions and preferred management strategies, based on the actual attributions and strategies elicited from staff interviews. However, the attempt to combine these elements may have led to difficulties in interpreting the results and testing the hypotheses. These difficulties may have been exacerbated by the size of the sample, floor and ceiling effects of variables, and possible Type I errors from strings of variables.

4.7 Clinical Implications

The inconclusive nature of some of the results and the mixed evidence supporting the hypotheses renders it more difficult to be sure of the clinical implications of the current study. Nevertheless, a range of potential implications can be surmised from it, if tentatively.

A wide range of attributional statements and management strategies was agreed with, and thought to be useful. There was some agreement as to which of these were deemed to be more or less important. It may be necessary for staff and managers to consider the usefulness of this in practice. The wide range subscribed to may imply that, given a certain situation, staff might explain violence in different ways, or different attributions may be salient at different times to different people. Again, a broad range of management strategies might be implemented for quite similar circumstances. This could be unhelpful if it reflected a lack of consistency amongst staff. There is much evidence in the psychological literature about the importance of stability and consistent responses to behaviours (e.g. Hall, 1989). Intra-consistency, whereby different people would be

expected to respond to the same behaviour in the same situation may be deemed important. Therefore, one implication of the current research might be that staff, management and outside agencies need to consider the consistency of hostel staff in explaining and managing violent incidents.

Alternatively, the acceptance of a broad range of attributions and management strategies in response to the fairly ambiguous vignette might imply that staff are open to a variety of approaches. This may be a positive attribute. It may be that staff do not adhere to strict uni-dimensional perspectives on their work. It could facilitate a more individualised client centred approach to the understanding and management of violent incidents, which may enhance their successful resolution through functional analysis (Clements, 1992). However, the limited staffing of homeless hostels, some having one member of staff on duty at any one time for 20 residents, renders individualised approaches difficult.

The HAS report also recommends more individual care planning and greater use of the Care Programme Approach (NHS Health Advisory Service, 1995). A case management approach whereby individuals' needs were assessed and access gained to the required services could benefit homeless people. However, this depends on case managers being able to influence both medical and social aspects of people's lives, and as Shepherd (1990) warned: "There are great dangers that service providers will place too much emphasis on the development of case management systems and too little on the service 'infrastructure' on which the work of case managers depends" (p.61).

In practice, it may be important for individual hostels to arrive at a consensus and reach policies as to the most useful ways forward, and to decide whether to have overall policies and individualised assessments of violent situations. It may be important to create a culture which enables the development of understandings of how behaviours emerge and different ways of construing events, perhaps through monthly meetings where behaviours are analysed and discussed. Psychologists may play a role in facilitating such debates and in training initiatives to focus attributions and management in the desired ways. Staff reported that they would like more training, debriefing, consultancy and supervision. Chaloner (1995) similarly discusses the benefits of these for staff coping with violent incidents and the effects on staff well-being. Psychologists are well placed to provide such services, in terms of skills, if not availability.

There was mixed evidence as to how differently staff attributed or managed behaviour if they were told the person had a diagnosis of schizophrenia. If the results had been more conclusive as to whether there were differences or not, it would have been possible to speculate about whether this was a helpful situation, or whether it ought to be changed. There may be pros and cons for staff having overarching schemas for schizophrenia, and different attributions and management. It might be argued that schizophrenia is a stigmatising label (Pilling, 1991), and people should not be labelled as such because this stigma is psychologically damaging (Drayton, 1995). It might be argued that they should be treated in the same way as other residents as the link between mental illness and violence is often over emphasised, leading to management using drugs, at the expense of taking account of alternative, individual, reasons for the violence (Sayce, 1995). Nevertheless, people with schizophrenia have special needs and difficulties not shared by other residents and these must be recognised whilst explaining or managing violent incidents, considering both "mad" and "bad" elements (Crichton, 1995b). Again, Perkins and Repper (1996) argue that all people have the same basic needs but that people with mental health problems may need specific help to meet these, due to their social disabilities.

Positive attitudes, external attributions and talking/caring management strategies were linked. It would be important to establish whether services desired staff to consider more external attributions and the types of management strategies deemed most useful. Research investigating the outcome of clients whose behaviour was attributed and managed differently might inform such a debate. Possible effects of attitudes on attributions and management strategies might lead to training implications.

Literature on Expressed Emotion, attributions and relapse has shown that high EE critical relatives made more internal enduring attributions, and high EE hostile relatives perceived the causes of illness events and symptoms to be more controllable and internal to the patient. Emotionally over involved relatives made more external attributions outside the individual's control (Barrowclough, Johnston and Tarrier, 1994). Better outcomes were associated with internal temporary attributions. The present study differs in that it considers attributions for a behaviour not necessarily associated with the illness. Hostel staff made quite similar numbers of internal enduring, internal temporary and external attributions. They made less internal enduring attributions for the person with schizophrenia than the other homeless man. Outcome in schizophrenia has been associated both with Expressed Emotion (Vaughn and Leff, 1976) and with attributional style

(Barrowclough, Johnston and Tarrier, 1994). It would be clinically important to consider the types of attributions used to explain behaviour and the levels of Expressed Emotion amongst hostel staff. Interventions might be deemed necessary to mediate these. This might take the form of training or be a consideration in staff recruitment (i.e. recruiting staff with lower EE and who make comparatively more internal temporary attributions), as it is in some NHS services (Shepherd and Singh, 1991).

Home (1994) suggests that training may be a useful way of sensitising police to wife abuse and changing their attitudes and attributions. Trute, Tefft and Segall (1989) argue for the greater dissemination of information to improve attitudes using formal education and the mass media. Equally, training may be useful in addressing the attitudes, attributions and management strategies of hostel staff. It may appear premature to conduct training with hostel staff based on the current findings since the results of the present study are not conclusive. Nevertheless, some non-statistically significant findings may be of interest and use to clinicians.

There were differences dependent on the prior training staff had received. Additionally, there were clear findings that staff felt unsupported by outside agencies and that they would like training on issues related to explaining and managing violence. Such training is also consistent with the recommendations of the Newby Report (Davies *et al.*, 1995), the Clunis report (Ritchie, Dick and Lingham, 1994) and the HAS review of mental health services for homeless people (NHS Health Advisory Service, 1995). Bairan and Farnsworth (1989) found that students' attitudes towards mental illness were more positive following a psychiatric nursing course. Again, Keane (1990) found medical students' attitudes to improve after a course in psychiatry although the most variance was accounted for by prior attitudes. Thus, training is likely to lead to improved attitudes.

One definite conclusion, which stems from the current study, is that hostel staff who were told the person in the vignette had schizophrenia reported that more psychiatric strategies would be preferred to manage the violence. Again, staff who attributed the violent behaviour to the person being difficult reported the greater usefulness of psychiatric strategies. It is appropriate that staff seek guidance (e.g. by phoning a mental health professional) if they perceive the person as having mental health problems or challenging behaviour. Hostel staff themselves do not have the skills, expertise or resources to deal with all such situations.

A practical implication is the limited resources on which staff can actually draw. In Leicester, there are two part-time community psychiatric nurses and a sessional consultant to support hostel workers and homeless people. This is insufficient to meet the demand, and those users who are not diagnosed as having mental health problems but exhibit challenging behaviour or have diagnoses of "personality disorder" are not supported. Hostel staff report feeling unsupported by outside agencies. The problem is not confined to Leicester. The Newby Report on the killing of Jonathan Newby, a volunteer in a hostel for homeless people, by a homeless man with mental health problems states: "some of the most vulnerable individuals at the highest risk receive the least service from formal care agencies, relying instead on night shelters and other projects for the homeless which are tolerant of challenging behaviour" (Davies *et al.*, 1995, p.51). Both staff and users may be considered vulnerable. Therefore, there may be a call, country wide, for greater statutory support for hostels. This would involve negotiations between purchasers and providers; alliances between the voluntary sector, social services and the NHS; and consultation with users and workers. It may particularly involve psychologists whose expertise in mental health, challenging behaviour, and organisational systems may all be required by hostels.

An important caveat, when considering the implications of the current study is that people may not necessarily do what they say they would find useful, or explain real situations in the ways they say they would the vignette. Management strategies reported as theoretically favourable, might not also be favoured in practice. There is some evidence, that, if tapped appropriately, attitudes may predict behaviours (Ajzen, 1988). Hall *et al.* (1993) in a study of the responses of the general public towards people with mental illness and the action they would take such as living next door, conclude by paraphrasing Rabkin *et al.* (1984): "attitudes remain the most reliable precursors of behaviour" (p.103). They also suggest that, whilst attitudes may be unstable, they are more stable when elicited in response to a concrete vignette rather than given in the abstract. The present study investigates attributions and what staff say might be helpful to deal with the incident described in a hypothetical vignette. Further research might be necessary to establish how staff attribute and manage incidents in practice. This might be facilitated by analysis of incident reports. Qualitative interviews might also enable a better understanding of real incidents as experienced by workers interviewed.

4.7.1 *Local Effects of Taking Part in the Process of the Research*

One of the practical implications of the research is the effect that it has had on the participants and the services involved in the process of the study itself. As a result of the process of being involved in the research, participants have begun to discuss the issues of how to explain and manage violent incidents. Staff and managers have requested training to address some of these issues. Managers are concerned about the implications of attitudinal measures. A secondary consequence has been that, for the first time in Leicester, psychology and psychologists have become involved in work with homeless hostels. This has led to discussions about the possibilities of psychology input within hostels; to actual consideration of what hostels want; to the instigation of a training programme (see Appendix 8); and negotiations with the purchasers about initial funding of several sessions of psychology each week specifically to support the hostels. Correspondence on this demonstrates the perceived benefits of such a process. It has also illuminated the inadequate knowledge health service staff have of homelessness and hostel issues, and the need for complementary training in partnership.

The local implications are part of an ongoing process. Feedback sessions with participants will also be forums for debate over potential ways of using the information gained from the research. They are also opportunities to re-validate the study and explore any findings which the participants themselves would have found surprising. Similarly, the process of presenting the research to consultants and managers in the health service may lead to service development discussion. The process is a circular one. From these discussions it could be anticipated that information would be gained which might inform future areas of research and methodology.

4.8 Summary of Future Research

Potential areas of future research arising from the current study include more rigorous or extensive studies to confirm the conclusions reached. Larger sample size and involvement of hostels from other areas would both increase generalisability and perhaps give more conclusive results.

It would be useful to explore the relationship between the current findings, which are based on reports and preferred actions of staff, and staff's actual behaviour and

explanations in real life situations. This might be investigated by a triangulation methodology. Staff's actual management strategies and explanations could be assessed from incident records already kept or from a more detailed prospective study of future incidents.

In order to investigate more fully the schemas of homelessness and of schizophrenia, a four way study involving vignettes with people with no labels, with a label of being homeless, with a label of schizophrenia, and with a dual label could be conducted. This would facilitate the teasing apart of the different schemas, whether they may be additive or mitigating, and which is the most salient.

It might be beneficial to use a more qualitative approach to explore staff's attributions for violent incidents. This would focus more on exploring the actual ways in which hostel staff naturally explain violent incidents, leading to emergent theory, instead of testing out prior hypotheses based on the theoretical literature. It might relate more closely with the actual experiences of staff, but at the expense of not relating to the literature.

Further research might also confirm the non-hypothesised result that drugs are a salient feature in attributions, similar to alcohol.

It would be interesting to relate the current study to the outcomes of homeless people with mental health problems. It would be particularly clinically relevant to consider the attitudes, attributions and management strategies of hostel staff if more certain predictions could be made about the possible ensuing outcomes. For example, it might be useful to investigate their relation to relapse in people experiencing schizophrenia or other mental health problems; the longer term effects on challenging behaviours or violence within the hostel; or the general atmosphere for workers and users.

4.9 Conclusions

Staff made fewer internal enduring attributions about the violent behaviour of a homeless person with schizophrenia in a vignette compared with a homeless person without schizophrenia, otherwise they made quite similar attributions. Staff rated psychiatric strategies as more useful in managing the behaviour of a person with schizophrenia, indicating the need for more input from mental health services. External attributions, positive attitudes and talking/caring management strategies were associated and are explainable within the frameworks of theories of balance and helping behaviour. The research points to a need for more discussion within hostels about desired management strategies and attributions, particularly regarding the benefits of treating people with mental health problems differently. Training may be one way of influencing staff's attributions, attitudes and strategies used. Psychologists are well placed to be involved in this. The study is especially exciting as it is the first to investigate homeless hostels in relation to wider psychological literature on attributions, attitudes and violence. The study points to a number of further areas of potential research.

REFERENCES

REFERENCES

Ajzen, I. (1988). *Attitudes, Personality and Behaviour*. Milton Keynes: Open University.

Amir, Y. (1960). Contact hypothesis in ethnic relations. *Psychological Bulletin*, 71, 319-342.

Andrews, H. (1996). *Review of the Development of Rehabilitation Services in Leicestershire, 1990-1996 and their Future Direction, 1996-2000*. Leicester Mental Health Services NHS Trust (available from the author, Psychiatric Rehabilitation Directorate, Towers Hospital, Leicester).

Antaki, C. & Brewin, C.R. (1982). *Attributions and Psychological Change: application of attribution theories to Clinical and Educational Practice*. London: Academic Press.

Aramburu, B. & Critchlow Leigh, B. (1991). For better or worse: attributions about drunken aggression toward male and female victims. *Violence and Victims*, 6, 31-41.

Aronson, E. (1995). *The Social Animal*. Second Edition. New York: Freeman & Co.

Bachrach, L.L. (1984). The homeless mentally ill and the mental health services: an analytical review of the literature. In H.R. Lamb (Ed.), *The Homeless Mentally Ill*, pp.11-54. Washington: American Psychiatric Association.

Bairan, A. & Farnsworth, B. (1989). Attitudes toward mental illness: does a psychiatric nursing course make a difference? *Archives of Psychiatric Nursing*, 3, 351-357.

Barrowclough, C., Johnston, M. & Tarrier, N. (1994). Attributions, expressed emotion, and patient relapse: an attributional model of relatives' response to schizophrenic illness. *Behavior Therapy*, 25, 67-88.

Brewin, C.R. (1984). Perceived controllability of life events and willingness to prescribe psychotropic drugs. *British Journal of Social Psychology*, 23, 285-287.

Brewin, C.R. (1988). Editorial: developments in an attributional approach to clinical psychology. *British Journal of Clinical Psychology*, 27, 1-3.

Brewin, C.R. & Antaki, C. (1987). An analysis of ordinary explanations in clinical attribution research. *Journal of Social and Clinical Psychology*, 5, 79-98.

Brewin, C.R., MacCarthy, B., Duda, K. & Vaughn, C.E. (1991). Attribution and expressed emotion in the relatives of patients with schizophrenia. *Journal of Abnormal Psychology*, 100, 546-554.

Brockington, I.F., Hall, P., Levings, J. & Murphy, C. (1993). The community's tolerance of the mentally ill. *British Journal of Psychiatry*, 162, 93-99.

Bryman, A. & Cramer, D. (1990). *Quantitative Data Analysis for Social Scientists*. London: Routledge

Burn, S.M. (1992). Loss of control, attributions and helplessness in the homeless. *Journal of Applied Psychology*, 22, 1161-1174.

Callanan, M.M. (1993). *Clinical Research Handbook.* South East Thames Clinical Training Scheme. Available from the SE Thames training course, Salomons Centre, Southborough, Tunbridge Wells.

Carlsmith, J.M., Ellsworth, P.C. & Aronson, E. (1976). *Methods of Research in Social Psychology*. Reading, Massachusetts: Addison Wesley Publishing Co.

Chaloner, C. (1995). Strategies for coping with violent incidents: the psychological consequences of exposure to violence. *Psychiatric Care*, 2, 162-166.

Clements, J. (1992). I can't explain ... "challenging behaviour": towards a shared conceptual framework. *Clinical Psychology Forum*, 39, 29-37.

Cochrane, R. (1983). *The Social Creation of Mental Illness.* London: Longman.

Cockerham, W.C. (1981). *Sociology of Mental Disorder*. Englewood Cliffs, New Jersey: Prentice-Hall.

Conning, A. & Rowland, L.A. (1992). Staff attitudes and the provision of individualised care: what determines what we do for people with long-term psychiatric disabilities? *Journal of Mental Health*, 1, 71-80.

Crichton, J. (1995a). The response of nursing staff to psychiatric inpatient violence. Paper presented at the XXI international congress on law and mental health, 26-29 June, 1995, Tromso, Norway.

Crichton, J. (1995b). Responding to psychiatric inpatient violence. In J. Crichton (Ed.) *Psychiatric Patient Violence: Risk and Response*, pp. 80-109. London: Gerald Duckworth & Co Ltd.

Critchlow, B. (1985). The blame in the bottle: attributions about drunken behaviour. *Personality and Social Psychology Bulletin*, 11, 258-274.

Davies, N., Lingham, R., Prior, C. & Sims, A. (1995). *Report of the Inquiry into the Circumstances Leading to the Death of Jonathan Newby (a volunteer worker) on 9th October 1993 in Oxford.* Oxford Health Authority.

Department of Environment Welsh Office (1994). *Local Housing Statstics, England and Wales*, No 110, HMSO.

Desforges, D.M., Lord, C.G., Ramsey, S.L. & Mason, J.A. (1991). Effects of structured cooperative contact on changing negative attitudes toward stigmatized social groups. *Journal of Personality and Social Psychology*, 60, 531-544.

Dillman, D.A., (1978). *Mail and Telephone Surveys: the Total Design Method.* New York: Wiley.

Drayton, M. (1995). The emotional impact of schizophrenia. *Clinical Psychology Forum*, 82, 15-20.

Eiser, J.R. (1978). Interpersonal Attributions. In H. Tajfel & C. Fraser (Eds), *Introducing Social Psychology*, pp. 235-255. Harmondsworth: Penguin.

Eker, D. (1989). Attitudes toward mental illness: recognition, desired social distance, expected burden and negative influence on mental health among Turkish freshmen. *Social Psychiatry and Psychiatric Epidemiology*, 24, 146-150.

Eker, D. & Arkar, H. (1991). Experienced Turkish nurses' attitudes towards mental illness and the predictor variables of their attitudes. *The International Journal of Social Psychiatry*, 37, 214-222.

Elmes, D.G., Kantowitz, B.H. & Roediger, H.L. (1992). *Research Methods in Psychology*. 4th Edition. St Paul, USA: West Publishing Company.

Fiske, S.T. & Taylor, S.E. (1991). *Social Cognition*. 2nd Edition. New York: McGraw-Hill.

Gardner, D. & Hopkinson, P. (1996). What's in a name? Looking at the labelling debate. *Changes*, 14,135-141.

Gravetter, F.J. & Wallnau, L.B. (1988). *Statistics for the Behavioural Sciences*. 2nd Edition. St Paul, USA: West Publishing Company.

Greaves, A. (1994). Organisational approaches to the prevention and management of violence. In T. Wykes (ed). *Violence and Health Care Professionals*, pp. 225-246. London: Chapman and Hall.

Gudjonsson, G.H. (1984). Attribution of blame for criminal acts and its relationship with personality. *Personality and Individual Differences*, 5, 53-58.

Guzewicz, T.D. & Takooshian, H. (1992). Development of a short-form scale of public attitudes toward homelessness. *Journal of Social Distress and the Homeless*, 1, 67-79.

Hall, J. (1989). Chronic psychiatric handicaps. In K. Hawton, P.M. Salkovskis, J.Kirk & D. Clark (Eds.), *Cognitive Behaviour Therapy for Psychiatric Problems*, pp. 315-338. Oxford: Oxford University Press.

Hall, P., Brockington, I.F., Levings, J. & Murphy, C. (1993). A comparison of responses to the mentally ill in two communities. *British Journal of Psychiatry*, 162, 93-99.

Hanks, P. (1986). *Collins Dictionary of the English Language*. London: Collins.

Harris, P. (1986). *Designing and Reporting Experiments*. Milton Keynes: Open University Press.

Harvey, J.H., Ickes, W.H. & Kidd, R.F. (1978). A conversation with Edward E Jones and Harold H Kelley. In J.H. Harvey, W.H. Ickes & R.F. Kidd (Eds), *New Directions in Attribution Research*, Volume 2, pp. 371-388. New York: Wiley.

Heider, F. (1958). *The Psychology of Interpersonal Relations*. New York: Wiley.

Hendessi, M. (1992). *4 in 10: Report on Young Women who become homeless as a result of sexual abuse*. London: CHAR.

Henwood, K.L. & Pidgeon, N.F. (1992). Qualitative research and psychological theorizing. *British Journal of Psychology*, 83, 97-111.

Hewstone, M. (1989). *Causal Attribution: from cognitive processes to collective beliefs*. Oxford: Blackwell.

Hogg, L.I. & Marshall, M. (1992). Can we measure need in the homeless mentally ill? Using the MRC needs for care assessment in hostels for the homeless. *Psychological Medicine*, 22, 1027-1034.

Home, A.M. (1994). Attributing responsibilty and assessing gravity in wife abuse situations: a comparative study of police and social workers. *Journal of Social Service Research*, 19, 67-84.

Howells, K. (1984). Public perceptions of mentally ill offenders. In D.J. Muller, D.E. Blackman & A.J. Chapman (Eds). *Psychology and Law*, pp. 151-159. Chichester: Wiley and Sons.

Howells, K., McEwan, M., Jones, B. & Mathews, C. (1983). Social evaluations of mental illness (schizophrenia) in relation to criminal behaviour. *British Journal of Social Psychology*, 22, 165-166.

Jones, E.E. & Davis, K.E. (1965). From acts to dispositions: the attribution process in person perception. In L. Berkowitz (Ed.), *Advances in Experimental Social Psychology*, vol 2, pp. 220-266. New York: Academic Press.

Keane, M.C. (1990). Contemporary beliefs about mental illness among medical students: implications for education and practice. *Academic Psychiatry*, 14, 172-177.

Leicester City Council (1996). *Record of Attacks on Leicester City Council Hostel Employees*. Paper available from Leicester City Council.

Leigh, C.B. & Aramburn, B. (1994). Responsibility attributions for drunken behaviour: the role of expectancy violation. *Journal of Applied Social Psychology*, 24, 115-135.

Levey, S. & Howells, K. (1995). Dangerousness, unpredictability and the fear of people with schizophrenia. *The Journal of Forensic Psychiatry*, 6, 19-39.

Lindsay, W.R. (1982). The effects of labelling: blind and nonblind ratings of social skills in schizophrenic and nonschizophrenic control subjects. *American Journal of Psychiatry*, 139, 216-219.

Major B., Mueller, P. & Hildebrandt, K. (1985). Attributions, expectancies, and coping with abortion. *Journal of Personality and Social Psychology*, 48, 585-599.

Mannetti, L. & Pierro, A. (1991). Health care workers' reactions to AIDS victims: perception of risk and attribution of responsibility. *Journal of Community and Applied Social Psychology*, 1, 133-142.

Marshall, M. (1989). Collected and neglected: are Oxford hostels for the homeless filling up with disabled psychiatric patients? *British Medical Journal*, 299, 706-709.

Marshall, M., Lockwood, A. & Gath, D. (1995). Social services case-management for long-term mental disorders: a randomised controlled trial. *The Lancet*, 345, 409-412.

Marteau, T.M. & Riordan, D.C. (1992). Staff attitudes towards patients: the influence of causal attributions for illness. *British Journal of Clinical Psychology*, 31, 107-110.

McDonnell, A., McEvoy, J. & Dearden, R.L. (1994). Coping with violent situations in the caring environment. In T. Wykes (Ed.), *Violence and Health Care Professionals*, pp. 189-206. London: Chapman and Hall.

Meyer, J.P. & Mulherin, A. (1980). From attribution to helping: an analysis of the mediating effects of Affect and Expectancy. *Journal of Personality and Social Psychology*, 39, 201-210.

Miles, A. (1987). *The Mentally Ill in Contemporary Society - a sociological approach.* 2nd Edition. London: Blackwell.

Mills, J., Jellison, J.M. & Kennedy, J. (1976). Attribution of attitudes from feelings: effect of positive or negative feelings when the attitude object is benefitted or harmed. In J.H. Harvey, W.H. Ickes & R.F. Kidd (Eds), *New Directions in Attribution Research*, Volume 1, pp. 271-289. New York: Wiley.

Mitchell, M. & Jolley, J. (1988). *Research Design Explained.* New York: Holt, Rinehart & Winston Inc.

Molvaer, J., Hantzi, A. & Papadatos, Y. (1992). Psychotic patients' attributions for mental illness. *British Journal of Clinical Psychology*, 31, 210-212.

NHS Health Advisory Service (HAS). (1995). *People who are Homeless, Mental Health Services, a place in mind: Commissioning and Providing Mental Health Services for People who are Homeless.* London: HMSO.

North, C.S., Smith, E.M. & Spitznagel, E.L. (1994). Violence and the homeless: an epidemiologic study of victimization and aggression. *Journal of Traumatic Stress*, 7, 95-110.

Perkins, R.E. & Repper, J.M. (1996). *Working Alongside People with Mental Health Problems.* London: Chapman & Hall.

Peterson, C., Semmel, A., von Baeyer, C., Abramson, L.Y., Metalsky, G.I. & Seligman, M.E.P. (1982). The attributional style questionnaire. *Cognitive Therapy and Research*, 6, 287-300.

Pilling, S. (1991). *Rehabilitation and Community Care*. London: Routledge.

Pyszczynski, T., Greenberg, J., Solomon, S., Cather, C., Gat, I. & Sideris, J. (1995). Defensive distancing from victims of serious illness: the role of delay. *Personality and Social Psychology Bulletin*, 21, 13-20.

Ritchie, J.H. (Chairman), Dick, D. & Lingham, R. (1994). *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. London: HMSO.

Rosenhan, D.L. (1973). On being sane in insane places. *Science*, 179, 250-258.

Ross, L. (1977). The intuitive psychologist and his shortcomings: distortions in the attributional process. In L. Berkowitz (Ed.), *Advances in Experimental Social Psychology* (vol 10), pp. 174-221. New York: Academic Press.

Rubin, Z. & Peplau, L.A. (1975). Who believes in a just world? *Journal of Social Issues*, 31, 65-89.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8, 27-37.

Sayce, L. (1995) Response to violence: a framework for fair treatment. In J. Crichton (Ed.), *Psychiatric Patient Violence: Risk and Response*, pp. 163-195. London: Duckworth.

Scott, J. (1993). Homelessness and Mental Illness. *British Journal of Psychiatry*, 162, 314-324.

Shepherd, G. (1990). Case Management. *Health Trends*, 22, 59-61.

Shepherd, G. & Singh, K. (1991). Some practical implications of the concept of expressed emotion in rehabilitation. Paper presented at a conference on 'Institutions and Family Interaction', Philippshospital, Riedstadt, Germany.

Singh, K.K., Melzer, D., Holbrey, A., Meddings, S. & Shepherd, G. (1992). The homeless mentally ill in hospital: a case control study of clinical presentation and care. (Paper available from the author, Meddings, S., Department of Clinical Psychology, Leicester University.)

Snyder, M. (1976). Attribution and behaviour: social perception and social causation. In J.H. Harvey, W.H. Ickes & R.F. Kidd (Eds), *New Directions in Attribution Research*, Volume 1, pp. 53-72. New York: Wiley.

Somerman, F.B. (1993). Value, attitude and belief determinants of willingness to accept a facility for the homeless. *Journal of Social Distress and the Homeless*, 2, 177-192.

SPSS Inc. (1993). *Statistical Package for the Social Sciences (Version 6.0)*. SPSS Inc.

Stratton, P., Heard, D., Hanks, H.G.I., Munton, A.G., Brewin, C.R. & Davidson, C. (1986). Coding causal beliefs in natural discourse. *British Journal of Social Psychology*, 25, 299-313.

Susser, E., Conover, S. & Struening, E.L. (1990). Mental illness in the homeless: problems of epidemiologic method in surveys of the 1980s. *Community Mental Health Journal*, 26, 391-414.

Tajfel, H. (1981). *Human groups and social categories: Studies in Social Psychology*. Cambridge: Cambridge University Press.

Tennen, H. & Afflek, G. (1990). Blaming others for threatening events. *Psychological Bulletin*, 2, 209-232.

Toro, P.A. & McDonell, D.M. (1992). Beliefs, attitudes and knowledge about homelessness: a survey of the general public. *American Journal of Community Psychology*, 20, 53-80.

Totman, R. (1982). Philosophical foundations of attribution therapies. In Antaki and Brewin (Eds), *Attributions and Psychological Change: applications of attribution theories to clinical and educational practice*, pp. 45-59. London: Academic Press.

Trute, B., Tefft, B. & Segall, A. (1989). Social rejection of the mentally ill: a replication study of public attitude. *Social Psychiatry and Psychiatric Epidemiology*, 24, 69-76.

Turner, B.A. (1981). Some practical aspects of qualitative data analysis: one way of organising the cognitive processes associated with the generation of grounded theory. *Quality and Quantity*, 15, 225-247.

Turnquist, D.C., Harvey, J.H. & Anderson, B.L. (1988). Attributions and adjustment to life-threatening illness. *British Journal of Clinical Psychology*, 27, 55-65.

Vala, J., Monteiro, M. & Leyens, J-P. (1988). Perception of violence as a function of observer's ideology and actor's group membership. *British Journal of Social Psychology*, 27, 231-237.

Vaughn, C.E. & Leff, J.P. (1976). The influence of family and social factors on the course of psychiatric illness. *British Journal of Psychiatry*, 161, 3-11.

Warner, R. (1985). *Recovery from Schizophrenia: Psychiatry and Political Economy*. London: Routledge & Kegan Paul.

Weiner, B. (1980). A cognitive (attribution)-emotion-action model of motivated behavior: An analysis of judgements of help-giving. *Journal of Personality and Social Psychology*, 39, 186-200.

Whittington, R. (1994). Violence in psychiatric hospitals. In T. Wykes (Ed.), *Violence and Health Care Professionals*, pp.23-24. London: Chapman and Hall.

Wicker, A.W. (1969). Attitudes *v.* actions: the relationship of verbal and overt responses to attitude objects. In N. Warren & M. Jahoda (Eds) (1973), *Attitudes*, 2nd edition, pp. 167-194. Harmondsworth: Penguin.

Wykes, T. (1994). Introduction. In T. Wykes (Ed.), *Violence and Health Care Professionals*, pp. 1-6. London: Chapman and Hall.

APPENDICES

APPENDIX 1

Leicester Hostels

There are currently 10 hostels in Leicester for homeless people. Most of these accept both women and men, although there is greatest provision for single homeless men. Currently most hostels include people with mental health problems amongst their residents. This may shortly change when Tichbourne Street specialises in people with mental health problems. There are also significant numbers of people with alcohol or drugs problems. Violence is experienced in each hostel. Records of incident reports suggest about one violent incident per hostel per month. However, staff claim this to be a low estimate: many staff reported that they experienced violent incidents on a weekly basis. It is tolerated more in the Night Shelter, but for shorter periods than elsewhere, where residents may stay longer.

Table - Details of Leicester direct access hostels for homeless people

Name of hostel	Managed by	Number of staff (including domestics)	Number of residents	% estimate with problems in mental health	% estimate with problems in drugs/ alcohol	Admission	Other
Night Shelter	City Council	10 (13)	35	33%	33%	direct access	mostly twin rooms closed during day crisis, short term (two weeks)
Upper Tichbourne St.	City Council	11 (17.5)	42	most		direct access	
Lower Hastings	City Council	6 (11.5)	22			direct access	
Loughborough Rd	City Council	6 (9)	23 (women)	some		direct access	
Border House	City Council	11 (18)	69 (in families)	some		direct access	400 clients per year
Mayfield	Action Homeless	8 (11)	28 (mostly men)	50%	50%	referrals and direct access	temporary (3-6 months)
Tigers Close	Shaw Homes	10 (15)	56 (men)	50%	50%	direct access	previous specialism in alcohol encourage change
St Peter's House		CLOSED					
Myrtle Rd	Foundation Housing Association	3 (more)	15 (men)	small numbers		mostly referral occasional direct access	specifically for young black men
St Stephen's Road	Foundation Housing Association	3 (more)	7 (women)	small numbers		mostly referral occasional direct access	specifically for young black women
Hunters Lodge	Independent	8	14 (men)	50%	40%	referrals and direct access	encourage rehabilitation many users have brain damage
Aylestone Project	YMCA					referrals	young people, encourage skills development

APPENDIX 2

Interviews with Hostel Staff

Semi-structured interviews were carried out with six staff working in hostels for homeless people in Cambridge. An interview guide was given to participants beforehand, outlining the areas to be covered. The interviews themselves lasted about 45 minutes each. The aim of the interviews was to gain background information on hostels; to produce scenarios of violent incidents in order to write a realistic vignette; and to elicit spontaneous attributions to be included in the questionnaire. The areas covered were:

1. Background information: day to day happenings in the hostels, support and training.
2. Experiences of difficult incidents and aggression, focusing on a couple of incidents they had recently been involved with.
3. Experiences of working with people with mental health problems.
4. Myths and stereotypes around homelessness.

Day to Day Routines

Hostels can be divided into those which accept referrals only (which might have a more specific therapeutic remit) and direct access hostels which have to accept anyone with no obvious history of violence or current inebriation, providing there is a vacancy. The main role of staff is administrative, for example, booking people in, sorting out DSS benefits and answering enquires. Most hostels use a key worker system whereby each member of staff is responsible for a group of 4 to 20 residents, depending on the hostel. Key workers may provide more emotional support to these residents and assist them in finding accommodation to move on to.

Support and Training

The quality and quantity of support and training was varied. People particularly valued weekly supervision and support groups run by a Psychologist. On a day to day basis they valued other workers and the handover period, and also the knowledge that if they wanted expert help with either specific residents or more general issues, they could call on the Community Support Team (consisting of a Psychologist, Community Psychiatric Nurse, Occupational Therapist and Psychiatrist). Staff did not receive specific training for

working in the hostels, but had received ad hoc training on breakaway techniques, managing violence, first aid, HIV/AIDS, mental health and equal opportunities. Some staff had received quite comprehensive training, whilst others had had none. On the whole they said they would like more training about dealing with violence and aggression and more debriefing and support from managers following incidents.

Experiences of Aggression and Violence

All of the staff interviewed had experienced aggression and violence at work. One man claimed it to be quite a rare occurrence whilst the others said they experienced it at least once a week, and sometimes more often as one incident would initiate another. They each described at least two incidents from the past month, their explanation for it and how they'd handled it. Many of the incidents followed a pattern of someone returning to the hostel having been drinking and then becoming violent when the member of staff refused to let them in due to policies on alcohol. Rather than summarise the staff's reports of violent incidents, some typical examples of incidents, using their own words, are given. The events are quite personal and emotional, such that a summary would not do them justice.

One woman described an incident from the previous week which she said was typical:

> *"A young man came into the building, he was very drunk. The other residents complained. He was asked to leave. He became verbally aggressive, shouting... It took ages for him to leave, lots of arguing and refusing to go... I threatened to call the Police. Just before he left, he and his girlfriend were physically fighting, strangling... In the end he left but came back to the door for a jumper. And then back again. I said "No." He was kicking the door, shouting, screaming. I was scared, I knew he could kick it down. I called the Police, 999, by now he'd gone.*
> *(Interviewer) How would you explain that incident?*
> *He'd been drinking and was angered because he's not allowed to drink in his own home. He was pretty unstable. Most people aren't just NFA, they've got other problems, mental health, alcohol, drugs, he was from a care home. He had problems managing his anger"*

Another member of staff discussed an incident of self-injury:

> *"Last Sunday a man was referred by a social worker, sent to Vic Road on Wednesday. Not given the staff any info, yet he was from the Norvick Clinic [Regional Secure Unit]. There was an incident at Vic Road, so he came to Willow Walk on Thursday and staff here hadn't got the referral. He says his illness is back, he's hearing voices, seeing his own death. Agitated. Threats to slash his wrists. Got the Doctor, not sure if he's hearing voices, yet he is feeling unsafe and wants to go to hospital. I was sat in the office, and heard smashing of glass. He'd smashed it and was hacking his arms. There was blood everywhere. He was very upset. The doctor asked him to put the glass down and he did. We talked about his feelings and didn't go straight for the chlorpromazine. But it can be hard to get them to get support from the system... "*

and:

> *"This woman was in her twenties. She'd been drinking but we didn't realise. She was winding up the other residents so they'd do stupid things and get into trouble. She came into the office, swearing and aggressive, you fuckin' this, fuckin' that. I should've said her behaviour was out of order and if she carried on she'd have to leave. Instead I ignored it because if I'd spoken she may've exploded more, and got taken by the Police and lost her accommodation. She's vulnerable. Her mum was a single parent with drink problems. She was filled with anger, drunk, let's it all out, pushing boundaries. And someone from outside took her out for a drink. Seen her mum recently. Been in care, abused, in the psychiatric and social work system."*

This final extract shows how frightening it can be:

> *"There was a disturbance in the corridor. A man was having a go at a woman about a gear deal. I asked if I could have a chat. He was verbally aggressive. He went off to get a radio and came back and was verbally and physically aggressive to a resident, assaulting other residents. Then I decided to phone the Police. I knew the man well. Yet he didn't recognise me. He barged into the office. I got a colleague to phone the Police from the other office, got the*

aggressor out of the office and locked it. We locked ourselves in, with this man outside beating the door. The Police took 20 minutes. The door was cracking open. I let the other residents out through the window. Roaring, lots of noise. I think he was coming down off speed and drink. And desperate because the DPS and GP refused to prescribe. He felt noone could help him."

The above quotations are reportedly typical of incidents faced by staff working with homeless people and the kinds of explanations and management strategies used by staff to deal with them.

People with Mental Health Problems

Staff said about half the people in their hostels had mental health problems, mostly schizophrenia. Each of the members of staff interviewed had experiences of incidents with people with and without mental health problems. They explained their aggression as being more due to illness factors rather than drink or personality. They suggested that if someone had mental health problems, they might be more lenient and compassionate and try to be more understanding, give more space, allow them to "speak their anger out". Although people with mental health problems could also be evicted, they said they would encourage them to seek support, to phone the Community Support Team and try to stabilise them so they could come back. This differed from the reaction to other homeless people who they said could be evicted and, if they had been seriously aggressive, could be blacklisted, preventing access to any hostel in the area.

Some staff claimed to treat people with mental health problems in the same way as everyone else, whilst others said they had more sympathy with them than with the others and preferred working with them. They thought the residents split into two groups and that other residents would have very little to do with those with mental health problems, scapegoating them for giving the hostel an image like being in a psychiatric hospital. Those with mental health problems were also seen to stick together.

Myths and Stereotypes

Staff were reluctant to discuss myths and stereotypes, since a local clinician had already spent some time addressing it. Nevertheless, they thought the main stereotype was that of homeless people being alcoholic, and thought working in the hostels reinforced this. They said the stress made it more probable that they would fall into an "us and them" mentality.

Interviews with Residents

Three unstructured, informal interviews were conducted with residents from two hostels. These validated, from a user perspective, the findings of the staff interviews. They explained how they had come to be homeless, for example, one man had split up with his wife and had driven to Cambridge in search of work, but had run out of money and had been in the hostel for a week. A teenage woman had been there since leaving home where she had been finding it difficult to cope with abuse. The residents seemed to think that staff dealt well with the violent incidents in the hostel although they favoured calling the Police more often. They explained most violence in terms of people drinking too much and were in favour of the dry policy despite that meaning that they couldn't go out for a drink themselves. Contrary to what the staff had said, they claimed they were unconcerned by those with mental health difficulties and did not differentiate, but treated them all the same.

From these interviews, themes were drawn out. Incidents mainly involved young men who had numerous problems such as drinking, difficult relationships with parents and others, and current setbacks. Incidents typically followed staff challenging them. A vignette based on incidents described in the interviews was produced. This involved a young man staying in a direct access hostel who had difficult relationships with his parents. He had several problems during the day, such as an argument with his girlfriend, losing money and having a headache. Staff in the vignette challenged him over tidying. It was decided not to include any information specifically related to drink as this might have become an overriding explanation.

APPENDIX 3

Questionnaire

A copy of the questionnaire is presented. Two versions were distributed: one had a vignette about a homeless man, the other about a homeless man with schizophrenia. The questionnaire breaks down as follows:

1. The vignette is presented
2. Attributional statements - items 1-16
3. Theoretical attributional - items 17-23
4. Management strategies - items 24-40
5. Social distance scale, homeless people - items 41-48
6. Psychological distance scale, homeless people - item 49
7. PATH - items 50-54
8. Social distance scale, people with schizophrenia - items 55-62
9. Psychological distance scale, people with schizophrenia - item 63
10. Just World Scale - items 64-83
11. Demographic and other items - 84-96

STAFF QUESTIONNAIRE

EXPLANATIONS AND MANAGEMENT OF AGGRESSIVE INCIDENTS IN HOSTELS FOR HOMELESS PEOPLE

SARA MEDDINGS
Trainee Clinical Psychologist
Community Rehabilitation Team
Sylvia Reid House
Forest Road
Narborough
Leicester
LE9 5EQ

0116 286 7711 (Thursdays and Fridays)

Thank you for completing this questionnaire and returning it using the envelope in the staff office.

Questionnaire

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

Please read through the story below and answer the questions which follow.

Story

John is a 28 year old man / man with schizophrenia who has been staying at a direct access hostel for homeless people in Leicester for a week. He left home at 16, after a series of arguments, as his parents didn't want him to live with them anymore. He was having a bad day. He'd woken up with a headache, which had been getting worse. He'd gone into town, where it had been noisy and crowded. In the morning, he'd lost some money on the dogs. Then he'd met his girlfriend for lunch and they'd had an argument.

When he returned to the hostel, the member of staff who answered the door challenged him about the state of his bed area and asked him to tidy up his clothes from off the floor. He became aggressive: shouting and swearing and he pushed the worker.

Based on what you know from this story and other information you know about people like John, please answer the following questions.

Below are some possible explanations for John's aggressive behaviour. How important would you say each of them is in explaining his behaviour?

Here are some examples of how to use the rating scale. If you think him being a chaotic person is very important, you would mark it like this:

he is a chaotic person *very important* [———————————————] *un-important*

if you think it is not at all important, like this:

he is a chaotic person *very important* [———————————————] *un-important*

or if you think it is partly important, like this:

he is a chaotic person *very important* [———————————————] *un-important*

1) he is a chaotic person *very important* [———————————————] *un-important*
2) he is angry *very important* [———————————————] *un-important*
3) he didn't understand the request *very important* [———————————————] *un-important*
4) he's been drinking *very important* [———————————————] *un-important*
5) he's been using drugs *very important* [———————————————] *un-important*
6) he is an unstable man *very important* [———————————————] *un-important*
7) he's mentally ill *very important* [———————————————] *un-important*
8) he's physically ill *very important* [———————————————] *un-important*
9) he lost money *very important* [———————————————] *un-important*
10) he's a violent man *very important* [———————————————] *un-important*
11) it was noisy *very important* [———————————————] *un-important*
12) he was trying to get his own way *very important* [———————————————] *un-important*
13) he was provoked by the staff member *very important* [———————————————] *un-important*
14) he was seeking attention *very important* [———————————————] *un-important*
15) his headache *very important* [———————————————] *un-important*
16) the argument with his girlfriend *very important* [———————————————] *un-important*

Overall would you say his behaviour was a result of:

17) factors personal to him and enduring *definitely* [———————————————] *definitely not*
18) factors personal to him and temporary *definitely* [———————————————] *definitely not*

Please answer the following questions:

19) factors external to him	*definitely*	[——————————]	*definitely not*
20) to what extent was the behaviour controllable by him	*very much so*	[——————————]	*not at all*
21) to what extent was he to blame	*very much so*	[——————————]	*not at all*
22) to what extent was it predictable	*very much so*	[——————————]	*not at all*
23) to what extent was it justifiable	*very much so*	[——————————]	*not at all*

Next, I would like to ask you about how you might handle the situation with John.

How helpful do you think the following methods would be in dealing with the situation?

24) calmly ask him to leave until he's more settled	*very helpful*	[——————————]	*very unhelpful*
25) call the police	*very helpful*	[——————————]	*very unhelpful*
26) feedback that you know he's angry	*very helpful*	[——————————]	*very unhelpful*
27) be understanding	*very helpful*	[——————————]	*very unhelpful*
28) counsel him	*very helpful*	[——————————]	*very unhelpful*
29) phone a health professional eg.GP	*very helpful*	[——————————]	*very unhelpful*
30) phone a mental health professional eg. psychiatrist, CPN	*very helpful*	[——————————]	*very unhelpful*
31) ban him from the hostel	*very helpful*	[——————————]	*very unhelpful*
32) get him admitted to the psychiatric hospital	*very helpful*	[——————————]	*very unhelpful*
33) look after him	*very helpful*	[——————————]	*very unhelpful*
34) evacuate other people	*very helpful*	[——————————]	*very unhelpful*
35) ask him what's wrong	*very helpful*	[——————————]	*very unhelpful*
36) give p.r.n. (emergency) medication	*very helpful*	[——————————]	*very unhelpful*
37) a short period of time out from preferred activities	*very helpful*	[——————————]	*very unhelpful*
38) carry on as if nothing happened	*very helpful*	[——————————]	*very unhelpful*
39) impose a sanction eg. hoovering	*very helpful*	[——————————]	*very unhelpful*
40) other (please specify)	*very helpful*	[——————————]	*very unhelpful*

Now, I would like to ask you about your attitudes to people who are homeless.

Please rate how much you agree or disagree with the following statements.

41) I'd be happy to move next door to someone who'd been homeless *strongly agree* [———————————] *strongly disagree*

42) I'd be happy to work closely with a colleague who is homeless *strongly agree* [———————————] *strongly disagree*

43) Homeless people frighten me *strongly agree* [———————————] *strongly disagree*

44) I wouldn't mind if a hostel for homeless people opened in my street *strongly agree* [———————————] *strongly disagree*

45) I would not associate with someone who's homeless *strongly agree* [———————————] *strongly disagree*

46) Homeless people should not be allowed to clutter the streets *strongly agree* [———————————] *strongly disagree*

47) I can imagine making friends with someone who's homeless *strongly agree* [———————————] *strongly disagree*

48) I can imagine falling in love with someone who's homeless *strongly agree* [———————————] *strongly disagree*

49) People who are homeless are similar to me *strongly agree* [———————————] *strongly disagree*

50) Society is responsible for people being homeless. *strongly agree* [———————————] *strongly disagree*

51) Many homeless people have themselves to blame. *strongly agree* [———————————] *strongly disagree*

52) Society should not have to support or house homeless people. *strongly agree* [———————————] *strongly disagree*

53) Society is turning away and letting down the homeless. *strongly agree* [———————————] *strongly disagree*

54) A nation should be ashamed of its homeless problem. *strongly agree* [———————————] *strongly disagree*

... and to people who have schizophrenia.

Please rate how much you agree or disagree with the following statements.

55) I'd be happy to move next door to someone with schizophrenia *strongly agree* [———] *strongly disagree*

56) I'd be happy to work closely with a colleague who's had schizophrenia *strongly agree* [———] *strongly disagree*

57) Schizophrenics frighten me *strongly agree* [———] *strongly disagree*

58) I wouldn't mind if a hostel for schizophrenics opened in my street *strongly agree* [———] *strongly disagree*

59) I would not associate with someone who has had schizophrenia *strongly agree* [———] *strongly disagree*

60) Schizophrenics should only be treated in psychiatric hospitals *strongly agree* [———] *strongly disagree*

61) I can imagine making friends with someone with schizophrenia *strongly agree* [———] *strongly disagree*

62) I can imagine falling in love with someone with schizophrenia *strongly agree* [———] *strongly disagree*

63) People with schizophrenia are similar to me *strongly agree* [———] *strongly disagree*

Next I would like to ask you about more general attitudes.

How much do you agree or disagree with the following statements?

64) I've found that a person rarely deserves the reputation s/he has *strongly agree* [———] *strongly disagree*

65) Basically the world is a just place *strongly agree* [———] *strongly disagree*

66) People who get "lucky breaks" have usually earned their good fortune *strongly agree* [———] *strongly disagree*

67) Careful drivers are just as likely to get hurt in traffic accidents as careless ones *strongly agree* [———] *strongly disagree*

68) It is a common occurence for a guilty person to get off free in court *strongly agree* [———] *strongly disagree*

... and these ones:

69) Students almost always deserve the grades they receive in school *strongly agree* [———·———] *strongly disagree*

70) Men who keep in shape have little chance of suffering a heart attack *strongly agree* [———·———] *strongly disagree*

71) The political candidate who sticks up for her principles rarely gets elected *strongly agree* [———·———] *strongly disagree*

72) It is rare for the innocent to be wrongly sent to prison *strongly agree* [———·———] *strongly disagree*

73) In professional sports, many fouls and infractions never get called by the referee *strongly agree* [———·———] *strongly disagree*

74) By and large, people deserve what they get *strongly agree* [———·———] *strongly disagree*

75) When parents punish their children, it is almost always for good reasons *strongly agree* [———·———] *strongly disagree*

76) Good deeds often go unnoticed and unrewarded *strongly agree* [———·———] strongly disagree

77) Although evil men may hold political power for a while, in the general course of history good wins out *strongly agree* [———·———] *strongly disagree*

78) In almost any business or profession, people who do their job well rise to the top *strongly agree* [———·———] *strongly disagree*

79) Parents tend to overlook the things most to be admired in their children *strongly agree* [———·———] *strongly disagree*

80) It is often impossible for someone to receive a fair trial in Britain *strongly agree* [———·———] *strongly disagree*

81) People who meet with misfortune have often brought it on themselves *strongly agree* [———·———] *strongly disagree*

82) Crime doesn't pay *strongly agree* [———·———] *strongly disagree*

83) Many people suffer through absolutely no fault of their own *strongly agree* [———·———] *strongly disagree*

And now, I would like to ask you about how supported you feel in your work.

84) How supported do you feel by colleagues in dealing with incidents such as in the story?

very [——————————————————] *not at all*

85) How supported do you feel by managers in dealing with incidents such as in the story?

very [——————————————————] *not at all*

86) How supported do you feel by outside agencies in dealing with incidents such as these?

very [——————————————————] *not at all*

How helpful would you find the following in dealing with incidents such as these?

87) training *very* [——————————————————] *not at all*

88) supervision *very* [——————————————————] *not at all*

89) consultancy sessions *very* [——————————————————] *not at all*

90) de-briefing *very* [——————————————————] *not at all*

91) other (please specify) ..... *very* [——————————————————] *not at all*

Finally, I would like to ask you some questions about yourself.

92) How old are you?

93) Are you female? male?

94) How long have you been working in your job?

95) How many people are usually on a shift where you work?

96) Do you have any formal qualifications for your job (eg. nursing, social work, NVQ)? YES NO

if yes, please specify .....

Thank you very much for completing this questionnaire.

Please put it in the sealed envelope and then in the labelled envelope in the office.

If you have any additional comments you would like to make, feel free to use the space below or attach an extra sheet.

19 February 1996

Dear hostel worker,

Violent incidents are common in hostels for homeless people, as has been shown by recent press coverage and the Newby Report. Interviews with hostel staff established that this is an area of concern to many hostel workers and professionals working in the field. A questionnaire was devised based on the suggestions and reported experiences of staff interviewed. You have been selected to participate in the final phase of a study of hostel workers' explanations and management of violent incidents, and are requested to complete the enclosed questionnaire and return it to me in the envelope provided.

You may be assured of complete confidentiality. I do not work for the City Council and neither will your managers see any of the questionnaires. The research is for part of my post-graduate training in clinical psychology and is funded by the health service. The results will be analysed by people outside your organisation and will not be traced to yourselves. They will then be fed back to you in summary form at a later date and you will be invited to a meeting to discuss them. They may also inform yourselves, managers and statutory agencies as to future input that might be required in hostels.

I would be grateful if you would complete the questionnaire prior to my visit next week when I will collect it. You might want to discuss your questionnaire or any issues it generates then, but if you have any queries about the questionnaire or the research more generally either now or in the future, please do not hesitate to call me on 0116-2867711 (Thursdays and Fridays).

Thank you in advance for agreeing to participate in this study and for the completion of the questionnaire.

Yours sincerely,

SARA MEDDINGS
Trainee Clinical Psychologist

APPENDIX 4

Factor Analyses of Attributions and Management Strategies

Factors for attributions, items and factor loadings (the variance accounted for is in brackets)

Factor 1	*Factor 2*	*Factor 3*	*Factor 4*
external (21%)	internal temporary (18%)	internal enduring / malevolent (11%)	other (8%)
he lost money (0.63)	he's been drinking (0.84)	not he's angry (-0.56)	he didn't understand the request (0.43)
it was noisy (0.78)	he's been using drugs (0.89)	he is a chaotic person (0.54)	he's physically ill (0.67)
his headache (0.89)	he's an unstable man (0.70)	he didn't understand the request (0.43)	he was provoked by the staff member (0.68)
the argument with his girlfriend (0.90)	he's mentally ill (0.41)	he's mentally ill (0.53)	
		he's a violent man (0.53)	
		he was trying to get his own way (0.65)	
		he was seeking attention (0.72)	

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

Factor 1	*Factor 2*	*Factor 3*	*Factor 4*	*Factor 5*	*Factor 6*
medical (17%)	punitive (16%)	tough caring treatment (11%)	talking/caring (8%)	ignoring (7%)	caring 2 (7%)
phone health professional (0.81)	call the police (0.78)	calmly ask him to leave (0.55)	feedback he's angry (0.76)	carry on as if nothing happened (0.85)	be understanding (0.77)
phone mental health professional (0.78)	ban him (0.82)	counsel him (0.69)	care for him (0.58)		care for him (0.50)
get him admitted to psychiatric hospital (0.79)	not ask what's wrong (-.57)	evacuate others (0.47)	ask what's wrong (0.52)		not p.r.n. (-0.46)
p.r.n. (0.32)		impose a sanction (0.57)			
time out (0.45)					

APPENDIX 5

Pilot Study

Dillman (1978) argues that pilot studies are important to ensure each question measures what is intended, the words are understood, questions are appropriately interpreted and closed questions include answers applicable to all respondents, to find if any questions are missed out or answers uninterpretable, and to establish motivation to complete it. Additionally, Mitchell and Jolley (1988) suggest they are important to check on timing, and Carlsmith, Ellsworth and Aronson (1976) to ensure the credibility of vignettes.

Dillman (1978) suggests there are three main ways of piloting questionnaires:

1. With colleagues who understand the purposes of the study and can assess whether the questionnaire can fulfil these objectives.
2. With potential users of the data such as policy makers and managers
3. With the group to be surveyed.

In the present context:

1. The objectives, method and questionnaire were discussed with psychologists and other professionals working with homeless people or people with mental health problems. They were able to consider practical implications and to comment on the reality of vignettes and suggested attributions and management strategies. They also supported my access to participants. Researchers in areas of homelessness, attribution and violence facilitated the early stages of the project, particularly in terms of proposed methodology and hypotheses.

2. The project was explained to the Leicester City Council Hostels Section Manager and the Psychiatrist with responsibility to develop NHS services to homeless people with mental health problems. They were keen to participate and to utilise the final results.

3. A pilot study was conducted with 20 workers in three Direct Access Hostels in London. The project was explained to hostel managers. Questionnaires, covering letters and stamped addressed envelopes for their return were distributed via the managers. Reminder letters were sent out 10 days later. Participants were asked to complete the questionnaire and were also invited to comment on the comprehensibility of questions, the validity of the

scenario and strategies and more general aspects of the questionnaire such as how useful it appeared and how threatening it was to complete.

There was a response rate of eight out of 20. This was disappointingly lower than expected but might be explained by the questionnaire's apparent lower validity to London hostel staff as it refers to Leicester in particular, and because of the timing of the pilot study proximal to Christmas. A low response rate would generate problems for generalisation as not all staff might be represented by it. Consideration would be necessary over possible differences between respondents and non-respondents, for example, over tolerance of attitudes or confidence in managing situations. Response rates for the main study were improved by greater contact with participants, including handing out the questionnaires in person at staff meetings and answering queries.

The direct feedback of participants suggested that a number of questions were difficult to comprehend through direct feedback. In particular it was necessary to change "p.r.n. medication" to "emergency/p.r.n. medication" and "time out" to "time out from preferred activities" as these were poorly understood concepts. Omissions could also have yielded important information. However, they were made by only one respondent, who explained this in terms of lack of information.

The vignette was viewed as realistic except that it was pointed out that people cannot lose money on the horses in the morning and so this was changed to losing money on the dogs. One respondent said it was not possible to comment on the vignette as it was ambiguous, however, this was left unchanged as it was intentionally so to elicit a variety of attributions and strategies. Some hostel staff also suggested that its ambiguous nature was realistic to their work situation.

Analysis of responses showed that a broad distribution of responses was elicited for most questions, including both extremes and middle points. This was less so for attitudinal measures, but this might have been predicted since it would be unlikely that people with very negative attitudes to homeless people would choose to work in hostels. Participants did not report problems in completing the attitudinal measures, although the possibly threatening nature of these may have contributed to a decreased response rate.

Data collected during the pilot study were not included in the final analysis.

APPENDIX 6

ETHICAL MONITORING

Will this project be submitted for approval by another Ethical Monitoring body?* Yes/No

Sara Meddings
Staff's attributions and management of violence in homeless hostels

If so, which? .....

Has approval been given? Yes/No

Key areas of ethical concern

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

Will the research involve any of the following populations?

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

Will some sort of deception be practiced?	☒ No	☐ Yes
Will a full debriefing be given to subjects subsequent to the work being completed?	☒ Yes	☐ No
Will subjects be informed of their right to withdraw from the study at any point?	☒ Yes	☐ No
Will research records remain confidential to the researcher concerned?	☒ Yes	☐ No
Will research involve invasive procedures or the ingestion of drugs or chemical substances?	☒ No	☐ Yes
Are there any other matters which might arouse ethical concern to which the Committee's attention should be drawn?	☒ No	☐ Yes
Have you read the Ethical Principles document issued by the British Psychological Society?	☒ Yes	☐ No

---

(for completion on behalf of the Departmental Ethical Committee)

Approved by ..... (Dr. A. Sunderland) Date 12/12/95

..... (Dr. C. McCrea)

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

APPENDIX 7

Complete data on the association between attributions for violent behaviour and management strategies.

	calmly ask him to leave	call the police	feedback he's angry	be understanding
he's a chaotic person	-.14	.01	.00	-.19
he is angry	.11	-.05	.02	-.06
he didn't understand	.08	-.10	.12	.11
he's been drinking	.11	.08	-.07	.07
he's been using drugs	.08	-.05	-.08	-.01
he's an unstable man	-.30*	.09	-.12	-.03
he's mentally ill	.07	.05	.20	.08
he's physically ill	.18	.15	-.08	.06
he lost money	.12	.08	.15	.06
he's a violent man	.06	.12	-.08	.04
it was noisy	.19	.13	.09	.01
he was trying to get his own way	.02	.14	.22	-.01
he was provoked	-.04	-.01	.16	.03
he was seeking attention	.02	.08	.21	.05
his headache	.03	.01	-.09	.05
argument with his girlfriend	-.04	.16	-.11	.02
enduring	.11	-.03	.05	-.08
temporary	.19	.05	.23	.07
external	.13	-.14	.01	-.07
controllable	.05	.00	-.21	-.12
was he to blame	-.13	.17	-.19	-.11
was it predictable	.05	.17	-.00	.09
was it justifiable	-.11	-.12	.11	.25*

	counsel him	phone health professional	phone mental health prof	ban him
he's a chaotic person	.01	.29*	.19	.06
he is angry	.10	-.19	-.29*	-.26*
he didn't understand	.02	.33**	.19	-.04
he's been drinking	-.00	.09	-.16	-.02
he's been using drugs	-. 06	.07	-.32**	-.15
he's an unstable man	-.17	.10	.06	.13
he's mentally ill	.02	.41**	.32**	.11
he's physically ill	.20	.17	.06	.05
he lost money	.15	-.04	-.04	-.09
he's a violent man	-.24	.26	.27*	.31*
it was noisy	-.13	-.03	-.17	-.09
he was trying to get his own way	-.14	.36**	.34**	.27*
he was provoked	.21	-.01	.02	-.14
he was seeking attention	-.17	.24	.40**	.24
his headache	.01	.19	-.09	-.15
argument with his girlfriend	.03	.13	-.25	-.05
enduring	-.11	.07	-.13	.09
temporary	.19	-.06	.24	-.04
external	.13	.09	.15	-.11
controllable	-.04	-.19	-.05	.17
was he to blame	-.09	-.01	-.16	.28*
was it predictable	.11	.11	.44***	.18
was it justifiable	.08	.19	.27*	-.17

	get him admitte to psych hospit	look after him	evacuate others	ask what's wrong
he's a chaotic person	.10	.01	.00	-.15
he is angry	-.38**	.28*	.03	.04
he didn't understand	.12	.07	-.05	-.14
he's been drinking	.06	.20	.10	.04
he's been using drugs	-.04	.07	-.01	-.02
he's an unstable man	.02	.13	-.06	-.15
he's mentally ill	.32**	.21	.02	.12
he's physically ill	-.05	-.18	.21	.04
he lost money	-.07	-.07	.07	.07
he's a violent man	.35**	.11	-.05	-.21
it was noisy	-.22	-.13	-.04	.15
he was trying to get his own way	.42**	.09	.18	-.10
he was provoked	-.16	.34**	.22	.07
he was seeking attention	.38**	.21	-.17	-.01
his headache	-.15	-.09	.05	.23
argument with his girlfriend	-.23	-.20	.05	.01
enduring	.20	-.13	-.12	.11
temporary	-.05	-.01	.11	.09
external	-.03	.03	.09	.27*
controllable	.02	.00	.08	.06
was he to blame	.10	-.07	.05	.01
was it predictable	.32**	.32**	.15	.05
was it justifiable	.00	.13	-.09	.03

	give p.r.n. medication	time out	carry on as if nothing happen	impose a sanction
he's a chaotic person	-.09	.09	-.02	.22
he is angry	.04	-.26	.14	-.13
he didn't understand	.03	.20	-.15	.15
he's been drinking	.17	.01	.15	.16
he's been using drugs	.21	.15	.09	-.04
he's an unstable man	-.01	-.13	-.15	-.16
he's mentally ill	.13	.09	-.12	-.09
he's physically ill	.21	.25	.11	.36**
he lost money	.05	.11	.04	-.02
he's a violent man	.06	.22	-.13	.28*
it was noisy	-.16	-.10	-.02	-.23
he was trying to get his own way	.07	.46	-.07	-.06
he was provoked	.22	-.13	.28*	.19
he was seeking attention	.29*	.06	.01	-.02
his headache	.02	.14	-.02	-.04
argument with his girlfriend	-.17	.07	-.00	-.05
enduring	.16	.06	-.21	-.26*
temporary	-.01	.17	-.07	.11
external	.46***	.21	.18	-.11
controllable	.03	-.09	.02	.22
was he to blame	-.10	.18	-.06	.04
was it predictable	.14	-.05	.16	.16
was it justifiable	.22	.08	-.11	-.01

APPENDIX 8

Programme of Hostel Teaching

UNDERSTANDING CHALLENGING BEHAVIOUR AND MENTAL ILLNESS

A one day course for Council Hostel Staff working with homeless people

Programme

9:15am	Introductions and Aims (morning session)
9:30am	Overview of Psychiatric Services and how to use them
10:00am	What is mental illness?
11:00am	BREAK
11:15am	The 1983 Mental Health Act: admission and aftercare
11:45am	Psychiatric drug treatment
12:15pm	LUNCH
1:00pm	Introductions and Aims (afternoon session)
1:10pm	A Psychological Perspective on Mental Health/Ill Health
1:30pm	Examples of Challenging Behaviour (small group activity)
	How it may be explained
	How you may feel
	What you might do
2:30pm	BREAK
2:45pm	Functional Analysis and Understanding Behaviours (ABC, STAR)
3:00pm	Practising Behavioural Analysis (groups with vignette and STAR chart)
3:30pm	Using Behavioural Data to Decrease Challenging Behaviour
4:00pm	Discussion
4:30pm	END