The meaning of 'challenging behaviour' for support staff and home managers of residential learning disability services

Thesis

UNRESTRICTED.

The Meaning of "Challenging Behaviour" for Support Staff and Home Managers of Residential Learning Disability Services

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DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

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Date 17.7.97

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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ABSTRACT

Staff perceptions of challenging behaviour and other "challenging problems" in their work with people with learning disabilities are likely to have a significant influence on how they respond to clients and to interventions by Clinical Psychologists. However, accounts of staff perceptions have failed to produce a coherent theory grounded in the experience of staff themselves.

The aim of the present study was to develop a theory of how staff describe and explain challenging problems. Grounded theory methodology was used. Ten Support Workers and eight Home Managers in residential learning disability services described their understanding of a challenging problem in relation to a client during semi-structured interviews. Client behaviour was the most commonly cited problem.

Results suggested that staff face dilemmas concerning whether to see behaviour as communication or a behaviour problem, how to balance firm responding with kindness, and how to deal with their unpleasant feelings evoked by the work. A theoretical account of the results suggested that staffs' emotional distance from or closeness to a client determines how they resolve the dilemmas.

The theoretical account should be subjected to further testing. It implies that staff need to be aware of their emotions and personal motivations in their work if they are to resolve the work dilemmas in the best interests of clients. Clinical Psychologists may be well placed to facilitate personal development programmes for staff to foster this awareness.

1. INTRODUCTION

This section describes how the theoretical and research literature, clinical practice issues and the author's personal experience led to the identification of the aims and questions addressed by the present study. In the field of learning disabilities "challenging behaviour" is identified as a construct comprising behaviour and perceptions of that behaviour. Theoretical and empirical accounts have tended to focus on behaviour and have not been thoroughly developed to explain perceptions of behaviour (or perceptions of other challenges). The perceptions of challenges amongst direct care staff[1] are likely to be particularly significant in determining the quality of life of people with learning disabilities as they determine the nature of services delivered to this population. They are also critical to the success of interventions to improve quality of life, facilitated by professionals such as Clinical Psychologists. The present study aimed to contribute to the development of a theory of perceptions of challenging problems (behavioural or otherwise) amongst staff working in residential services for people with learning disabilities. Qualitative research methods were identified as the most suitable to address this aim.

1.1 What is Challenging Behaviour?

The conduct of people with learning disabilities appears to have caused concern since the time of the earliest writings on the subject. An eighteenth century account of "cretins", for example, suggested that "they abandon themselves to the pleasures of the

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[1] Direct care staff may work in either residential settings, day services or other environments. Throughout this dissertation the terms "direct care staff" and "staff" are used to refer to staff who support people with learning disabilities in residential services, unless otherwise stated. However, many of the issues discussed in relation to this group may also to apply to staff working in other settings.

senses of all kinds and their imbecility prevents them from seeing any crime in this" (Coxe, 1779: Cited in Ryan and Thomas, 1987, p.89). In the nineteenth century, one of the justifications given for the building of rural asylums and colonies for the education and care of "idiots" was to protect members of society from the residents (Jones, 1972).

Definitions and explanations of conduct problems of people with learning disabilities (always produced by people *without* learning disabilities) have shifted and changed significantly over the years, as have conceptualisations of learning disability itself. Some of the oldest and most influential conceptualisations of conduct problems in this group have emphasised causal factors "within" the individual such as a defect of morality or brain biology. This trend has been reflected in people being described as having "problem behaviour" or themselves being "difficult" or "problems" (Joyce, 1995).

During the 1980s the term "challenging behaviour" came into use to describe conduct problems. The term was promoted in order to highlight that behaviours are problems to the extent that they are *seen as* problems. As Blunden and Allen (1987) pointed out, the term "emphasises that such behaviours represent challenges to services rather than problems which individuals with learning disabilities in some way carry around with them" (p.14). The implication of the term "challenging behaviour" is that the phenomenon has two components which are likely to interact with one another: a behaviour, and the perception of a behaviour as challenging. The definition of challenging behaviour which has achieved the greatest currency includes both components, describing the phenomenon as "behaviour of such intensity, frequency or

duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit or deny access to and use of ordinary community facilities" (Emerson, Cummings, Barrett, Hughes, McCool and Toogood, 1988, p. 7).

Despite an increasing acceptance of a role for perceptions of behaviour in definitions such as that of Emerson et al. (1988), operational definitions of challenging behaviour continue to emphasise characteristics of the behaviour itself (defining challenging behaviour as stereotypic, self-injurious or aggressive behaviour, for example; Hastings, 1996). Some have suggested that this continued emphasis on behaviour should be counteracted by shifting the focus of enquiry and intervention to "challenging needs" or "challenging environments" (McGill, 1993).

1.2 Accounts of the Causes of Behaviour Typically seen as "Challenging"

Neurobiological, behavioural and psychodynamic accounts have been proposed to explain behaviours which are typically seen as challenging, such as self-injury or aggression. Each of these accounts makes little reference to how behaviour is perceived, however. Each type of account is summarised below.

1.2.1 Neurobiological Accounts

Most neurobiological theories have focused on the role of neurotransmitters (chemical messengers of the central nervous system) in modulating behaviour. Three classes of neurotransmitter (dopamine, serotonin and opioid peptides) have been implicated as linked to behaviour disturbance in recent research. Evidence suggests that disruption

of dopamine pathways during child development is implicated in the genesis of self-biting (Nyhan, 1994), that low levels of serotonin are linked to aggression (Baumeister and Sevin, 1990) and that opioid peptides (substances related to morphine and heroin) are released when people self-injure, perhaps leading to analgesia, euphoria and addiction (Sandman, 1991).

Another area of neurobiological theory development concerns the identification of "behavioural phenotypes" associated with genetic disorders. The strongest link between genetic disorder and behaviour has been demonstrated in the cases of Lesch-Nyhan syndrome (always associated with self-biting) and Prader-Willi syndrome (always associated with over-eating) (Murphy, 1993). Although fruitful in explaining the origins of behaviours themselves, neurobiological theories do not attempt to explain perceptions of behaviour amongst those who observe them.

1.2.2 Behavioural Accounts

Behavioural theories of challenging behaviour have been developed within the discipline of "applied behaviour analysis", which uses techniques based on learning theory to change behaviour (Baer, Wolf and Risley, 1968). The dominant theoretical stance within applied behavioural analysis has construed challenging behaviour as an example of *operant behaviour*. According to the operant model behaviours are *learned* through the occurrence of rewards or the removal of aversive stimuli when the behaviours occur. Behaviours are said to be *reinforced* when their frequency increases as a result (Blackman, 1974).

The operant model has given rise to widespread practice of functional analysis; a process of identifying the function of challenging behaviours within the physical and social environment through systematic recording of the antecedents and consequences of the behaviour. On the basis of this analysis, events thought to reinforce the behaviour are then manipulated with the aim of modifying the occurrence of the behaviour. Operant procedures have been shown to be effective in reducing unwanted behaviours in people with learning disabilities, for example through differential reinforcement of other behaviours or time-out from positive reinforcement (Murphy and Oliver, 1987). However, behaviour change produced by operant procedures has proved resistant to generalisation across service environments, and sometimes can not be produced at all (Clements, 1992).

Some behavioural accounts of challenging behaviour have stressed the importance of broader features of the environmental setting than behavioural contingencies alone. These accounts have recognised that challenging behaviour occurs within a complex and dynamic social system and that "ecological" factors or "setting events" such as a crowded or noisy interpersonal environment are likely to influence behaviour (Reese and Leder, 1990; LaVigna and Willis, 1995).

Behavioural theories of challenging behaviour represent a useful addition to neurobiological theories in that they offer a (sometimes highly sophisticated) explanation of the role of the environment in the development of behaviours. However, both types of theory fail to account for the processes by which some behaviours are perceived as challenging and others are not.

1.2.3 Psychodynamic Accounts

Psychodynamic theorists have proposed that challenging behaviours have conscious and unconscious meaning for the people who perform them, and that understanding and interpretation of this meaning in a therapeutic relationship can be beneficial to clients and may reduce their inclination to perform the behaviours (Sinason, 1994; 1992). Sinason described the case of a man with severe learning disabilities who was referred to her because he was banging his head on walls and exposing his genitals to staff (Sinason, 1994). During conversation with the client Sinason discovered that the client had been sexually abused during childhood (whilst dressed as a girl). She interpreted the man's exposure of his genitals as an unconscious attempt to prove to the world that he had been "treated as the wrong gender" and his headbanging as an unconscious attempt to erase painful memories of the abuse. Sinason reported that the client's challenging behaviour was dramatically reduced following a series of six therapy sessions during which she interpreted his behaviour, allowing him to bring the unconscious meanings to consciousness.

Accounts of challenging behaviour based on individual psychodynamics add to neurobiological and behavioural theories by focusing on broader issues than clients' behaviour. However, like these theories, individual psychodynamic approaches have not examined the processes by which staff and others understand the "challenge" in challenging behaviour or other challenging problems.

1.3 The Clinical Relevance of Perceptions of Behaviour

Although most accounts of challenging behaviour have emphasised the causal processes behind behaviour rather than perceptions of it, perceptions of the behaviour of people with learning disabilities are likely to significantly affect the quality of their lives. Beliefs held by members of the public affect the ease with which people with learning disabilities are able to live in community settings and engage in community life (Roycroft and Hames, 1990). The perceptions of behaviour amongst direct care staff who support people with learning disabilities in service settings are likely to have a particularly powerful impact. Over 20,000 people with learning disabilities were supported in staffed accommodation in Britain in 1992 (Malin, 1995) and many people in this situation spend the vast majority of their time in contact with staff in the service setting (Firth and Short, 1987). The beliefs of direct care staff are therefore likely to shape the social and physical environments which may influence the occurrence of much challenging behaviour. They are also likely to influence any intervention responses to challenging behaviour conducted in partnership with outside professionals such as Clinical Psychologists. The possible significance of each influence is assessed below.

1.3.1 The Impact of Staff Beliefs on the Occurrence of Challenging Behaviour

Within the behavioural literature concern has been expressed that direct care staff may behave in ways which exacerbate clients' behaviour. Thus, observational research has shown staff providing some form of positive attention in response to challenging behaviour once in every 10 to 20 occurrences, which could be enough to reinforce the behaviour (Hastings and Remington, 1994). Staff self-report studies also indicate that

staff are likely to respond to challenging behaviour in ways contrary to behaviour analytic theory, even when behavioural interventions have been set up by outside professionals (Intagliata, Rinck and Calkins, 1986; Hastings, 1996). These findings have led some to hypothesise that staff have beliefs and feelings about clients' behaviour which are more influential in shaping their responses than their knowledge of behavioural techniques (Hastings and Remington, 1995; Bromley and Emerson, 1995).

1.3.2 The Impact of Staff Beliefs on Interventions Facilitated by Clinical Psychologists

The beliefs of care staff are not only likely to affect the service they provide on a day to day basis, but also staff involvement in interventions with this client group by professionals such as Clinical Psychologists (Hill-Tout, 1992). Traditionally, many Clinical Psychologists have offered solutions to challenging behaviour based on applied behaviour analysis and required direct care staff to implement these by changing their own behaviour towards a client (Clements, 1992). Such interventions often flounder once outside involvement is withdrawn, however (Georgiades and Phillimore, 1975). This has led to recognition that sustainable interventions require those implementing them to have a sense of "ownership" of the process, the intervention being consistent with their belief system (Hill-Tout, 1992). Consultancy approaches from the field of organisational development are increasingly being used to guide such interventions in health and social services settings. These emphasise the need to plan interventions in partnership with staff from all levels of an organisation so that their beliefs and perceptions are integral to the change process (Brunning, Cole and Huffington, 1990).

1.4 Accounts of How Behaviour is Perceived

Clinical Psychologists intending to incorporate an understanding of staff perceptions into challenging behaviour interventions are faced with a paucity of theoretical and empirical accounts of these perceptions, how they develop and how they differ between staff with different roles in services. Two theoretical accounts (Social Role Valorisation and Attribution theory) are relevant but these have not been comprehensively researched with staff working with people with learning disabilities. A more empirically-based account is also emerging (e.g. Hastings, Remington and Hopper, 1995), but this has not yet given rise to extensive theory development. The three accounts are assessed below.

1.4.1 Social Role Valorisation

Social Role Valorisation (SRV) has been described as both a service philosophy and a theory (Wolfensberger, 1972; 1983; Emerson, 1992). As a service philosophy based on the original Scandinavian conceptualisations of Normalisation, it has been influential in shaping services with the aim of according basic human rights to people with learning disabilities. However, it has been argued that SRV goes beyond early Normalisation ideas by proposing a theory of the processes by which people with learning disabilities (and their behaviour) are perceived by others (Emerson, 1992).

Social Role Valorisation does not specifically address perceptions of behaviour as "challenging" but rather seeks to explain perceptions of people with learning disabilities and their behaviour as "deviant". Wolfensberger argued that there are powerful and unconsciously-driven social processes by which people with learning disabilities come to

be seen as "deviant" and are thus denied fundamental human rights. The central process in this "deviancy-making" is said to be the denial of "socially valued roles" to this group, such as the role of employee, homeowner or university graduate. Wolfensberger proposed that it was necessary to counter "deviancy-making" by providing optimum conditions for devalued individuals to acquire socially valued characteristics and roles.

When applied to "challenging behaviour", Social Role Valorisation implies that perceptions of behaviour at a societal level and within services are important determinants of how people with learning disabilities are treated. It suggests that behaviour will be more likely to be seen as "deviant" when those performing the behaviour have a low value attached to their social roles. However, SRV does not emphasise the micro-social and individual psychological process by which values and beliefs about client behaviour are adopted and developed by staff working in services. Furthermore, Social Role Valorisation has been the subject of little research and evaluation, so it's value as a theoretical tool remains unproved.

1.4.2 Attribution Theory

Attribution theory describes the processes by which people explain events that they observe or experience (Heider, 1958; Kelley, 1967). The theory suggests that people may explain the behaviour of others either in terms of causes within the person (internal attribution) or in terms of environmental causes (external attribution). Fenwick (1995) applied attribution theory to staff perceptions of challenging behaviour, constructing an account of how service workers form beliefs about challenging behaviour and how these beliefs might influence their emotions and methods of intervention. He hypothesised that

when staff made internal attributions concerning their client's challenging behaviour they are more likely to see the behaviour as within the client's control, react with angry or hostile emotions and be less inclined to make helpful interventions. Staff making external attributions were said to be more likely to see the behaviour as outside the client's control and react more sympathetically and helpfully.

This theoretical account, unlike Social Role Valorisation, has been *applied* specifically to the detailed processes by which challenging behaviour may understood and explained by staff within learning disability services. The theory has been *developed* outside of these contexts, on the basis of general psychological research, however. The theory's applicability to staff perceptions of challenging behaviour has not been specifically investigated.

1.4.3 Empirical Accounts of Staff Beliefs and Feelings about Challenging Behaviour

Both SRV theory and attribution theory may be applied to explain staff perceptions of challenging behaviour, but their application has not been widely researched. Research has been conducted specifically investigating staff beliefs about the causes of challenging behaviour, their emotional reactions to challenging behaviour and how beliefs and feelings develop over time. This research is presented below.

1.4.3.1 Staff Beliefs about the Causes of Challenging Behaviour

Staff beliefs about challenging behaviour were examined in a research study reported by Hastings (1996), Hastings, Remington and Hopper (1995) and Hastings and Remington

(1995). This will be referred to as "the Hastings study". The Hastings study required over 100 qualified and unqualified nursing staff from a mental handicap hospital to respond to questionnaires. Staff were asked to identify strategies for intervening in response to one of three vignettes describing clients displaying stereotypic, self-injurious or aggressive behaviour. Participants' responses to open-ended questions were categorised using "content analysis" techniques (Dey, 1993). Providing attention and stimulation were amongst the most commonly cited short-term strategies, which according to behavioural principles could be expected to reinforce challenging behaviours (Hastings, 1996).

The Hastings study also required staff to rate their agreement with each of 25 statements describing possible causes of the behaviour described in their vignette (Hastings et al., 1995). A factor analysis of responses revealed that participants with experience of the behaviour explained it as a communicative act, self-stimulation, biologically-caused, or a response to the social and physical environment. The authors concluded that these responses were largely consistent with behaviour analytic formulations of challenging behaviour although staff strategies for intervention were not. Hastings et al. (1995) speculated that staff were using their beliefs about the causes of challenging behaviour to inform a "needs-based" strategy for intervening which assumed that the needs expressed by behaviour should be responded to and met, rather than a "functional" strategy which would propose the de-coupling of the behaviour from these types of staff responses.

Another questionnaire survey concerning staff beliefs about challenging behaviour was carried out by Bromley and Emerson (1995). Care staff working with learning disabled individuals were asked to respond to an open question about the causes of the challenging behaviour displayed by one of their clients. Responses were sorted into categories, revealing that the most common causal attributions concerned the client's internal psychological state or broad features of the client's past or present environment. Bromley and Emerson (1995) concluded that these were causes over which care staff could feel little sense of control, and that this may reduce their motivation to carry out behavioural interventions.

1.4.3.2 Staff Emotional Responses to Challenging Behaviour

Care staff have also reported a number of emotional reactions to challenging behaviours. The Hastings study (Hastings and Remington, 1995) included questionnaire items requiring staff to report emotional reactions to the behaviours described by the vignettes. Staff responses indicated that they felt fear, sadness and frustration when confronted with challenging behaviour. Participants were especially likely to report fear of clients' self-injurious or aggressive behaviour. Hastings and Remington (1995) speculated that emotional reactions such as these were likely to influence staff interventions, for example by motivating staff to avoid contact with clients.

Bromley and Emerson (1995) found that participants in their study commonly reported annoyance, anger, fear, sadness and despair in response to clients' aggressive and self-injurious behaviour. The authors concluded that these emotional reactions could

motivate staff interventions to stop behaviours quickly which in the longer term were likely to maintain the behaviours (for example, by providing attention contingent on behaviours, the function of which was to access staff attention).

1.4.3.3 The Development of Staff Beliefs and Feelings over Time

The findings of the Hastings study suggested that staff beliefs and feelings about challenging behaviours may change over time. The beliefs of nursing staff who had experience of the challenging behaviours described by their vignette were compared to the beliefs of those who did not (Hastings et al., 1995). The experienced group were said to have more clearly identified "aspects of behavioural models of challenging behaviours that are dominant in the research and intervention literatures" (p. 481), whereas inexperienced participants were more likely to cite emotional states and environmental events that triggered the behaviour. This suggested that staffs' beliefs increased in their concordance with behavioural models as they gained experience. Hastings and Remington (1995) reported data from the same study that showed experienced participants had developed an emotional "immunity" to challenging behaviour, being less likely to report fear and more likely to report "feeling nothing" than the inexperienced group.

The research studies cited above suggest that staff report beliefs and feelings about challenging behaviour that could explain their typical failure to work according to pure behavioural principles, and that these beliefs and feelings may change over time. The research has been useful in developing thinking about the processes involved in staff perceptions, but has been limited to questionnaire studies and has frequently asked for

responses to vignette examples rather than participants' actual experience of challenging behaviour. Although the studies have involved both quantitative and qualitative analyses none has included more in depth and exploratory methods of data collection; asking staff about their actual experience of working with clients. Furthermore, the studies have made no distinction between staff with different roles in services.

1.5 The Present Study: Research Aims and Questions

The following research questions were posed on the basis of an examination of the theoretical and research literature. The rationale for each is described below.

Research Question 1: How do staff working in residential services for people with learning disabilities formulate (describe and explain) challenges to their service in relation to a particular resident?

The present study aimed to extend previous theoretical and empirical accounts of the processes by which care staff perceive challenging behaviour in learning disability services. One rationale for this was to overcome the bias in previous challenging behaviour research towards examination of behaviour rather than perceptions of it (or other challenges). The present study adopted a new terminology in "challenging problems" to reduce the risk of implying to participants that they were expected to talk about behaviour. Another rationale was to add to theoretical accounts of staff perceptions of challenging problems by conducting research grounded in the experience of staff themselves. To this end the present study used in-depth interviews about staff experiences rather than questionnaires about hypothetical situations.

Research Question 2: How do staff formulations of challenging problems develop and change over time?

Research has suggested that staff beliefs about and emotional responses to challenging behaviour change as they become more experienced. The present study aims to illuminate further the processes by which staffs' understanding develops. This information is likely to be clinically relevant as Clinical Psychologists may be involved in attempts to facilitate development in staff views.

Research Question 3: In what ways are Home Managers' and Support Workers' formulations similar and different?

In the present study, Home Managers and Support Workers were included to ensure a wide representation of views. This also allowed examination of whether conceptualisations of challenging problems were influenced by the nature of a staff person's role in the service and their relationship with the client seen as presenting a challenge. These issues have not been examined by previous research, but have clear clinical significance. Effective consultancy by Clinical Psychologists in services for people with learning disabilities is likely to require a wide representation of the views of service staff and the development of an understanding of how the views and responses of different staff are inter-related.

1.6 Rationale for Choosing a Qualitative Methodology

The use of in-depth interviewing of participants and qualitative "grounded theory" methodology (Strauss and Corbin, 1990) offers the best method for developing the sparse theory in this area, whilst grounding this theory directly in the experience of care staff. It has been suggested that qualitative methodologies may be used for both

epistemological and technical reasons (Henwood and Pidgeon, 1995). Qualitative methodology was adopted for the present study for both types of reason. Epistemologically, qualitative research is grounded in a view of the universe as not containing single truths but multiple valid perspectives. This view is highly compatible with a conceptualisation of challenging behaviour as a phenomenon made up of perceptions as well as behaviour. Technically, qualitative methodology based on grounded theory techniques appeared to be the best suited to developing theory in an area which has lacked theory and failed to link theoretical accounts comprehensively to research. Quantitative methods might have been preferable if a coherent and research based theoretical account of staff perceptions was available for further elaboration. Another technical advantage of qualitative methodology was that it may be particularly well suited to capture the richness and subtlety of staff beliefs and ideas in a way which is not possible if responses are reduced to pre-defined quantitative categories (Smith, 1995).

1.7 Safeguards to Ensure Rigour (Reliability and Validity) in Qualitative Research

Qualitative research is widely criticised for failing to pass tests of methodological rigour (Sandelowski, 1986). All research has the potential to produce results which have limited generalisability beyond the specific individuals involved in the study, and to be based too greatly on the subjective bias of the researcher. Quantitative research carries a number of safeguards to ensure "rigour" and thus minimise the risk of such outcomes. Checks on "external validity" increase the chances of the methodology producing generalisable findings. Checks on "reliability" and "internal validity" reduce the risk of

methodology producing results over-influenced by the researcher's subjective bias. These safeguards can not easily be applied in the same way to qualitative research. Alternative safeguards have therefore been proposed, including "fittingness" as a safeguard against ungeneralisable research, and "auditability", "credibility" and "reflexivity" to safeguard against overly subjective research. The nature of these safeguards and their application to the present study are outlined below.

1.7.1 Fittingness

The generalisability of quantitative research is evaluated according to the effectiveness of steps taken to ensure external validity. External validity is maximised when the participants, tests and testing situations of a study form a close match with real-life conditions. This is usually achieved by employing sampling methods designed to achieve a "representative sample" and ensuring that tests used have been compared to other trusted criteria thought to measure the phenomenon under study. In qualitative research sample sizes must be kept small to produce a manageable quantity of data, so a representative sample is unlikely. Furthermore, the "tests" used are often in-depth interviews comprising interactions between a unique researcher with a unique participant in a unique context, making comparisons with other measures meaningless. "Fittingness" has therefore been proposed as a qualitative alternative to external validity (Guba and Lincoln, 1981). A study is said to have a high level of fittingness when its findings can "fit" into contexts outside the study situation and "fit" the data from which they were derived including its typical and atypical elements (Sandelowski, 1986). During the present study fittingness was assessed by asking participants to comment on

the generalisabilty of the results. In addition, efforts were made to include typical and atypical data in the analysis.

1.7.2 Credibility

The risk of the researcher's subjective bias exerting too powerful an influence on quantitative research is reduced by maximising the internal validity of the research. A study is internally valid to the extent that the tests and instruments used measure what they are supposed to measure. This minimises the possibility that the findings are an artefact of the method of investigation chosen by the researcher (Sandelowski, 1986). In the case of qualitative research (which does not employ clearly defined tests or instruments), "credibility" has been proposed as an alternative criterion of rigour (Guba and Lincoln, 1981). A qualitative study is said to be credible when it presents such faithful descriptions or interpretations of human experience that people having that experience would immediately recognise it from those descriptions or interpretations as their own. During the present study, credibility was assessed by asking participants to comment on the extent to which the results reflected their own experience.

1.7.3 Auditability

Subjective bias is also kept in check in quantitative research by safeguards to ensure reliability. Reliability refers to the consistency or stability of a testing procedure. Inherent in the goal of reliability is the aim that the study procedure should be repeatable, and that if it were repeated the same results could be expected. Because qualitative research emphasises the uniqueness of human situations it violates the assumption that procedures could ever be repeated identically (Giorgi, 1971).

"Auditability" has been suggested as an alternative criterion of rigour relating to the consistency and stability of qualitative research (Guba and Lincoln, 1981). A study is said to be auditable when another researcher can clearly follow the "decision trail" used by the investigator in the study. The present study maximised auditability by the author keeping a research diary outlining thoughts and ideas that influenced him at each stage of the research process (Appendix 1).

1.7.4 Reflexivity

A philosophical foundation of qualitative research is that it is a "reflexive" activity, that is an activity during which the researcher forms part of the world they are researching (Smith, 1993). Recognition of this reflexivity implies that researchers' subjective bias and experience of the research is an unavoidable and important source of creativity (Strauss and Corbin, 1990; Henwood and Pidgeon, 1995). However, if qualitative researchers are to avoid merely *applying* their own perspective to new data, it has been suggested that they must be aware of and make explicit their own biases and how these may influence the research process and outcome (Rubin and Rubin, 1995). This explicit reflexivity has been achieved in the present study by including first person accounts of the author's bias and experiences as influences on the research process in this section and in the Discussion. The author's personal relationship to the research idea is described in this way below:

> **The research idea was conceived at a time when I was struggling to integrate internalised and externalised views of human distress. During my first two years of training I attended placements and teaching which highlighted internal psychological processes and I engaged in much direct therapeutic work. Entering my final year of training I took up an elective placement in a learning disability community team which prided itself on its externalised, socio-political view of**

distress, where clinicians tended to work with service organisations rather than individuals. I may have arrived at the present research idea partly with the motivation of trying to resolve the internal conflict that this presented. Perhaps I hoped that direct care staff could show me a way of incorporating both internal psychological and external socio-political processes into my understanding of psychological difficulties (including "challenging behaviour").

I had worked both as a Support Worker and a Home Manager in a residential learning disability service before starting Clincal Psychology training. In both roles I was driven by a strong affiliation to the philosophy of Normalisation and Social Role Valorisation (Wolfensberger, 1983). I began to question my total acceptance of this philosophy during my Clinical Psychology training, however. Perhaps by designing a study to record the views of staff in similar roles I was seeking to re-experience some of the clarity of understanding and purpose in my work that I had felt in my previous posts.

My experience of working in learning disability services as both a direct care worker and as a Trainee Clinical Psychologist had led me to believe that Home Managers and Support Workers often had disparate views of clients and the challenges presented by them. This motivated me to investigate whether such a difference would be borne out by research.

2. METHOD

2.1 Design

A qualitative research design was used to investigate the research questions. Data were collected using semi-structured interviews and interview transcripts were analysed using "grounded theory" methodology (e.g. Strauss and Corbin, 1990; Charmaz, 1995). Themes relevant to the first two research questions were identified from the data. A simple numerical comparison of the themes discussed by Home Managers and Support Workers was undertaken to address the third research question. The credibility and fittingness of the results were assessed by asking participants to comment on the analysis at this stage. Finally, a theoretical account was proposed to explain the results obtained.

2.2 Participants

Participants were 18 people who worked in residential services for people with learning disabilities. Participants were recruited from 10 residential services in two counties in the south of England. From each service one participant was a "Support Worker" with responsibilities for day to day care of an identified resident. Eight of the services also provided a participant who was a "Home Manager" with direct management responsibility for the service provided to the identified resident[2].

[2] Interviews were carried out with a Home Manager from all 10 participating services. However, the tape recorder used to record interviews malfunctioned during two of these interviews and most of the recording was lost. These two interviews were therefore excluded from further use in the study.

2.2.1 Sampling Criteria

Qualitative research based on grounded theory methodology aims to develop and expand theory rather than test the applicability of theory to a population (Strauss and Corbin, 1990). For this reason, sampling in the present study was not planned primarily to achieve representativeness of the population of residential staff, but to include a range of staff with a sufficient diversity of views to allow comprehensive investigation of the phenomena under study.

The best method for achieving the necessary diversity is *theoretical sampling*, whereby participants are selected on the basis of characteristics which are found to be relevant during the ongoing analysis of data (Chenitz and Swanson, 1986). Theoretical sampling was not possible during the present study because simultaneous data collection and analysis would have been prohibitively time-consuming. However, an attempt was made to include a diversity of participants in the study using the characteristics of services known from information available from the local Social Services Inspectorates.

Participants were recruited from services representing a range of sizes, locations, philosophies, provider agencies and levels of resident need (as indicated by the cost of placements; with more expensive placements assumed to indicate greater support needs). By chance, the recruitment process resulted in men and women of a range of ages (27-73) being discussed by male and female managers and support workers.

Services were not approached if they had previously received clinical input from the author or from the "Crisis Support" component of the local Community Learning

Disabilities Team during the past three months, as it was thought that this would compromise participants' freedom to express their opinions.

2.2.2 Recruitment Procedure

Services were recruited by telephoning Home Managers identified on lists of homes for people with learning disabilities registered with two Social Services Inspectorates. A total of 16 services were approached. Two declined to participate because of lack of staff time and four were unable to identify a resident who challenged the service.

Home managers in each participating service were asked to identify the resident who "currently presents the greatest challenge to the service" for discussion. Home Managers were also requested to ask the Support Worker who "works most closely" with that resident (for example the keyworker) if they would also be willing to participate. Home Managers and Support Workers from each service were asked to discuss the same client to allow comparison of their formulations (research question 3). Characteristics of participating services, staff and the residents and challenges that were discussed are shown in Table 1.

Table 1: Characteristics of Participating Staff, Services and the Clients Discussed

Participants' Pseudonyms (Home Manager then Support Worker)	Client's Pseudonym	Service Organisation	Service Size (number of residents)	Cost of Placements (£)	Client Age	Summary of Description of the Challenging Problems
Sally Kate	Brian	Social Services group home	6	237	32	Hitting people, overeating, night waking, staff difficulty understanding his needs
Jim Helen	Andy	Voluntary Agency with Christian links - large group home	12	237-456	29	Withdrawal and panic attacks
Lee Alan	John	Voluntary Agency group home	7	286	27	Sexual interest in staff and allegations that staff abuse him
Ruth Melanie	Cathy	Voluntary Agency group home	6	278-444	29	Turbulent romantic relationship between two clients
Laura Richard	Bill	Private Company - large country house	25	343	57	Sexual approach to men in public toilets, depression
Andrea Charlotte	Matthew	Private Company - Challenging Behaviour Unit	26	560	36	Physical attacks on staff and residents
Wendy Kerry	Tina	Voluntary Agency - large country house	16	650	29	Headbutting, headbanging, staff difficulty understanding her needs
Agnes Anna	Margaret	Voluntary Agency with Christian links	19	310-400	56	Continually seeking staff attention
Gail (Support Worker only)	Eric	Private Company - Large Country House	32	350	32	Ripping clothes, anal poking
Lara (Support Worker only)	Jessie	Private Company - Large Country House	32	244-267	73	Banging doors, throwing things, staff difficulty responding to her needs

2.3 Procedure

2.3.1 Ethical Considerations

Procedures were designed to enable participants to make an informed choice about participation, to provide an opportunity for them to discuss any difficult feelings arising from interviews and to allow them access to the research findings. Confidentiality was ensured for participants and the clients who were discussed. The research proposal was granted full ethical approval by the Salomons Centre Ethics Panel on 6 March 1997 (Appendix 2).

2.3.1.1 Informed Consent

A written information sheet was provided for participants explaining the objectives and procedures of the research, their rights to withdraw at any stage and procedures for debriefing and confidentiality (Appendix 3). On meeting each participant the author drew their attention to the information sheet, invited them to ask questions and asked whether they wished to proceed. They were then asked to sign a consent form (Appendix 4). Prior to interview participants were encouraged to consider whether it would be appropriate to ask the consent of the identified resident to be discussed.

2.3.1.2 Debriefing

At the end of the interview participants were asked about their experience of participating; all reported a positive or neutral experience. Participants were also provided with a telephone number and invited to contact the author if they wished to discuss any issues which had arisen from the interview; none made contact. All participants were provided with a summary report of preliminary research findings for

them to comment on. They will be provided with a final comprehensive research report in due course.

2.3.1.3 Confidentiality

Names and identifying details of participants, their services and clients were disguised in all records of the research (including this dissertation). Interview transcripts are stored securely and will be destroyed within three years of interview. It may be necessary to retain them for this period for use in preparing the research for publication. Audio tape recordings of interviews were erased following transcription.

2.3.2 Development of the Interview Format

A semi-structured interview format was developed, comprising a list of topics to be covered during each interview. This format was intended only as a guide for the author; with each participant it was anticipated that lines of enquiry specific to their circumstances would also be followed up.

The interview format was developed using a method described by Mason (1996). The first two research questions were scrutinised and a series of sub-questions generated in order to elicit information relevant to the research questions. For each sub-question possible probe questions and topics of discussion were produced. For the third research question a series of sub-questions relating to the work role and relationships of participants was added to elucidate the numerical comparison of formulation themes discussed by Home Managers and Support Workers. The resulting sets of sub-questions and probe questions were then combined in a coherent order to produce an

interview guide for the author (Appendix 5). The structure of the interview guide and rationale for the inclusion of the sub-questions are summarised below.

Section 1: Role and Relationships

This section comprised the sub-questions: "What is your role in this service", "What is your role in relation to the other participant from this service?", and "What is your role in relation to the resident we will be discussing?". These questions comprised a check for ensuring that within each service one participant had management responsibility for the service as a whole and one had more specific knowledge or responsibility in relation to the resident being discussed. The information about roles and relationships was intended to aid understanding of similarities and differences in the formulations of challenging problems reported by Home Managers and Support Workers (third research question). These sub-questions were usually addressed at the start of interviews as they allowed participants to become accustomed to the interview situation before other issues were explored in more depth.

Section 2: Formulation of Challenges to the Service in Relation to the Identified Resident

This section comprised the sub-questions: "You/your manager have/has identified that there is a problem or concern in relation to this resident. How do you understand this problem or concern?"; "What factors do you think have caused the problem?"; and "What factors do you think keeps the problem going?". These questions were designed to elicit information of relevance to the first and third research questions without portraying or assuming a particular perspective on the problem.

Section 3: Development and Change in Formulations over Time

This section comprised the sub-questions: "How did you understand the problem when you first encountered it?"; "How did your view change (if at all) since then?"; and "What caused each significant change in your view?". These questions were designed to elicit information relevant to the second research question.

2.3.3 Refining the Interview Format

Qualitative interviewing is aimed at collecting information seen as relevant to the topic under investigation by participants as well as the researcher. It is therefore necessary for the review of interview procedures to be continuous throughout a study rather than confined to an early "pilot" phase as may be required for quantitative procedures (Rubin and Rubin, 1995). For this reason every participant in the present study was asked at the end of their interview to comment on the interview process and whether it could be changed to make it easier for them to talk about relevant issues. The first participant reported that she felt it would be helpful to ask participants "is there anything else you would like to say about that?" at various points throughout the interview, as she had felt unsure when to mention things not specifically asked about by the author. The author incorporated this feature into all further interviews. All subsequent participants reported that they felt the format had allowed them to cover the relevant issues and that it had been a positive or neutral experience. There were no further suggestions for changes.

2.3.4 Interview Procedure

Each interview took place in a private office at the participant's work place. Interviews lasted between 40 minutes and an hour and all but one were audio-tape recorded to

allow accurate transcription. One participant preferred not to be recorded so extensive notes were taken by the author instead. The author introduced each interview by saying it would be a reasonably informal discussion, that he would be led by what the participant thought was relevant and that he had a list of topics which he would like to cover at some point during the discussion.

The author aimed to conduct interviews according to guidelines for semi-structured interviewing suggested by Smith (1995). There was an attempt to establish rapport with the participant, the ordering of questions was flexible, questions were constructed to be neutral rather than value-laden, jargon was avoided and open questions were used in preference to closed questions. Smith argued that these guidelines encourage participants to speak in depth about the issues as they understand them, in their own language. At suitable intervals during each interview the author summarised his understanding of the participant's viewpoint and asked if he had understood correctly.

2.4 Data Management And Analysis

2.4.1 Transcription of Interviews

Tapes of interviews were transcribed by a commercial secretarial agency and transcripts checked and corrected by the author. The notes taken during the interview which was not tape recorded were transcribed by the author.

2.4.2 Analytic Procedure

Interview transcripts were analysed using techniques based on grounded theory methodology (Glaser and Strauss, 1967; Strauss and Corbin, 1990; Charmaz, 1995).

Grounded theory approaches aim to generate theory by developing progressively more abstract conceptual categories to synthesise and explain the data and the relationships between them (Charmaz, 1995). The present analysis similarly comprised a process of systematically summarising the data. Thus text was summarised at increasingly abstract levels in the form of *margin codes, codes, categories* and *themes*. Margin codes were summaries of text relevant to the research questions. Codes were groupings of margin codes from individual interviews. Categories were groupings of codes from across different interviews. Themes were groupings of categories. Table 2 shows the steps by which three portions of text were summarised and sorted into the same theme. This is followed by a description of each stage of data analysis.

Table 2: Examples of Interview Text and the Margin Codes, Codes, Categories and Theme assigned to them.

Text	**Margin Code**	**Code**	**Category**	**Theme**
"He is quite a large lad, has always had a tendency to try to intimidate and he's a biter." (Andrea)	He bites people	He is verbally abusive and physically violent to staff	Violence to People	Client Behaviour is a Problem
"But he still resisted going out for quite a while. Going out *at all*." (Jim)	He resisted going out at all	He has withdrawn from his usual activities and routines	Withdrawal	
"I can't even get him to go for a haircut." (Helen)	He won't even go to get a haircut	He is withdrawing from all activity		

2.4.2.1 Coding Within Each Transcript

Highlighter pens of three different colours were used to select text which was relevant to each of the three major areas of data collected: role and relationships, formulation of

challenges to the service in relation to the identified resident, and changes and developments in this formulation over time. A brief summary of each highlighted sentence was recorded in the margin of the transcript as a *margin code*. These margin codes were then typed into a word processor and cut-and-paste functions used to shuffle them into groups according to common features. Each of these groupings was then summarised by a *code* heading. The end result of this process was that within each transcript a number of codes were identified which were relevant to each of the three areas of data collected.

2.4.2.2 Identification of Categories and Themes Across Interviews to Answer Research Questions 1 and 2

The codes (including the margin codes which each code summarised) relating to the first two research questions were printed out from all 18 interviews. The author then sorted these codes into categories according to common features, referring back to the original transcripts as necessary to check how codes related to one another. The categories which were produced were then sorted into themes according to common features. Up to this point analysis had been predominantly *descriptive*. The identification of themes required a greater degree of *interpretation* of data.

2.4.2.3 Comparison of Themes to Answer Research Question 3

The two interviews from Support Workers (Gail and Lara) which were not matched to interviews from Home Managers because of the malfunctioning tape recorder were excluded from this part of the analysis, so that the comparison only involved pairs of participants who had discussed the same client. The interview data relating to the

remaining 16 participants' work roles and relationships were analysed in the same way as the rest of the interview data to produce categories and themes. The categories were listed and the number of Home Manager and Support Worker participants who contributed data to each category recorded. A visual comparison was then made to ascertain differences in roles and relationships between the two groups.

The themes identified in relation to the first research question were then listed and the number of Support Workers and Home Managers who contributed data to each theme was recorded. The results were tabulated and compared visually to compare the formulations of challenging problems presented by the two groups. Silverman (1981) has argued that "counting" procedures such as this provide a means of summarising a whole body of qualitative data in a way that is ordinarily lost in intensive qualitative methods. The results of the comparison of formulation themes were assessed in the context of the results of the comparison of roles and relationships, and in the context of specific comments made by participants about the effect of their role on their views of challenging problems.

2.4.3 Steps taken to Maximise the Rigour of the Research

2.4.3.1 Credibility and Fittingness

The degree of credibility and fittingness of the present study was assessed by the use of "respondent validation", a procedure whereby participants were sent a summary of the findings of the study and asked to comment on them (Henwood and Pidgeon, 1995). A written summary of the initial findings was sent to participants (Appendix 6) along with a feedback form (Appendix 7). The form required them to comment on the initial

findings in terms of how well these fitted the participant's experience of the client discussed at interview (credibility), and how well they fitted the experience of service workers "in general" (fittingness). The feedback received was also taken into account during the final stage of analysis when a theoretical account of the data was constructed.

2.4.3.2 Auditability and Reflexivity

The author kept a research diary (Appendix 1) as a tool to enhance his awareness of his own assumptions about the research area. This awareness was used to ensure that these assumptions and biases were not merely used as a template against which to "fit" the data. The diary was appended to this Dissertation to increase the auditability of the study.

2.4.4 Construction of a Theoretical Account of the Data

The final stage of analysis comprised the construction of a theoretical account of the patterning found in the data during the identification of categories and themes. Morse (1994) suggested that theory development in qualitative research should be seen as the evaluation of alternative "guesses" at explanations of the data, a continuous process of speculation, falsification and verification in an attempt to arrive at the "best fit" theory. The "best fit" theory was said to be the one that provides the most comprehensive, coherent and simplest model for linking diverse and unrelated data in a useful way (Morse, 1992). The theoretical account proposed during the present study was arrived at by the author hypothesising links between different themes, interpreting the patterning of themes in the accounts of different participants, and referring back to

interview transcripts to verify the emerging theory. It was not possible to seek participant feedback on the proposed theoretical account within the time scale of the study.

3. RESULTS

Results are presented for each of the three research questions in turn. For the first two research questions the themes derived from the analyses are described and illustrated with quotations from interview transcripts. For the third research question themes pertaining to participants' roles and relationships are presented, followed by a tally of the themes describing Home Managers' and Support Workers' formulations of challenging problems. This is supplemented with quotations from interview transcripts. Finally, a theoretical account is proposed as the "best fit" explanation of the three sets of results.

3.1 Research Question 1: How do Service Workers Formulate (Describe and Explain) Challenges Presented to their Service in Relation to a Particular Resident?

Coding of interview data relating to this research question generated 198 codes. These were sorted into 42 categories (Appendix 8). Thirteen themes were identified by grouping categories according to common features. Three types of theme were identified: staff *descriptions* of challenging problems, staff *explanations* of challenging problems, and staff *dilemmas* and difficulties of understanding and responding to problems. The themes of each type are listed in order of prevalence in Table 3.

Table 3: Themes Sorted by Type, and Number of Participants Represented for Each Theme

Type of Theme	Themes	Number of Participants Represented
Staff Descriptions of Challenging Problems	Client behaviour is a problem	11
	Client emotions are a problem	5
	Client relationships are a problem	3
	Staff perceptions are the problem	1
Staff Explanations for Challenging Problems	The problem is caused by the client's ordinary and understandable motivations, characteristics and reactions to events	15
	The problem is caused by client disability or illness	10
	The problem is caused by the client's need to seek attention from staff	7
	The problem is caused by the client's hostile motivations or deviant characteristics	6
	The problem is caused by inappropriate staff and service responses to the client	4
Staff Dilemmas and Difficulties of Understanding and Responding to the Problem	How can we maintain boundaries/ exert control and still be kind and respectful?	14
	How can we deal with the unpleasant feelings evoked in us by working with this client?	10
	It is hard to understand the problem and maybe we can never fully understand	10
	Should we understand the behaviour as a communication or as a behaviour problem?	9

Problems were most commonly described as involving client behaviour, followed by client emotions and relationships. The most common explanations for problems cited "ordinary and understandable" client characteristics, but others cited factors implying that clients had "deviant or hostile" characteristics. Staff accounts contained reference to four dilemmas regarding how to manage their thoughts, actions and feelings in relation to challenging problems.

3.1.1 Staff Descriptions of Challenging Problems

Four themes encompassed staff descriptions of the challenging problems discussed during interviews. Participants described client behaviour, emotions or relationships as a problem, or suggested that staff perceptions of the client were the problem. While the themes were not mutually exclusive, participants tended to give some themes greater emphasis than others, and some adopted one theme exclusively throughout their interview. The themes are described below.

3.1.1.1 Client Behaviour is a Problem

Staff made extensive reference to client behaviour as a challenging problem. The theme comprised the eight categories shown in Table 4.

Table 4: Categories Comprising the Theme "Client Behaviour is a Problem", and Number of Participants Represented for each Category

"Inappropriate" Sexual Behaviour	6
Violence to People	4
Withdrawal	3
Problems related to Control of Eating	3
Self-injury	2
Destruction of Property	2
Obsessional Behaviour	1
Theft	1

The following account by Gail provides examples of the categories of "violence to people", "self-injury" and "destruction of property":

> **"Basically he'll be all right and then all of a sudden he goes quite white and he'll start being verbally abusive, lots of self punishment and then he'll start to kick items of furniture, it doesn't matter what it is, or he'll deliberately destroy his own belongings, just smash them to pieces... Most of the time he's fighting you while you're standing between him and whatever he's trying to destroy." (Gail)**[3]

[3] In all quotations ... indicates an omission of text.

3.1.1.2 Client Emotions are a Problem

Staff also made reference to the client's emotions as a primary problem (not as an explanation for behaviours or relationships), as shown in Table 5.

Table 5: Categories Comprising the Theme "Client Emotions are a Problem", and Number of Participants Represented for each Category.

Anxiety and Panic	3
Depression	2

3.1.1.3 Client Relationships are a Problem

Three participants highlighted client relationships as a primary problem (not an explanation for behaviours or emotions). Ruth's account illustrates the theme:

> **"There's Cathy's relationship with Steve, who's one of the residents here... He's a very serious person and Cathy is more bubbly and light-hearted, wants to have fun. They get on very well for short periods of time, but living together they have completely different expectations of each other, and Cathy in particular I feel is definitely disappointed in how that's developed." (Ruth)**

3.1.1.4 Staff Perceptions are a Problem

One participant suggested that staff had mistakenly labelled the client's behaviour as challenging:

> **"I think the problem has been people's inability to treat him as an exuberant outgoing person and not see a lot of this exuberance as challenging. We are very quick to put challenging behaviour labels on people, and whose challenge is it? Is it the staffs?" (Kate)**

3.1.2 Staff Explanations of Challenging Problems

Staff explanations of the problems they described were encompassed by five themes, which again were not mutually exclusive. Explanations varied on a dimension of "ordinariness-deviance" according to the extent to which client motivations or characteristics were seen as ordinary and understandable or deviant and hostile. Some

explanations were clearly ranged at one end of the dimension or the other (these were grouped under two themes). Explanations citing disability and illness or "attention seeking" seemed to fall at a neutral midpoint on the dimension. Some explanations cited various inadequacies in the staff or service response to the client. These tended to be associated with other explanations at the "ordinary" end of the dimension. The five themes are described below.

3.1.2.1 The Problem is Caused by the Client's Ordinary and Understandable Motivations, Characteristics and Reactions to Events

Participants frequently referred to client characteristics as ordinary and "understandable" in their explanations of problematic client behaviour, emotions and relationships, as shown by the categories in Table 6.

Table 6: Categories Comprising the Theme "The Problem is Caused by the Client's Ordinary and Understandable Motivations, Characteristics and Reactions to Events", and Number of Participants Represented for each Category

Problem caused by client's personal history and life events	10
Behaviour as communication/ expression of feelings	9
Behaviour as choice-making	5
Behaviour as expression of normal personality traits	3
Behaviour as non-malicious loss of control	2

Challenging behaviour was frequently seen as an act of communication, an expression of feelings or a means by which the client could make choices given a limited repertoire of communication skills. Sally explained an incident when Bill hit people at his day centre as a way of expressing his dislike for the activity he was attending:

> **"He expressed the fact that he didn't like it there. I feel that was why he was displaying this disruptive behaviour; because he didn't actually like being there... He has not got any speech apart from "hello" and "mama", which has a lot to do with it." (Sally)**

The explanation that behaviour was a means of communicating and expressing ordinary feelings and wishes signalled participants' empathy with the client they were describing. This empathy was further demonstrated in explanations which proposed that the behaviour was merely an expression of ordinary personality traits. Kerry explained Tina's challenging behaviour as a result of her being a tidy person, for example:

> **"One day one of the resident's curtains was coming off the rail and nobody had really noticed it apart from Tina and she would not come out of that room, she started slapping and stamping her feet until somebody had re-hooked the curtain... You do get people in real life who are very tidy people and it's very important to have tidy homes, almost to an obsession as well, so maybe she's just one of those people." (Kerry)**

Some participants speculated about how life experiences such as the death of a relative or sexual abuse must have impacted on the client, explaining problems as an understandable response to traumatic events (Helen, Melanie, Kate).

3.1.2.2 The Problem is Caused by Client Disability or Illness

Participants referred to cognitive impairment, autism and a variety of physical and mental illnesses as implicated in the genesis of the problems that they had described, as indicated by the categories in Table 7.

Table 7: Categories Comprising the Theme "The Problem is Caused by Client Disability or Illness", and Number of Participants Represented for each Category

Cognitive impairment	5
Autism	4
Mental illness	4
Physical illness	3

These factors were generally cited as if they were explanations in themselves:

> **"It's emotions he has trouble coping with. I don't know whether he can't cope with the feelings they give him inside, I don't know. If I could get in there and find out, I'd know, but I'm sure some of it is. Probably it comes from his autism, because autistic people don't actually relate to feelings." (Andrea)**

On further questioning participants tended to have only hazy ideas about the nature and course of the conditions they described. Disability and illness were not described as "deviant" but were said to have a cyclical or variable effect on problems, suggesting that problems caused by disability or illness could not be understood and were far from "ordinary".

3.1.2.3 The Problem is Caused by the Client's Need to Seek Attention from Staff

This theme comprised eight codes representing seven participants. Participants referred to clients' behaviour as "attention seeking". Some participants implied that this had a "deviant" motivation, requiring no further explanation:

> **"The whole of the room had been upturned, plants thrown across the room, TV on its side, and it's purely he wants somebody's attention, he wants somebody to rush down and sort it out." (Lee)**

In other instances, client's motivations to seek attention were explained as "understandable" because the staff were not able to provide enough attention, because the client was used to being the centre of attention in their family, or because the client desperately wanted to be liked (Ruth, Agnes, Anna).

3.1.2.4 The Problem is Caused by the Client's Hostile Motivations or Deviant Characteristics

Three categories of explanation were based on characteristics of the client that were seen as deviant or hostile and one category hinted at deviance (behaviour seen as copied from another client), as shown in Table 8.

Table 8: Categories Comprising the Theme "The Problem is Caused by the Client's Hostile Motivations or Deviant Characteristics", and Number of Participants Represented for each Category

Behaviour is vindictive/an attack	4
Sexual urges seen as deviant	3
Problem caused by personality traits seen as deviant	2
Behaviour is copied from another client	2

Characteristics of the client seen as deviant or hostile were almost exclusively used to explain problems described as consisting of the client's *behaviour*, as in Gail's explanation of Eric's attacks on other clients:

> **"Physical aggression can be directed at other clients and it doesn't have to be provoked. It just means that that person was standing in the wrong place at the wrong time. He really is horrible. I can't think of another way to describe it... There doesn't ever seem to be a reason... He just decides that he's going to do this and he just does it." (Gail)**

Several participants referred to "homosexual urges" as causes of clients' "challenging" sexual behaviour, and some clearly perceived these urges to be deviant. Thus Richard explained Bill's tendency to "chat up" men in public toilets:

> **"He's gay and that's it, you're not going to change it... I don't think there is a cause as such, it's just the way he is and at those particular times he must be a bit frustrated I suppose sexually... Personally I was disgusted really, because that's how I think towards them, but then I didn't have a go at him to say it was disgusting, or I thought it was wrong that he's gay, even though I do think that." (Richard)**

3.1.2.5 The Problem is Caused by Inappropriate Staff and Service Responses to the Client

Some participants suggested that problems were caused by a failure or inadequacy of staff or the service. This theme comprised the three categories of staff or service response shown in Table 9.

Table 9: Categories Comprising the Theme "The Problem is Caused by Staff and Service Responses to the Client", and Number of Participants Represented for each Category.

Staff do not understand client's communication	4
Service is not flexible enough to respond to individual needs	2
Staff do not understand client's needs	1

Staff reported that their colleagues or they themselves did not understand their client's communication or needs. Staff reported that it was important for staff to develop a "shared language" with clients (Wendy). "Staff egos" were seen as an obstacle to developing this:

> **"You're here to learn their language, they're not here to learn yours. No matter if it's a spoken language or physical language, whatever it is, we're here to learn... Learning to speak their language and not letting your ego get in the way, because that's basically it in dealing with anybody with challenging behaviour." (Kate)**

Inflexible service systems were seen as additional obstacles to responding sensitively to clients' individual needs and communications. Lara described the difficulty of balancing her understanding of Jessie's needs and wishes against an inflexible service policy:

> **"We have to be flexible. I feel that is the main challenge... Everybody goes out twice a week, and it's difficult to explain to managers: 'she doesn't want to do it today, she doesn't want to go out'. They say 'But you have to find a way to get her out of the house', but she doesn't want it. It's difficult to balance." (Lara)**

This inflexibility may occur when managers do little direct client work and therefore do not build a knowledge of this into their expectations of how staff should support clients (Lara). Another cited obstacle to service flexibility to meet clients' individual needs was inadequate funding, which meant there were insufficient funds for Brian to be accompanied by staff to do as many outside activities as he would like (Kate).

3.1.3 Staff Dilemmas and Difficulties of Understanding and Responding to Problems

Four themes were identified which referred to dilemmas and difficulties for staff working with challenging problems. The dilemmas concerned how to think about problems (two themes), respond to problems (one theme) and how to deal with feelings about problems (one theme). The themes are described here in the order that makes most conceptual sense, not in order of prevalence (shown in Table 3).

3.1.3.1 It is Hard to Understand the Problem and Maybe we can Never Understand

This theme concerned a difficulty of understanding challenging problems. It consisted of two categories, shown in Table 10.

Table 10: Categories Comprising the Theme "It is Hard to Understand the Problem and Maybe we can Never Understand", and Number of Participants Represented for each Category

It's hard to understand	10
Maybe we can never fully understand	2

Staff were engaged in considerable struggles to work out the causes and suitable responses to the complex and multi-faceted challenges which they described:

> **"It's *so* complicated, you could spend your entire shift trying to analyse everything and never get there... I've racked my brains out trying to help him but it's totally impossible." (Helen)**

For some, the struggle had been so arduous and fruitless that they wondered if they should accept that there were limits on the extent to which they would ever be able to understand and solve the problems.

3.1.3.2 How Can we Maintain Boundaries/ Exert Control and Still be Kind and Respectful?

The most prevalent dilemma for staff concerned how they should *respond* to behaviour seen as challenging. This dilemma was the extent to which they should respond firmly to behaviour with clear boundaries and the extent to which they should respond to behaviour with "kindness" (Table 11). This dilemma was particularly salient for staff who felt that their client's behaviour was "attention seeking".

Table 11: Categories Comprising the Theme "How Can we Maintain Boundaries Exert Control and Still be Kind and Respectful?", and Number of Participants Represented for each Category

The dilemma of how to maintain boundaries and exert control and still be kind and respectful	8
Client did/ does not have firm boundaries in their family and wants the same treatment here	7
We need to balance the needs of all the clients	5
Breaking the pattern set in the family makes the behaviour worse	5
The client demands a lot from staff	3

Participants reported that they thought it necessary at times to exert control or "maintain clear boundaries" on the client's behaviour for the client's own benefit. The need to control was seen as potentially conflicting with being kind. Several staff had resolved this dilemma by proposing the need to be "firm but kind":

> **"...you have to be very careful to stay firm with her... You might be firm but at the same time no matter what they do you must be there for them. Firm but kind, that's what it is." (Agnes)**

The perceived need to exert control was also seen as conflicting with attempts to treat clients as adults capable of making adult choices. This posed problems for Ruth, who was in a dilemma about how much to interfere in the relationship between two clients to alleviate the conflict between them:

> **"We've been thinking about trying to give them both a breathing space, to let some of the pressure off, but then you get to that line again and think 'stop interfering - it's their choice'." (Ruth)**

Gail resolved the dilemma by suggesting that staff should control Eric's behaviour as if he was a child and gradually nurture him up to a level of adult responsibility for his behaviour.

Participants reported that a cause of the dilemma of how much to maintain firm boundaries was that clients had come from family environments where they were the "centre of attention" and always "got their own way", and that they expected the same treatment from staff:

> **"John spent most of his life with his parents who have really mothered him... He likes to have everything done for him, he doesn't want to do things for himself, so you've got that conflict because obviously coming here we're trying to get people to be independent." (Lee)**

Participants felt it was impossible to live up to client expectations such as these because of the need to be fair to all the residents in the home by protecting others from the identified client's behaviour, or providing attention equally to all the residents (Agnes, Kerry).

3.1.3.3 Should we Understand the Behaviour as a Communication or as a Behaviour Problem?

The two categories comprising this theme referred to how to *understand* problems, as well as how to respond to them. The theme concerned the dilemma of whether to see challenging behaviour as communication or as a behaviour problem (Table 12). This dilemma was referred to explicitly in some accounts and implied in others, notably those

which suggested that responding to the behaviour as if it represented a valid communication by the client ran the risk of exacerbating the problem of the behaviour.

Table 12: Categories Comprising the Theme "Should we Understand the Behaviour as a Communication or as a Behaviour Problem?", and Number of Participants Represented for each Category

If we respond to it as communication the behaviour will get worse	5
The dilemma of seeing the behaviour as a communication or a behaviour problem	4

Whether the behaviour was seen as communicative or as a behaviour problem clearly had conflicting implications for how staff felt they should respond. When the problem was seen as "behavioural" it was seen as important not to "reward" or "reinforce" it by responding. However, viewing behaviour as a valid communication implied that the behaviour's message should be interpreted and responded to. Wendy described the dilemma in interpreting Tina's tendency to slap herself:

> **"She'll slap herself to say 'I don't want to be here any more', then it's a question of do you always let her have her own way... If you reinforce the behaviour she's not going to get out of it." (Wendy)**

Other participants facing a similar dilemma had decided that it was best not to view the behaviour as communication, as this implied a response which would make the behaviour "worse". Alan described how he had opposed a plan for his client John to see a therapist to discuss his sexuality after John had made allegations that staff had touched him inappropriately:

> **"At one time it was felt that someone outside the service should come and speak to him but I felt this might stir things up inside him and he could start inventing things... It's not something where you can come up with a solution, because if you addressed it to him he could go and make an accusation, so with this you're in a catch-22." (Alan)**

There were hints in some accounts that it may be emotionally harder for staff to maintain a view of the behaviour as a communication:

> **"Even when she has been *all day* up and down the house banging the doors I *try* to see her as an individual, I try to know that when she does that or throws her cup onto the carpet it's because she wanted to tell you something." (Lara)**

There were also indications that staff might find it cognitively easier to construe problems as consisting of behaviour rather than face the dilemmas of a richer and more complex conceptualisation:

> **"Steve's behaviour is more easy to define - like if he's being aggressive, you can define it and work out an action plan. With Cathy there are so many different things, and how much are we actually encroaching on her personality and her choices in life, to try to change that or adapt her behaviour, perhaps we're trying to mould her too much." (Ruth)**

3.1.3.4 How can we Deal with the Unpleasant Feelings Evoked in us by Working with this Client?

A final dilemma for staff concerned how they should respond to unpleasant feelings that were evoked by working with the client. The categories comprising this theme are listed in Table 13.

Table 13: Categories Comprising the Theme "How can we Deal with the Unpleasant Feelings Evoked in us by Working with this Client?", and Number of Participants Represented for each Category

The client evokes unpleasant feelings in the staff	8
Fear can be overcome by getting to know the client	2
We need to protect ourselves with procedures	2
We need to protect ourselves by "shutting off" emotionally	1

Several participants made reference to staff being afraid of clients, although none admitted to being frightened themselves. Andrea reported that Matthew's violent attacks on staff and residents "can be quite daunting", for example. Fear was seen as an unnecessary and unwanted reaction to clients. Charlotte reported how she had been

"bothered" by an incident when Matthew had slapped her in the face unexpectedly, but emphasised how important it was not to be frightened. Other participants seemed to feel more frustrated with clients than afraid of them. Lara, for example, described her annoyance with Jessie's continual banging on tables and calling out. The feelings evoked for some participants were experienced as very powerful and unpleasant, as illustrated by Kerry:

> **"I still get to breaking point sometimes, I have to say 'take her away I can't cope anymore!'." (Kerry)**

Getting to know the client "as a person" was cited as an effective way of overcoming fear of them. Charlotte described how staff from another part of the service where she worked were very frightened of Matthew because they didn't know him:

> **"Matthew's one person here that the staff will say they're frightened of, which is a big problem... He's not frightening when you know him. It's when you know him you start to see the nice side... When you know him very well you know if you're safe to be on your own with him or not." (Charlotte).**

An alternative way of getting rid of unpleasant feelings was to "shut off". Gail reported that it was imperative that she dealt with her anger and frustration in this way:

> **"I get so angry because I feel that we should be doing more for Eric, but on the other hand what can we do?.. I can go home at the end of the day and of course I've got to shut off. I can't go home thinking about Eric because I'd go mad." (Gail)**

Another possible means of overcoming unpleasant feelings may have been to use safety procedures as a form of protection. Alan and Lee suggested that they had attempted to deal with feelings of being at risk of John making sexual advances towards them or allegations against them by introducing guidelines and procedures to ensure their "safety" whilst working with him.

3.2 Research Question 2: How do Service Workers' Formulations of Challenges Change Over Time?

Coding of interview data relating to this research question generated 54 codes. These were sorted into 10 conceptual categories, as shown in Appendix 9. These categories were grouped into five themes relating to the process and outcome of views changing. The most commonly described outcome of changes in views was the theme "I have become more sympathetic", which usually resulted from getting to know the client. The theme "My views have not changed" represented an alternative outcome. When views *did* change and develop this was explained as a result of processes of "Collecting information and input from others", "Working directly with the client", or "The behaviour itself has changed". The two themes pertaining to the outcome of views changing are presented below, followed by the three themes pertaining to process by which views changed.

3.2.1 I have Become more Sympathetic

This theme comprised the four categories shown in Table 14.

Table 14: Categories Comprising the Theme "I have Become more Sympathetic", and Number of Participants Represented for each Category

I have become more sympathetic through getting to know the client	8
At first I thought the client was a pain	4
At first I thought the problem was in the client's nature	4
I have become more sympathetic through changes in societal attitudes	1

Charlotte described how she initially thought Matthew had violence in his nature but had started to have greater sympathy for him as she got to know and understand him better:

> **"When I first met Matthew I didn't actually work with him... It sounded like he really was very violent, and I think now I just perceive him as very muddled...and I actually feel very sorry for him because I think he must really go through it at times. I didn't know him then, but now I know he's a nice lad, he really is. I don't think I really had any concept of him. He was almost like a violent person, or maybe not even a violent person, just violent." (Charlotte)**

Other participants initially reacted to the client or their problem as "a pain" or something that had to be dealt with, but later came to have greater sympathy for the client "as a person". The key to changes such as this was said to be "getting to know" the client:

> **"With the slapping, my first opinions were it was a pain in the neck, not really understanding. Having a lot to do, it was just something else to contend with. But since then I think, because I'm working with Tina more closely I feel a lot more sympathetic as to why she does it... I think I understand why she does it now and don't get quite so frustrated." (Kerry)**

Only once was an increase in sympathy accounted for by other factors, when Laura described how her increased acceptance of Bill's sexual behaviour reflected greater acceptance of homosexuality in society during the past fifteen years.

3.2.2 My Views have Not Changed

This theme comprised eight codes representing six participants. These participants reported that there had been no changes in their view of the problem under discussion since they first encountered it. Some had stayed with explanations based on client "deviance" such as homosexual urges (Alan) and others with explanations based on ordinary characteristics of the client such as insecurity (Agnes) or explanations based on staff responses to the client such as staff misinterpretation of behaviour (Kate).

3.2.3 My View has Developed Through Collecting Information and Input from Others

One process by which views were said to have developed was through discussion and consultation with other people, although outside help was not always seen as useful (Table 15).

Table 15: Categories Comprising the Theme "My View has Developed Through Collecting Information and Input from Others", and Number of Participants Represented for each Category

Outside professionals were helpful	4
Outside Professionals were unhelpful	3
Collecting information	3

Outside professionals were seen as having helped participants to change their views, usually through offering alternative interpretations of the problem or facilitating staff discussion of the problem. Ruth, for example described how her view of the problem with Cathy and Steve's relationship had changed as a result of the input of a Community Nurse:

> **"Originally it was very much Steve's problem. It was very much, 'we've got this problem with Steve,' he was just not accepting Cathy into the home. I think it wasn't probably until we spoke to the Community nurse who was able to take more of an objective view and say 'Well, he's bound to be a bit unsettled but what about Cathy's expectations?'" (Ruth)**

However, other participants expressed reservations about professional input. Gail, for example, reported that professional input did not help because the professionals did not know what it was really like to work with the client:

> **"If Eric's social worker, psychiatrist or psychologist could spend a week with Eric and see what Eric's life was like, what Eric's real life is like, not from what I say, but to see him when he goes into one of these moods and he's beating himself, there's not anything that you can do to console him. Then maybe, just maybe they'd understand what it's like for us, every day." (Gail)**

Collecting information from other sources had also led to changes in participants' views. This often involved participants making contact with the client's parents or day service and finding out more of the client's history and whether problems occurred in other settings. Helen described the process of investigating alternative explanations for Andy's withdrawal from activities as "like being a detective", involving consulting the GP, day centre staff and Andy's parents.

3.2.4 My View has Developed Through Working Directly with the Client

This theme comprised eight codes representing seven participants. All codes referred to experience of working directly with the client as a factor which had changed participants' views of the problem. Some reported that observing the client (and staff working with them) had shed new light on the problem. Sally, for example, changed her view of Brian from seeing his "hitting out" as a result of an "aggressive nature" to seeing it as a result of an unmet need for reassurance:

> **"I just felt that the person hadn't given him the reassurance - the fact that if he was in the bathroom they would wait for him and wouldn't go without him - he wasn't getting the usual responses that his keyworker would give because the keyworker *knew* him better. I suppose it was then that my perception changed as to why he might hit out; because we weren't fulfilling his *need*." (Sally)**

Staff also found their own experiments in responding to the problem had shifted their views. Agnes explained how these types of experiments had led her to develop her idea of being "firm but kind" with Margaret.

3.2.5 My View has Changed Because the Behaviour has Changed

This theme comprised seven codes representing six participants. Not surprisingly, participants reported that when behaviour or problems themselves changed, their view

of them also changed. All participants reporting changes in the problem said it had "improved".

3.3 Research Question 3: In what ways are Home Managers' and Key Support Staffs' Formulations Similar and Different?

3.3.1 Roles and Relationships for the Two Groups

Data referring to the work roles and relationships of the eight Home Managers and eight Support Workers included in this analysis were grouped into 12 categories (see Appendix 10). These categories were in turn collected together as five themes. The number of members of each group contributing to each category is shown in Table 16.

Table 16: Categories Comprising Themes relating to Participants' Roles and Relationships, and the number of Home Managers (HM) and Support Workers (SW) Represented for Each Category.

Theme	Category	HM	SW
Amount of Contact and Involvement with Client	Support Worker has more	3	3
	Home Manager has more	1	0
Key Responsibilities	Hands-on Work with Clients.	5	8
	Management.	8	3
Supervision Relationship	Formal and Informal Supervision	5	6
	Informal Supervision only	2	1
Relationship with Other Participant	Open and Honest	3	1
	Good	3	1
	Stormy	1	0
Relationship with Client	Good Close Relationship based on Current Contact.	2	5
	Good Close Relationship based in Past Contact.	2	0
	Problems in the Relationship.	2	1

The themes that emerged from the analysis of participants' descriptions of their roles and relationships suggested that the Home Manager and Support Worker groups had been selected so that they differed in terms of their roles and relationships. The data

show that the Home Manager group tended to have less contact with the clients than the Support Worker group. Home Managers reported being more involved in management activities such as recruitment and administration than Support Workers, although some in the Support Worker group did have some management responsibility. Each pair of participants from a service had a working relationship whereby one supervised the other. This generally involved informal contact and formal supervision meetings. The relationships were usually characterised as "open and honest" or "good". Support Workers and Home Managers also tended to report good relationships with the identified client. Support Workers made reference to a current high level of contact when describing a good relationship, whereas Home Managers tended to refer to previous intensive involvement with the client as relevant, for example before they were promoted (Wendy).

3.3.2 Formulations of Problems by the Two Groups

The tally of the number of Home Managers' and Support Workers' accounts represented in each theme relating to formulations of challenging problems is shown in Table 17 (eight Home Managers and eight Support Workers were included in the analysis).

Table 17: Number of Participants Represented from the Home Managers (HM) and Support Workers (SW) Groups for each Theme.

Type of Theme	Themes	HM	SW
Staff Descriptions of Challenging Problems	Client behaviour is a problem	6	4
	Client emotions are a problem	3	2
	Client relationships are a problem	1	2
	Staff perceptions are a problem	0	1
Staff Explanations for Challenging Problems	The problem is caused by the client's ordinary and understandable motivations, characteristics and reactions to events	7	6
	The problem is caused by client disability or illness	5	4
	The problem is caused by the client's need to seek attention from staff	4	2
	The problem is caused by the client's hostile motivations or deviant characteristics	2	3
	The problem is caused by inappropriate staff and service responses to the client	2	1
Staff Dilemmas and Difficulties of Understanding and Responding to the Problem	How can we maintain boundaries/ exert control and still be kind and respectful?	7	5
	How can we deal with the unpleasant feelings evoked in us by working with this client?	4	5
	It is hard to understand the problem and maybe we can never fully understand	6	4
	Should we understand the behaviour as a communication or as a behaviour problem?	5	3

This tally showed no clear difference in the way the groups formulated challenging problems. Two participants spontaneously made reference to the interaction of their role and relationships with their views of challenging problems, however (Wendy and Lara). Wendy indicated that Home Managers such as herself can struggle with a sense of responsibility for solving challenging problems. She compared her current role to that when she used to work as a Support Worker in the same service:

> **"As I've got promoted or as I've had additional responsibilities I feel I need to set some kind of example, or maybe show a plan to try and do it *this* way, whereas before it was never my responsibility." (Wendy)**

Home Managers can also face difficult decisions over how to allocate staff who work most effectively with a particular client presenting a challenge to work with that client, whilst being fair to staff so that they have a break from the most challenging situations. This presents a dilemma of how to balance the needs of the clients with the needs of the staff (Wendy).

Support Staff can face very different pressures as a consequence of their role. Some saw themselves as advocates for the individual needs of their clients because of the relationship they have built up with them (Lara, Kerry). However, this can place them in conflict with the needs of the service or their manager:

> **"Sometimes if the clients want to go out we have to say 'No, because you have to clean your room this morning'. It's the manager's decision, and the client will be upset and cry: 'I want to go out', and you are in the middle... But on the other hand you don't want to let the client down because they cannot speak for themselves, you feel that you have to speak for them." (Lara)**

3.4 Results of the Respondent Validation Exercise

Nine of the 18 participants responded to the request for comments on the summary of findings (Appendix 10). Eight returned feedback forms and one wrote a joint letter with her Home Manager, feeding back comments. The comments made by participants are recorded in Appendix 11. Eight respondents referred to the theme summary as broadly reflecting their views, one referred to the summary as "interesting" and two expressed some reservations. Three respondents referred to the theme summary as an accurate account of service workers' views in general, three suggested that such generalisations could never be completely accurate because of the individual differences between staff, and three did not make clear comment on the issue. The only suggested

additions to the analysis were that staff may deal with unpleasant feelings by "avoiding the client" (one participant) and that views may change through staff reading or attending training events (three participants). The only findings not recognised by respondents were the theme "The problem is caused by the client's hostile motivations or deviant characteristics" (one participant) and the suggestion that Home Managers' and Support Workers' different roles influenced their views of problems (letter from one participants, written by or with her Home Manager). The implications of this feedback for the credibility and fittingness of the results are discussed in the Discussion section.

3.5 Towards a Theoretical Account of How Staff Formulate Challenging Problems

This section comprises a theoretical account thought to be the "best fit" explanation of the study findings. The results suggest that staff face dilemmas over how to deal with challenging problems at emotional, cognitive and behavioural levels. At an emotional level they are faced with a need to overcome unpleasant feelings by getting emotionally closer to the client ("getting to know" them) or distancing themselves from the client (either by "shutting off", using safety policies and guidelines or avoiding the client). At a cognitive level they must decide whether to view the behaviour as a valid communication of need or as a learned "behavioural problem". At a behavioural level staff try to respond with kindness and respect and at the same time to be firm with boundaries on behaviour.

Each of these dilemmas may be seen as different aspects of a choice for staff between adopting a position of emotional closeness or empathy with the client and a position of

emotional distance from the client. Individual staff seem to place themselves at different points on this dimension of emotional closeness-distance with clients and thus vary in how they resolve the dilemmas. Each staff person's position on the dimension may also change over time.

Where staff place themselves on the dimension may affect how they describe and explain challenging problems, and specifically the extent to which they see challenging problems as a result of deviant or hostile client factors. Staff who develop an emotional closeness or empathy with a client by "getting to know" them, by seeing behaviour as communication and by balancing firmness with kindness appear more likely to understand challenging problems as resulting from non-deviant characteristics of the client or from the service rather than the client (Charlotte, Kate, Lara, Wendy, Kerry, Agnes, Anna). Staff who retain emotional distance from a client by "shutting off" or instigating safety procedures, seeing behaviour as a learned "behaviour problem" and emphasising the need for firm boundaries without tempering this with the need for kindness appear more likely to explain problems in terms of hostile or deviant client factors (Lee, Alan, Laura, Richard, Gail).

Over time, staff can move towards the "emotional closeness" end of the dimension by getting to know and understand their client, and thus become more sympathetic to them. The process of getting to know and understand a client is primarily accomplished by spending time with them. Information and input from others can perhaps influence the process, however.

Home managers may, by virtue of their role, struggle with a sense of responsibility for solving problems and for balancing the needs of staff and residents. They also report having less contact with clients than other staff. Perhaps this affords them some emotional distance which might be necessary for them to tackle the issues of solving problems and balancing staff and client needs. Support Workers, on the other hand, can find themselves in the position of being emotionally closer to clients than managers are. They are therefore at risk of being caught "in the middle" advocating for their client's needs through negotiation with a manager who may not be so acutely aware of them.

4. DISCUSSION

In this section the results are evaluated with reference to the theoretical and research literature. Methodological issues are then discussed with reference to the literature, the author's experience of conducting the research and participants' feedback. Finally, the implications for further research and clinical practice are discussed.

4.1 Evaluation of Results

The results pertaining to each research question are discussed below and followed by a discussion of the theoretical account that was constructed from the results.

4.1.1 How do Home Managers and Support Staff Formulate (Understand and Account for) Challenges to their Service in Relation to a Particular Resident?

4.1.1.1 Staff Descriptions of Challenging Problems

There are similarities between the descriptions of challenging problems provided by participants in the present study and definitions of "challenging behaviour" in the academic literature. Participants in the present study usually described challenging problems as centred on client behaviour, in line with the emphasis on behaviour in the literature. The identification of staff perceptions of a client as a problem in themselves in the present study accords with the view of challenging behaviour as a construct comprising both behaviour and perception of that behaviour (Emerson, 1995).

Behaviours which participants described as challenging represented a similar range to those defined as challenging in the literature. Felce and Lowe (1993) defined severely challenging behaviour as characterised by "physical aggression, destructiveness, self-injury, temper tantrums, wandering off, anti-social behaviour, and inappropriate sexual

behaviour". The categories of behaviour identified in the present study formed a close match with this list, with only "problems related to the control of eating" (present study) and "wandering off" (Felce and Lowe, 1993) having no clear matches.

Although some aspects of descriptions of challenging problems offered by participants in the present study were similar to those found in the literature, descriptions from the present study had greater breadth than traditional definitions of "challenging behaviour" allow. Emerson et al. (1988) defined challenging behaviour as behaviour likely to threaten physical safety or limit access to community facilities. Participants in the present study who referred to the challenge facing them as a relationship between clients or client emotions were not describing *behaviour* and were not describing situations where physical safety or community access were at risk. Staff were implicitly given permission to describe this broader range of challenges by the careful wording of interview questions which did not assume that client behaviour was the central issue. Participants in the present study did not emphasise the effects of their client's behaviour on access to community life as a challenge facing staff.

4.1.1.2 Staff Explanations of Challenging Problems

The categories of explanations offered by participants in the present study as causes of challenging problems represented a similar range of perceived causes to that reported in other studies. Bromley and Emerson (1995) asked 70 direct care staff in residential services to complete an open question on a questionnaire about the causes of a client's challenging behaviour. Responses were sorted into 11 categories, including "Internal psychological state or mood", "Past environment", "Attention seeking", and "Form of

communication/ control". These categories appeared to represent many of the same responses as obtained in the present study. However, the categorisation of these responses differed, with categories in the present study formed largely according to the degree of deviance or ordinariness alluded to in participants' responses. This discrepancy may highlight the subjectivity of any categorisation scheme, which depends on the perception of the researcher as to what constitute the characteristics of responses which should be used to sort them into categories. Alternatively, it is possible that the present study, by employing interviews rather than questionnaires, allowed the researcher to make a more in depth assessment of participants' responses.

4.1.1.3 Staff Dilemmas and Difficulties in Understanding and Responding

In identifying key dilemmas and difficulties experienced by staff the present study fulfilled the aim of grounded theory studies to identify the key concerns of the participants in relation to the phenomenon under study (Strauss and Corbin, 1990). Each of these key concerns is discussed below.

It is Hard to Understand the Problem and Maybe we can Never Fully Understand

Participants reported that they were engaged in significant struggles to understand and respond effectively to challenging problems. This active effort of staff to produce solutions in challenging circumstances is rarely recognised by conventional research in this area, which has at times has appeared to blame staff for challenging behaviour, reporting that staff behaviour is "often counter-habilitative...contributing to the conditions under which challenging behaviours may develop" (Hastings and Remington, 1994, pp. 423 & 428).

How can we Deal with Unpleasant Feelings Evoked in us by Working with this Client?

The results of the present study suggested that staff experience a number of unpleasant feelings as a result of their work, notably fear and frustration, and that staff have a number of ways of dealing with these feelings, comprising getting to know the client, shutting off, protecting themselves with safety procedures or avoiding the client.

Staff have also reported unpleasant emotional reactions to their work with challenging behaviour in previous studies. Bromley and Emerson (1995) included items in their questionnaire for care staff asking them to indicate what proportion of the staff team usually felt anger, annoyance, despair, disgust, fear and sadness in response to their client's challenging behaviour. All of these reactions were said to occur widely in response to clients' aggression, self-injury and destructiveness.

Hastings and Remington (1995) found that similar emotional reactions were reported by nursing staff responding to their questionnaire and that many staff also reported concern, empathy and a desire to help. The present study went beyond the scope of previous studies by highlighting ways in which staff may try to deal with their emotional reactions. The suggestion in the present study findings that staff can either adopt a strategy of seeking greater emotional closeness or greater distance appears consistent with Hastings and Remington's (1995) findings that staff report empathic reactions as well as unpleasant emotions.

How can we Maintain Boundaries and Exert Control and Still be Kind and Respectful?

The results of the present study suggested that staff face a dilemma of how to balance a need to be "firm" (maintain boundaries on the client's behaviour) whilst at the same time remaining "kind" (respectful and caring) towards them. There was a striking similarity between this theme and a theme identified in the only published grounded theory study of learning disability service staff known to the author. Clegg, Standen and Jones (1996) asked staff to describe their relationships with clients with severe learning disabilities and found that one of the themes raised was a dilemma about the level of *control* to exert in these relationships. This suggests that the dilemma of how to balance "firmness" and "kindness" was not an isolated or anomalous experience of staff participating in the present study.

These two potential responses may correspond to the alternative intervention strategies described as "functional" and "needs-led" approaches by Hastings et al. (1995). "Functional" interventions are said to occur when staff use behavioural principles, responding to a behaviour on the basis of an assessment of its function and how this function can be removed (for example, by responding to "attention-seeking" behaviour by ignoring the behaviour and teaching more appropriate means of seeking social contact). This approach may correspond to staff in the present study's expression of a need to be "firm". "Needs-led" interventions are said to occur when staff respond to a behaviour in a way aimed at meeting the need which the behaviour is thought to express (for example when staff respond to behaviour thought to express a need for attention by providing attention). This approach may correspond to staff in the present study's expression of a need to be "kind".

Hastings et al. (1995) produced evidence that care staff do not follow a strict "functional" approach and that staff may instead adopt a "needs-based" approach. The results of the present study suggest that staff can have leanings towards both approaches, and that some actively seek to accommodate both in their practice.

Should we Understand the Behaviour as a Communication or as a Behaviour Problem?

Staff reported that they could either understand clients' behaviour as a communication of need or as a behaviour problem. Participants reported that viewing the behaviour as communication implied responding to that communication (a needs-led approach), but that this approach could make the behaviour "worse" (as predicted by a functional approach). Some staff clearly favoured one understanding over the other, but some were aware of both possible views and that they had alternative implications for responding.

The finding that staff report a link between their understanding of a behaviour (or other problem) and their response to it is contrary to suggestions arising from previous research that staff responses to challenging behaviour may not be strongly linked to their beliefs about its causes. Hastings et al. (1995) suggested that staff beliefs were consistent with a functional approach, but that staff do not use these beliefs to inform a functional response to behaviour, perhaps because a "needs-based" response seems "more natural" (p.481). The findings of the present study suggest that staff probably *do* act on their beliefs, but that they may be trying to accommodate two sets of beliefs with different implications for responding. There was no support for the suggestion that

"needs-based" responses come more naturally to staff, with participants suggesting that there were emotional and cognitive obstacles to them holding on to a view of client behaviour as communication or "needs-based". The finding that some staff actively endeavour to retain a needs-based perspective may explain the often cited observation that staff do not adopt pure behavioural approaches to intervention.

4.1.2 How do Staff Formulations of Challenging Problems Develop and Change over Time?

Participants in the present study generally reported becoming more sympathetic to clients with challenging behaviour over time, moving from a position of seeing clients' behaviour as a threat or "a pain" to seeing it as understandable. Other participants reported that their views had not changed, but no reference was made to staff becoming less sympathetic to clients over time. The pattern of results suggests that "non-sympathetic" reactions are common initial responses to clients who are seen as presenting challenging problems, and that staff cultivate sympathy towards the client over time by forming a relationship with them.

The Hastings study indicated that experienced staff appear relatively "immune" to unpleasant emotional reactions to challenging behaviour compared to inexperienced staff, suggesting that staff may be employing a coping mechanism to enable them to continue in a stressful situation (Hastings and Remington, 1995). The results of the present study suggest that staff may achieve some sort of "immunity" to "non-sympathetic" emotional reactions by spending time with the client getting to know them. Gathering information from others may facilitate this process, allowing staff to

better understand and empathise with clients' motivations for their behaviour. Shutting off emotionally, introducing safety procedures or avoiding the client may be alternative routes to such immunity, as reported elsewhere in the present study.

Contrary to the findings of the present study and the Hastings study, it has also been found that staff can become *less* sympathetic to clients over time (Fallon, 1983). Fallon reported that staffs' initial feelings of empathy, optimism, curiosity and fear in relation to their clients changed after several months to frustration, anger, detachment and guilt. The tendency of participants in the present study to report only *increases* in sympathy could mean that this is by far the more common change process. Alternatively, it may reflect a reporting bias (with staff more willing to report positive changes in their thinking), or a sampling bias (with staff being more willing to participate in the research if they had successfully resolved their work-related emotional conflicts).

4.1.3 In What Ways are Home Managers' and Key Support Staffs' Formulations Similar and Different?

A crude numerical comparison between the formulations of challenging problems offered by Home Managers and Support Staff suggested that the formulations of challenging problems by the two groups of staff were broadly similar. This reflected a tendency observed during the data collection for Home Managers and Support Workers within the same service to formulate challenging problems in similar ways. The finding is consistent with psychodynamic understandings of organisations which suggest that individual defences can develop to reflect the pattern of defences prevalent throughout an institution (Obholzer, 1994).

The finding was surprising when considered in the light of the other results, however. These suggested that the Home Manager group tended to spend less time with clients than the Support Worker group and that spending time getting to know clients was seen as a significant determinant of staff perceptions of problems. It is possible that differences in formulations may have been present but left undetected during the present study. The failure to find differences may have reflected the crude method of comparison, which did not examine the subtleties of the accounts. Alternatively, the widespread agreement between Home Managers and Support Workers may have reflected the sampling method, whereby Home Managers chose which Support Worker should be interviewed. There may have been a tendency to pick someone who held similar views in the hope that this would present the service in a favourable light. A final possibility is that Support Workers from each service were motivated to report similar formulations to their Home Manager because the author had made contact through the manager and thus may have appeared to be affiliated to them.

Where staff commented directly on the effect of their role in the service on their views there were some indicators of differences between Home Managers and Support Workers. Further investigation will be needed to refine and develop the ideas that were presented.

4.1.4 The Proposed Theoretical Account

The proposed theoretical account is at an early stage of construction and requires further evaluation and development. However, as a proposed theory for further testing it represents a useful addition to a field which has been conspicuously lacking in theory.

It appears to illuminate processes hypothesised by Attribution theory and Social Role Valorisation theory, as outlined below.

Attribution theory was applied in an attempt to understand staff perceptions and reactions to challenging behaviour by Fenwick (1995), who suggested that staff responses to challenging behaviour may be influenced by whether behaviours were attributed to causes internal or external to the client. The theoretical account proposed in the current study suggests that the key dimension predicting staff responses may not be internal or external attributions but "deviant" or "ordinary" attributions. Thus, the explanation that challenging behaviour occurs as a communication or expression of feelings appeared to be cited by staff who favoured balancing firmness with kindness and overcoming unpleasant feelings by getting to know the client. Despite the internal attribution of the problem, staff in these cases did not appear to react with hostile and angry feelings and responses, but rather with empathy and understanding, perhaps because behaviour as an expression of feelings was seen as "ordinary" and understandable.

Social Role Valorisation proposes that the process of "deviancy-making" is a powerful cause of difficulties for people with learning disabilities (Wolfensberger, 1983; Emerson, 1992). Wolfensberger proposed that a societal perception of people with learning disabilities as "deviant" is largely caused by the denial of valued social roles for this group, and that this "deviancy-making" can be reversed by the provision of valued social roles. The theoretical account built from the results of the present study suggests a different emphasis, that "deviancy-making" occurs when people *distance themselves*

emotionally from people with learning disabilities. The value of clients' social roles did not feature in staff accounts as a relevant factor in this process. The theoretical account suggests that the key antidote to "deviancy-making" may be building relationships with people with learning disabilities.

4.2 Evaluation of Method

Methodological issues are discussed in this section. The effect of the sampling and recruitment procedure is evaluated, followed by the possible effect of the author's subjective bias. Finally, the measures taken to ensure the rigour of the research are discussed and their effectiveness evaluated.

4.2.1 Sampling and Recruitment

The sampling and recruitment methods used in the present study were not designed to meet statistical assumptions about generalisability as required by quantitative research, but to access a range of participants to enable the thorough exploration of the research questions (Pope and Mays, 1995). It appeared to be successful in this regard, as participants were able to discuss issues relevant to the research questions in some depth. Nevertheless it is important to speculate about how the sampling and recruitment methods may have influenced the results.

During the present study the only criteria used for sampling were the size, cost, agency and location of services, and the age and gender of clients to be discussed. Although the use of these criteria ensured that a range of services and clients were represented it did not guarantee that a representative range of opinion was accessed.

Furthermore, the sampling and recruitment procedures used may have favoured the recruitment of participants with particular views. As participation was voluntary some Home Managers who were approached about the study declined to participate. Home Managers who agreed to participate may have been more motivated towards understanding and responding to challenging problems than those who declined. Also, the fact that Support Worker participants were picked to take part by the Home Managers may have resulted in an unusual level of agreement between the views presented by the two groups.

The sampling method could have been improved if it had involved more traditional "theoretical sampling", so that participants were selected on the basis that they could illuminate theory being derived from ongoing data analysis (Chenitz and Swanson, 1986). This would have enabled more careful and thorough exploration of hypothesised theoretical ideas in partnership with participants. True theoretical sampling was not possible during the present study. The analytic process was so time-consuming that it would have slowed down the entire research process prohibitively if the partial analysis of data had been a pre-requisite for later sampling decisions.

4.2.2 The Role of the Author's Subjectivity

The author's subjective views and experiences inevitably influenced the way in which the present study was conducted and the results it produced. Qualitative researchers have recognised this influence as an important source of creativity for understanding the connections between data (Strauss and Corbin, 1990). However, qualitative researchers must avoid merely applying their own perspective to data by cultivating

awareness of their own biases and how these may influence the research process and outcome (Rubin and Rubin, 1995). An attempt is made below to identify the main areas of possible bias and their impact, in a first person account by the author:

Production of the theoretical account involved increasing amounts of interpretation rather than description of data as the analysis progressed. My biases undoubtedly must have influenced my interpretations. However, it is very difficult to judge the extent to which I retained a grounding in the data and avoided fitting data to my preconceived understanding. Reading the theoretical account that I produced I find a close concordance between what it proposes and my own experience of challenging work with people with learning disabilities. This close concordance may have resulted from my bias being too powerful. Alternatively it may have occurred because the theory is an accurate reflection not only of the experiences of the participants, but of other workers such as myself.

In order to avoid my bias smothering the data I took care to move repeatedly between theorising and perusing the data. Whenever I made interpretations in order to develop a theme or the theoretical account I endeavoured to check that this interpretation was the "best fit" with the data that I could produce.

I am aware that in several areas of the study my bias may have had a particularly powerful influence. The design of the study was influenced by my biases and experience in at least two ways. Firstly, my bias towards seeing challenging problems as including phenomena other than client behaviour led me to word interview questions carefully to allow discussion of other "challenges". This must have directly influenced the results, broadening their scope. Secondly, my history of undertaking exclusively quantitative research prior to this study led to my decision to compare Home Manager and Support Worker accounts of challenging problems by constructing a tally of themes (a pseudo-quantitative technique) rather than addressing this research question directly during interviews. This methodology may have made it less likely to find differences between the views of participants in the two groups.

My bias and experience was also influential during the analysis of results, particularly during the identification of themes and the construction of the theoretical account. Extra care was taken in the following two areas to ensure that the themes and theory derived comprised a "best fit" with the data. Firstly, I

categorised staff explanations of challenging problems according to the extent to which they cited "deviant" or "ordinary" client factors. I was aware that my knowledge of Social Role Valorisation theory and recent attendance at a training conference on the subject had probably heightened my awareness of issues of perceived deviance and ordinariness contained in participants' accounts, and may have influenced me to categorise explanations of challenging problems according to the extent to which they were cited. Secondly, I emphasised the issue of emotional closeness to or distance from clients as central to the theoretical account. I was aware that my experience in my clinical work of trying to achieve a balance between direct client work and indirect consultancy work may have been motivated by a need to regulate my emotional closeness to clients, and may thus have heightened my awareness of the issue.

4.2.3 Assessment of the Rigour of the Research

The present study incorporated safeguards to maximise the auditability, credibility and fittingness of the research. The extent to which these safeguards were effective is evaluated below.

4.2.3.1 Auditability

The aim of building auditability into a research study is to open up the research process to the scrutiny of others. An adequate level of auditability was achieved in the present study. The research diary recorded the author's key decisions and ideas as they occurred, enabling readers to trace the steps taken during the research process (Appendix 1). In addition, the inclusion of the author's reflexive accounts of his experience of carrying out the research (including the role of his subjective bias on the study) opens up the research to a level of scrutiny that is not possible on the basis of many traditional research reports (Banister, Burman, Parker, Taylor, Tindall, 1994). In order for scrutiny to actually occur, a range of people must have access to reports of

the research. To this end a comprehensive report of the research process and outcome will be sent to participants inviting comment in addition to the respondent validation exercise already completed. Attempts will also be made to publish the research, thus opening it to scrutiny by academic and clinical professionals.

4.2.3.2 Credibility

A study is "credible" to the extent that it presents such faithful representations of experience that participants can recognise these experiences as their own. The feedback from the "respondent validation" exercise during the present study suggested that participants generally recognised the initial findings as reflecting their own interview with the author, although some pointed out aspects that they did not recognise (Appendix 11). One of the participants wrote a joint letter with her manager denying recognition of the idea that staff need to control clients, despite this having been a central feature of her interview. This illustrated the possible incompatibility between private and public beliefs held by staff.

The mixed feedback also raised the question of to what extent participants might be expected to recognise their own accounts in a thematic summary of several different accounts. It was perhaps unrealistic to expect every participant to recognise every aspect of the summary as their own, as individual views differed widely. This was pointed out by participants who responded (see Appendix 11). On the other hand, it has been suggested that participants may be biased towards accepting researchers' accounts as credible because of the likely power imbalance between researcher and participant (Henwood and Pidgeon, 1995). The extent to which the respondent

validation exercise assessed credibility was limited. Only half the participants responded and the proposed theoretical account had not yet been developed at the time of the exercise so its credibility was not assessed.

4.2.3.3 Fittingness

A study is said to have achieved a high level of "fittingness" when its findings "fit" contexts outside the study situation. Fittingness was assessed during the respondent validation exercise by asking participants to report the extent to which the analysis reflected service workers' views "in general". Some participants gave feedback suggesting fittingness, but others pointed out the difficulty of making generalisations because all clients, staff and situations are different (Appendix 11). This served as a reminder that generalisations about staff views should be made cautiously. Unfortunately, the respondent validation exercise produced a limited assessment of the fittingness of the results. The proposed theoretical account had not yet been developed at the time of the exercise and participants were therefore not given the opportunity to give feedback on its fittingness. Furthermore, participants' assessments of fittingness may have been clouded by their assessments of how well the findings accorded with *their own* experience. Fittingness could be assessed more thoroughly by conducting further interviews with new participants.

4.3 Implications for Future Research

The present study raised a number of new questions to be addressed by future research, thus suggesting that the study had value in terms of its "generativity" (Henwood and

Pidgeon, 1995). These questions included further questions for exploratory study and some specific hypotheses suitable for testing in larger scale quantitative studies.

The most pressing requirement for future research is for further testing and development of the proposed theoretical account. This should involve the theoretically driven sampling of service workers who are likely to illuminate the issues raised in the account. Services that run emotional support services for staff may be able to provide participants with particular awareness of the emotional issues for staff working with challenging problems, for example. Participants should also be sought who could provide data which do not fit the existing theoretical account. These could be sought by asking staff teams to comment on the theoretical account and selecting the most vehement critics for interview.

Further qualitative investigation of the effect of role in the staff team (for example, as a Home Manager or Support Worker) on formulations of challenging problems would also be useful. The methods used in the present study gave rise only to preliminary ideas concerning this effect. Future research should involve in depth questioning of staff about the effect of their role on their view of problems. Another way of investigating how different team members formulate problems would be through larger scale quantitative study, perhaps involving entire teams completing questionnaires pertaining to the "dilemmas of understanding and responding" identified by the present study. It would be interesting to develop a typology of team functioning in relation to the dilemmas. Perhaps all staff in some teams try to accommodate both sides of the dilemmas, whereas other teams split into staff who resolve them one way (for example,

through opting for functional approaches) and others who resolve them another way (for example, through opting for needs-based approaches).

The theoretical account which was constructed gave rise to a number of hypotheses which could be tested on a larger sample using quantitative methods, thus exploring the generalisability of the account. These hypotheses are listed below:

a) Staff who favour functional over needs-based responses to challenging problems are more likely to explain the problems in terms of client deviance;
b) Staff who favour emotional distance from clients over emotional closeness to clients presenting challenges are more likely to explain the problems in terms of client deviance;
c) Where staff views change over time they tend to become more sympathetic to clients.

Each of these hypotheses could be investigated through a questionnaire or structured interview study to elicit information about the relationships between the relevant variables from a representative sample of service workers. Investigation of the final hypothesis would necessitate longitudinal study.

4.4 Implications for Clinical Practice

The results of the present study emphasise that people working in residential learning disability services have many different perspectives on challenging problems. Participants referred to a broader range of problems as "challenging" than client behaviour, and cited many different causes of these problems. This suggests that professionals such as Clinical Psychologists should adopt a flexible approach to

intervention, being prepared to listen to the multiple perspectives offered by staff and not assume one "right" understanding or approach. In naming and promoting their services, Psychologists should not restrict their input to dealing with "challenging behaviour".

The theoretical account proposed that staff face a number of dilemmas in their work. In order to maximise the quality of life of clients, services and external consultants such as Clinical Psychologists should therefore support staff to resolve the dilemmas in ways which best serve client needs. Behavioural interventions have typically required staff to resolve their dilemmas in a particular way, for example to see behaviour as a behaviour problem rather than as a communication and to respond by policing firm boundaries. The theoretical account proposed that how staff resolve dilemmas in their work depends on the closeness of their emotional relationship and empathy with clients. These emotional issues are likely to obstruct attempts to simply "persuade" staff to resolve dilemmas and respond in a particular way. This may explain the failure of carefully planned interventions imposed in services without adequate consultation.

Staff may need to examine their motivations for adopting particular views or responses, so that client need rather than staff need is prioritised in deciding how staff dilemmas are resolved. This could be facilitated by services recruiting staff on the basis of their openness to examine their own psychological processes and by providing opportunities for personal development for staff. Specifically, this could involve providing a safe forum for staff to explore emotional issues related to their work. Clinical Psychologists,

when external to services, may be ideally placed to facilitate events or ongoing programmes of this nature.

The results of the present study revealed much similarity in the formulations of challenging problems reported by staff with different roles in the same service. If staff are to be facilitated to find creative solutions to challenging problems it may be important to stimulate greater debate and diversity of views than was apparent from these results.

Managers and professionals were sometimes criticised during the present study for not understanding clients because of their lack of contact with them. Both managers of services and professionals such as Clinical Psychologists should take heed. They may need to spend time building relationships with clients if they are to design effective interventions to address problems and if they are to gain the respect of the service workers who would be required to participate in their implementation.

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Appendix 1

Research Diary

Research Diary

19 February

The last week has been a major struggle. I was all set up and ready to pilot an entirely different project, but as the time approached to explain the project to the first participant I became aware that the project had been through so many pragmatic changes, that I could no longer describe what my research aimed to achieve.

I became frustrated with the constraints of the quantitative methodology - and was aware of the limitations of a small cross sectional quantitative project which hoped to illuminate how service organisations varied dependent upon whether they were run in the public, private or voluntary sector. I started introducing swathes of qualitative methodology in an attempt to make the project more meaningful. But in the process I lost sight of any theoretical underpinnings which the project may once have had.

I think the problem was largely caused by having to set up the project before I was immersed in the context of learning disability services. I did not know what my intellectual puzzle was. Now, four months into my elective learning disabilities placement I have come up against my intellectual puzzle: How do people who work in services understand "challenging behaviour". The whole of the service where I am on placement is set up to respond to referrals in relation to concern in services about "challenging behaviour" of service users.

There is a powerful discourse on placement that referrers locate service problems in the behaviour of service users, and that the role of the community team consultants is to shift this understanding. But do referrers really locate the problems in this way, or do they have a richer understanding of the problem when a service is challenged by the conduct of a service user? It seems that clinical work often involves shifting perceptions without getting much feedback from staff, so we never really know what they are thinking.

Perhaps this new project can answer this question. It also is a chance to think about "what is a systemic way of working?" which I've been thinking about a lot recently, as everyone says they are doing this in the community team, but there seems to be some difficulty defining it!

At last I feel some enthusiasm for my project. It feels a relief to have changed over. Now I just have to worry about getting ethical approval from Salamons, and I'll be ready to go. For the first time too, the project actually seems do-able in the time available (fingers crossed).

6 March

Time has flown since the last entry - I have a tight schedule now to complete the research in time for the deadline. Today I heard that the project has received ethical approval. I therefore went ahead with contacting the first potential participant services. All expressed some interest, although one Home Manager insisted that nobody in her service "has challenging behaviour". I will meet her to see whether she can think of someone who "presents a challenge to the service". In terms of theoretical sampling it may be advantageous to include a service which primarily faces challenges from residents other than aggression (the often assumed meaning of challenging behaviour).

I'm still feeling very positive about my dramatic switch to this project. It allows some integration of the thinking I'm doing on the family therapy part of my elective placement and the thinking I am doing in relation to the organisational work in the learning disabilities service.

17 March

Two visits today to different services whose managers have expressed some interest in participating. Some problems for both in contemplating participating. At one the manager said that it would be very hard to think of one resident who presents more challenge than others, and the staff team had not been keen when she mentioned the project. At the other the manager was keen but felt that the keyworker would not be. It seems like a lot of effort can be wasted in visiting services just to discuss the project. Given my time scale, I must restrict negotiating entry to services to phone calls, and save visits for interviews only.

I'm feeling quite anxious about getting the data in time, and thinking I will only be able to do minimal "theoretical sampling" which would require sequential planning of interviews. It takes so long to get something set up in some services that I'm forced to start negotiations with several services simultaneously.

18 March

Did my first interview today.

26 March

I have just completed my first pair of interviews. It have felt a little uncomfortable maintaining a non-leading position, just listening and summarising, without influencing the direction of the interview. The first one I think I led the direction too much, and the Home Manager said in feedback that she felt a little constrained to talk about "behaviour", although her own view came across in the end. I think I was better during the second interview (with the Support Worker), developed a slightly better introductory spiel, stressing how I wanted her to lead as far as possible, summarising the topics I wanted us to cover, and saying that I had a list of points I wanted to cover at

some point in the interview. At feedback she said she felt she was able to say everything she wanted to and did not feel led. She was very enthusiastic about having been asked her opinion and really took up the point that most research on CB has not asked the views of those closest to it.

16 April

I've done one interview yesterday and another three today, bringing my total to six. One participant did not want to be tape recorded but I found I was able to record what he said quite well. He said he could not even speak on answerphones.

Today for the first time I did a pair of interviews at the same service consecutively. This presented the difficulty that I already had one perspective on the problem in mind quite clearly when I came to do the second interview. At one point I felt myself quite clearly angling a question after a particular response during the second interview, as I knew a particular event had been significant which the second participant was not mentioning. However, as far as possible I avoided this trap.

I have found someone who will transcribe the interview recordings for me and have written out instructions for them. I am very pleased with this outcome, as it should save me hours of laborious transcribing. It is laborious enough typing up my prolific notes from my unrecorded interview today!

27 April

Following another week of interviewing I have now completed 14 interviews and am taking stock of how I should choose further interviews to do on the basis of theoretical sampling. Although I have not yet started the formal analysis, some things appear to be clear. Firstly, six out of seven residents discussed are men. Secondly, five of the seven problems discussed involve sexuality issues. I will try to recruit services for the remaining interviews who can discuss challenges posed by a female client. I am less inclined to exclude problems where sexuality is an issue, as it will not be clear whether this is an issue in each case until interviews are complete, and as it may be an important finding in itself.

Interviews have been going well. Some of the material about sexual abuse is extremely disturbing, however.

On a practical note, I am still finding it difficult to conduct two interviews consecutively in the same service, as I inevitably form a view of the problem during the first interview, and this can influence my questions during the second interview. This has been far less of an issue when I have conducted interviews in the same service some days apart. Life has been hectic enough that in these circumstances I often remember surprisingly few details from one interview to the next. When I have done consecutive interviews (in four out of seven cases so far) I have probably been influenced to pursue information in the second interview that has come to light in the first (thus

homogenising the two interviews) but also to pursue differences of opinion (thus differentiating the two interviews). It is hard to say whether one process may have been dominant over the other.

3 May

The final four interviews are now set up and data collection should be complete within the next seven days. I have not really used "theoretical sampling" to choose interviews to set up, because I have not yet developed theory to test by sampling particular constituencies. However, I have taken care that men and women with learning disabilities are talked about, that male and female staff are involved, that a range of sizes and types of residential homes are sampled, and that a range of problems are discussed. In fact I have had little control over this process and have tended to leave it up to participating managers which resident is discussed.

My overall impressions at this stage are that participants are rarely putting themselves "in the shoes" of their clients, and are often giving little acknowledgement to the internal world and emotional life of the clients. Where the internal world is recognised it appears to be by keyworkers who see themselves as advocates for the client in a somewhat hostile service which sees the problem in a different way.

Many of the problems talked about have involved sexuality issues, especially same sex relationships. Services appear to either try to ignore sexual needs and/or invoke risk-limiting procedures to protect staff.

My thoughts are now turning to the analysis. It appears to make sense to summarise how each participant is making sense of the discussed problem, and only then attempt to summarise how *I* make sense of how *they* have made sense of things.

In supervision Jan highlighted how my position as "psychologist" is likely to have profoundly affected the accounts that people offered me. They may have emphasised their behavioural interpretations, for example, expecting that this was what I was looking for.

19 May

It is now over a week since I completed the last of the interviews (10 May), with a final flourish of three on one Saturday afternoon. The interviews have been exhausting, not least because of the painfulness of the stories which have been told during them. I find it hard to summarise any overall impressions which I am left with having completed twenty interviews. I am still left feeling that the level of awareness of the internal psychological world of people with learning disabilities by their staff is very limited. However, I have found interviewees to be compassionate, caring, and very engaged in trying to support their clients. Perhaps what has been missing for many has been clarity of thinking about the psychological processes of clients. I am aware, however, that I came to this study with this very same world-view, since the

days when I worked in a large mental handicap hospital and heard staff laugh at the proposition that it was worth talking to the patients. I must beware that I don't colour the analysis with this prejudice.

In thinking about writing a method section I have been reflecting on my own motivations for producing this study. It was born, somewhat painfully, at a time when I was in a desperate struggle on placement trying to understand the "systemic approach" which was much talked about in the team, but somehow an elusive concept to grasp...i.e. what exactly is "the systemic approach"? I was also struggling with the design of a quantitative dissertation project, frustrated by my apparent inability to construct something meaningful.

On another level I was struggling with a dilemma over how close I wanted to be to people in distress. This is a dilemma that has been a theme in my working life, with moves from direct client work to pure research and back again. It had again popped up as a dilemma at this point in my clinical training. Having become tired of and sceptical about therapy during the first two years of training I chose a final year placement in a service which prided itself on its anti-therapeutic stance. I was keen to work organisationally, indirectly, to influence services for the benefit of clients. But at some level I now realise I also wanted to escape from the difficulties of client contact. Having done this, however, on this placement as in my previous research post, I found myself unsatisfied and floundering, hankering after some client contact. It is perhaps this personal dilemma which prompted me to investigate whether support workers (high client contact assumed) and managers (lower client contact assumed) have different perspectives on client-related problems.

My own struggle to understand challenging behaviour having spent most of my training engaged in an individualistic, internalised psychology, and then coming to a placement where problems were seen as external and environmental (and the internal world largely ignored) may well have prompted me to investigate how others understood these issues.

2 June

I have just completed analysis of the first pair of interviews. I feel good that I have been reasonably clear in my thinking about exactly what steps I am going through to complete the analysis of each interview. However, I am far less clear about how the pair of interviews can be compared, and commonalities and differences detected. This seems a far more interpretative task than the descriptive process of summarising each transcript.

The other news is that the tape recorder I have been using to record interviews has been faulty, so two interviews have been lost, meaning in effect that two dyads are unusable. I am faced with the choice of excluding this data, or re-interviewing two participants, an option I hardly relish given the time available.

29 June

Developing themes to encompass the explanations of challenging problems has been tricky, as I could not see obvious conceptual groupings. As I struggled with the data reading and rereading it I grappled with the idea that these explanations were based to greater and lesser extents on participants being able to empathise with the client or see their behaviour as understandable. Few actually made reference to this, however. Some explanations seemed to see the client as deviant in some way. I am left wondering the extent to which my knowledge of SRV has influenced my identification of these themes based on "deviance".

4 July

The analysis is finally complete and the walls of the study are papered with wallpaper covered in assembled clippings from interviews. The analysis process has been incredibly time consuming, taking over two weeks of full time work. However, I am pleased with the results, having been able to identify themes in the data which look interesting. Now all I have to do is finish the write-up!

Appendix 2

Letter Granting Ethical Approval

Salomons Centre
David Salomons Estate, Broomhill Road
Southborough, TUNBRIDGE WELLS
Kent TN3 0TG

Telephone: 01892 515152
Fax: 01892 539102

Our Ref: AL/LT/075
Direct Fax: 01892 507660
E-mail: t.lavender@salomons.org.uk

SALOMONS CENTRE

Mr A Whittington
Trainee Clinical Psychologist
Salomons Centre

6th March 1997

Dear Adrian,

Re: The Meaning of "Challenging Behaviour" for Support Staff and Home Managers of Residential learning Disability Services

The Ethics Panel is pleased to provide full ethical approval for your research project. The Panel would, however, like to draw your attention to:

(i) It was assumed that the written summary of the theoretical account referred to on page 4 was the same as the summary of findings you referred to in the Project Information Sheet. If this was not the case could you clarify for the Panel

(ii) It seemed that you would actually require three information sheets, one for each of the three groups of people involved in the research, that is, service managers, home managers and support workers. Each sheet would need to be worded slightly differently.

(iii) You say that the tapes will be destroyed (page 5) but not what will happen to the transcripts. The Panel would be grateful if you could clarify this point.

Apart from these points the Panel were impressed with the thoroughness of the proposal and the way in which the ethical issues had been considered and taken into account.

We wish you well with the project and would be extremely interested to see the results.

Yours sincerely,

Dr Tony Lavender
Chair of Ethics Panel

Appendix 3

Information Sheet for Participants

RESEARCH PROJECT INFORMATION SHEET
Please keep this sheet for future reference

The Meaning of "Challenging Behaviour" for Support Staff and Home Managers of Residential Learning Disability Services.

Aims of the Project

There is often concern in residential services about the behaviour of particular residents and the challenge that this presents for their service. This phenomenon has been called "challenging behaviour".

Definitions of "challenging behaviour" and theories to explain it have tended to be produced by academics and researchers, and have not been closely based on the experience of people who work with the problem on a daily basis. This is perhaps one reason why interventions to respond to the problem by outside consultants such as Clinical Psychologists are not always effective.

This project aims to investigate in detail how Support Staff and Home Managers understand how a particular resident presents a challenge to their service. It is hoped that ten services will participate. The findings are likely to enable Clinical Psychologists to plan more effective ways of helping services to help residents.

What will the Project Involve?

If your service agrees to participate I will ask the Home Manager to think of the resident who currently "presents the greatest challenge to the service". The Home Manager and the Support Staff person who works most closely with this resident will be interviewed. Interviews will be relatively unstructured, and will consist of discussion leading from the following questions:

- What is your role in this service and what is your work background?
- How do you understand the problem with the identified resident?
- What factors do you think have caused the problem, and what keeps it going?
- How has your view of the problem changed over time?

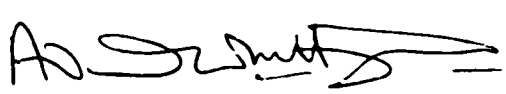
Interviews will last approximately one hour each and will be tape recorded. Each participant will be sent a summary of the findings of the study at a later date and asked to answer a brief questionnaire about the findings. Following this a final report of the findings will be produced and sent to each participant and Service Manager involved with the project.

Confidentiality

Information given by participants will be treated as strictly confidential. Audio taped records will be erased as soon as the interviews have been transcribed. All names and identifiable details of participants, their services and residents will be disguised in *all* written records of the research and discussion about the research. Interview transcripts will be stored securely and destroyed within three years.

Withdrawal from the Project

You are free to withdraw your service from the project at any time without giving a reason. If you wish to withdraw, or have any questions or concerns about the project, please telephone me at the



Adrian Whittington
Psychologist in Clinical Training

Appendix 4

Consent Form

RESEARCH PROJECT
CONSENT FORM

The Meaning of "Challenging Behaviour" for Support Staff and Home Managers of Residential Learning Disability Services

I have read the information sheet concerning this project and understand the aims and nature of the research. I understand that my answers at interview and on a questionnaire will not be traceable to me or the service I work in when results are stored and written up.

I consent to participating in the research project as outlined on the information sheet.

Signature.....

Name in Block Capitals.....

Work Address.....

.....

.....

THESE DETAILS WILL NOT BE ATTACHED TO YOUR INTERVIEW RESPONSES

Appendix 5

Interview Guide

INTERVIEW GUIDE

Role Information

What is your role in this service?

Job title/ responsibilities/ what do you do each day?

Can you describe your work background?

What other jobs have you done?

What is your role in relation to the other interviewee from this service (i.e. Home Manager or key support staff person)?

What do you do that they don't?/ Supervision/ Power/ Responsibility/ describe the relationship

We are going to be talking about X. What is your role in relation to X?

What do you do with them?/ describe the relationship

Formulation of Challenges to the Service in Relation to Identified Resident (X).

You/your manager have/has identified that there is a problem between X and other people involved with this service. How do you understand that problem?

Describe the problem in detail/ Describe any of the people involved

What factors do you think have caused the problem?

Why this problem?/ Why these people involved?/ why now?

What factors do you think maintain the problem?

What keeps it going?/ What would happen if it went away?

Development and Change in Formulations over Time

How did you understand the problem when you first encountered it?

How did you first come across the problem?/ What did you think about the problem then? Causes/ What kept it going?/ Plot time line from then until now/

How did your view change (if at all) since then?

Mark points on time line/ significant changes/ regular intervals

What caused each significant change in your view?

Outsiders/ knowledge/ events/ supervision/ training

Looking back over the interview:

Would you like to make any comments on the process of our discussion?
Which questions were most meaningful to you, which were least meaningful?
How could the interview have been changed to make it more meaningful to you?
Are there important questions which I did not include?

Appendix 6

Summary of Initial Findings Sent to Participants

The Meaning of 'Challenging Behaviour' for Support Staff and Home Managers of Residential Learning Disability Services

30 June 1997

SUMMARY OF INITIAL FINDINGS

I have now completed analysis of eighteen discussions with Support Staff and Home Managers. Each discussion concerned a particular resident who was seen as presenting a challenge of some sort to the service. By combining information from different participants using a method known as "Grounded Theory" I have identified a number of themes in participants accounts.

Inevitably this process of identifying themes is subjective and relies on my own understanding and interpretation of what people have said. It would therefore be helpful if you can comment on these themes, to clarify ideas which I have perhaps interpreted incompletely or incorrectly.

Please read through the themes outlined below and comment in as much detail as you can. It would be helpful if could you consider:

- Do the themes apply to your understanding of the client we discussed?
- Do the themes apply more generally to how people in services understand challenges presented by residents?

I have used the term "challenging problems" to refer to challenges presented to services by residents. The term "staff" is used to refer to support staff and staff with management responsibility for the home.

Adrian Whittington
Psychologist in Clinical Training

1. Staff Descriptions of Challenging Problems

Staff describe the main challenge presented to the service by a resident using one or more of the following ideas:

a) **Client Behaviour is a Problem** (e.g. sexual behaviour, violence, withdrawal, eating, self-injury, destruction of property, obsessional behaviour, theft)

b) **Client Emotions are a Problem** (e.g. anxiety, depression)

c) **Client Relationships are a Problem** (e.g. relationship between residents)

d) **Staff and Service Responses to the Client are a Problem** (e.g. staff don't understand client's communication or needs, service not flexible enough to respond to individual needs, staff mistakenly label client's behaviour as challenging)

2. Staff Explanations for Challenging Problems

Staff explain the causes of challenges presented to the service by a resident using one or more of the following ideas:

a) **The problem is caused by the client's hostile motivations or deviant characteristics** (e.g. behaviour is vindictive, client has deviant sexual urges, client has deviant personality traits, behaviour is copied from another client).

b) **The problem is caused by the client's understandable and ordinary motivations, characteristics and reactions to events** (e.g. the behaviour is a communication or expression of feelings, a result of the client's personal history, a way of making choices, a result of normal personality traits, or a non-malicious loss of control).

c) **The problem is caused by the client's illness or disability** (e.g. cognitive impairment, autism, physical illness or mental illness).

d) **The problem is caused by staff being too egocentric, managers not having enough direct contact with clients, or inadequate service funding**

3. Staff Difficulties and Dilemmas of Understanding and Responding to the Problem

Staff face the following difficulties and dilemmas in understanding challenges and responding to them:

It is hard to understand the problem and maybe we can never fully understand.
Staff are engaged in considerable struggles to work out the causes and suitable responses to challenges.

Should we understand the behaviour as a communication or as a behaviour problem?
Staff are faced with a dilemma of how to *understand* challenging behaviour, with two possible views seen as conflicting:

a) Seeing the behaviour as "behavioural", implying that staff should take care not to reward or reinforce the behaviour.
b) Seeing the behaviour as a valid communication or expression of feeling or choice-making and therefore interpreting and responding to the behaviour's message.

How can we maintain boundaries and exert control and still be kind and respectful?
Staff are also faced with a dilemma of how to *respond* to challenging behaviour, with two possible responses seen as potentially conflicting:

a) Responding firmly to the behaviour (policing clear boundaries on what is and is not acceptable)
b) Responding with kindness and understanding, perhaps giving the client something that they seem to be asking for through the behaviour (e.g. attention).

How can we deal with the unpleasant feelings evoked in us by working with this client?
Staff can experience a variety of unpleasant feelings as a result of their work with clients, including fear and frustration. There are several ways of dealing with these feelings. These ways of dealing with feelings appear to conflict with one another:

a) Staff can overcome fear by getting to know the client.
b) Staff can protect themselves from their unpleasant feelings by "shutting off".
c) Staff can make themselves feel safer by following safety procedures.

4. Changes and Developments in Staffs' Views of Problems over Time

Staff's views of challenging problems may or may not change and develop over time.

Staff become more sympathetic to the client over time by getting to know them
Where change does occur, staff often become increasingly sympathetic to the client. Staff can initially see the problem as "a pain", but through getting to know the client they come to understand them better and feel more sympathetic towards them

Staff views develop through collecting information and input from others
Collecting information from outside the service (e.g. from parents or a day service) can lead staff to change their views of a problem. This process of ruling out possible explanations for a problem by collecting information can be "like being a detective". Outside professionals such as community nurses, psychiatrists and psychologists can offer a new perspective on a problem which leads to staff views changing. These professionals are not helpful when they don't understand what the client is really like, however.

Staff views develop through information gained by working directly with a client
Working directly with clients gives staff valuable information which sheds new light on problems. The information can be obtained by observing the client and by experimenting with different responses to the challenge that they present.

Staff views change when the client's behaviour "improves"
Staffs' views of a problem change when the client's behaviour improves. For some staff this is the only way that their views change.

5. Similarities and Differences between Support Staffs' and Home Managers' Accounts of Challenges

Of the eighteen people I had discussions with for the research, ten were staff whose job primarily involved direct client work (referred to here as Support Staff) and eight were staff whose job primarily involved management responsibility for the service (referred to here as Home Managers).

The initial analysis has not revealed any systematic differences in the accounts which Support Staff produced compared to Home Managers. However, the following ideas were hinted at:

a) Home Managers struggle with a sense of responsibility for solving challenging problems
b) Home Managers struggle to allocate staff effectively so that staff who can cope with particular clients work with those clients, but not to the extent of getting burnt out.
c) Support Staff act as advocates for client's individual needs, and as a result can find themselves in conflict with the needs of the service and its managers.

Appendix 7

Participant Feedback Form

FEEDBACK FORM

Please return this form in the stamped addressed envelope.
It should be posted no later than Thursday 10 July.

1. To what extent do the themes in the Summary of Initial Findings reflect your views of the problem which we discussed? How could the themes be improved?

2. To what extent do the themes in the Summary reflect how service workers understand challenges presented by residents *in general*? How could the themes be improved?

3. Please add any other comments you would like to make on the content of the Summary or your experience of taking part in the research project.

Continue on the other side if you need to....

Appendix 8

Categories and Codes Relating to Research Question 1

CODES ALLOCATED TO CATEGORIES AND THEMES: RESEARCH QUESTION 1

Themes in bold
Categories underlined
Interview Number in Margin

1. Staff Descriptions of Challenging Problems

Client Behaviour is a Problem

"Inappropriate" Sexual Behaviour

3 He has expressed sexuality inappropriately
4 He used to be sexually aggressive towards staff
5 John wants a homosexual relationship with staff
6 John makes sexual advances to me and other male staff
6 John makes accusations that residents and staff have made sexual advances to him
9 Bill accosts men for sexual contact in public toilets
9 Bill raped two other residents
10 Bill has a sexual problem which involves chatting up men in public toilets

Violence to People

1 He hits and pushes people
11 He is verbally abusive and physically violent towards staff
12 He is aggressive and bites people
12 His aggression builds up and escalates slowly
14 He is violent and self-abusive

Withdrawal

3 He has withdrawn from his usual activities and routines and is resistant to going out at all
4 He is withdrawing from all activity
11 Matthew's behaviour and illness is cyclic and changeable, from withdrawn to manic and sociable

Problems Related to Control of Eating

1 He does not control his own food and drink intake
11 He demands food obsessively and gets wound up by this
17 Tina does not want to eat and is distressed at meal times

Self-injury

14 He is violent and self-abusive
17 She abuses herself physically in a number of ways

Destruction of Property

5 He throws things purely for attention
14 Eric is a sweet little boy one minute and a horror the next, destroying everything in sight

Obsessional Behaviour

17 She is obsessed with certain objects and always needs these with her or she gets upset

Theft

9 Bill stole a fur coat on holiday

Client Emotions are a Problem

Anxiety and Panic

3 He gets really anxious when he goes out

11 He has had panic attacks since childhood

12 He is scared of things and has panic attacks

Depression

9 Bill has got no humour and his mood and attitude change quickly

10 He gets depressed and moans a lot

Client Relationships are a Problem

7 Cathy has been disappointed by her long term relationship with Steve since she moved in here - possibly she had unrealistic expectations

7 Both Cathy and Steve aren't making enough compromises to adapt to each other in their relationship

8 Cathy gets hurt because she expects attention from Steve (her partner) all the time but he doesn't give this - she needs to get used to this

8 Cathy gets down about her relationship and then misses her parents

20 She is oversensitive and has turbulent relationships

Staff Perceptions are a Problem

Staff mistakenly label client's behaviour as challenging

2 Staff mistakenly label the client's outgoing, exuberant personality as challenging

2. Staff Explanations for Challenging Problems

The problem is caused by the client's understandable and ordinary motivations, characteristics and reactions to events

Problem is caused by client's personal history or life events

1 Client has experienced a lot of instability - needs reassurance that things will happen when we say they will

2 The client was afraid of a staff member for a very long time

2 Brian experienced significant loss associated with his father's death

2 Client experienced rejection as a result of hospitalisation from age sixteen

3 He may have become withdrawn because he has lost trust in people following sexual incidents at the day service or how these were handled

4 He has experienced a lot of loss and change
4 He has got no friends, just staff
4 There was concern over an incident at the day service which they wouldn't give details of
7 Maybe Cathy hasn't had time to adjust to living here yet
8 Cathy has not settled in here
8 It has been hard for Cathy to leave home and she misses her parents
12 I think his behaviour problems started in childhood
14 He's been through a lot of change and difficulties
14 He was sexually abused which accounts for some of it
19 There are underlying insecurities related to her family of origin
20 Maybe past events have made her insecure

Behaviour as communication/ expression of feelings

1 Client is expressing feelings by hitting people
2 Client's behaviour is a means of expression or communication
4 Andy shows us how he's feeling through his behaviour
5 Andy trashed things when he's worried in the night
11 He gets very wound up about his family and has attacked them - he's desperate to see them but gets too excited by it
12 I think the build up of aggressive behaviour is related to his anxiety about things
12 Excitement about Christmas triggers his behaviour
16 His behaviour is a means of communication
17 She abuses us because she is distressed and wants to show us this
18 She slaps herself to express her feelings

Behaviour as choice-making

1 Client is expressing choice
1 Client is becoming more happy and confident
1 Brian's needs have changed
3 He may be showing us he has decided he wants to change his activities, doesn't want to go to the day service any more
4 He may have decided to change his activity schedule
7 Maybe this home isn't right for Cathy
7 Cathy isn't happy here and says she wants to go back to living at her parents
16 She throws tea or bangs doors etc. when she doesn't want to do something

Behaviour as expression of normal personality traits

1 Brian has risen to position of most dominant character in the home
2 Staff mistakenly label the client's outgoing, exuberant personality as challenging
18 Perhaps she's just expressing who she is - her personal preferences and opinions

Behaviour as non-malicious loss of control

11 He is a nice man who loses control of his behaviour (and bowels) from time to time
12 He is aggressive when he loses control, it's not malicious

The problem is caused by client disability or illness

Cognitive Impairment

1 Brian gets up to go out in the night because he does not understand time
2 Brian has no concept of time
11 He gets angry when he feels incompetent
12 He has a short term memory problem and makes things up to fill the gaps when he can't remember something
19 Her cognitive impairments limit her communication and make this irritating

Autism

3 He has autism
11 Matthew gets wound up because he's frightened by his feelings because he has autism
17 She has a cluster of obsessions and social problems associated with autism, which I see as having a physical cause
18 Perhaps she sticks to routines because of autism

Mental Illness

4 At one stage we thought it was a mood-related illness
11 Matthew has a manic illness (which I know little about) relate to his learning disability
16 She had/has a mental illness, perhaps transmitted in her genes
19 She has suffered from Bulimia

Physical Illness

3 He may be physically ill with a thyroid problem
4 He looked physically ill at first
18 She is underweight because she isn't interested in food - maybe related to GI problems
18 She slaps herself to alleviate physical pain (through the release of adrenaline)

The Problem is Caused by the Client's Need to Seek Attention from Staff

5 He throws things purely for attention
5 Maybe he makes allegations to get attention
11 Sometimes he teases and seeks attention, but it's a fine line between this and threatening
14 Maybe he gets like he does to get attention
17 Tina's behaviour ensures she gets attention from us. Perhaps because this is a large busy unit she doesn't get enough attention when she's quiet
18 Some of the slapping may be learned behaviour to get one-to-one attention
19 She'll do anything for attention
20 She wants desperately to be liked but ends up alienating herself by trying too hard

The problem is caused by the client's hostile motivations or deviant characteristics

Behaviour is vindictive/ an attack

4 It's like a punishment to get back at someone

5 Making allegations could be retaliation for me (and others) rejecting his advances

5 Maybe he makes allegations to get back at people when they've asked him to do things he doesn't like

6 He might make allegations when he's dwelling on someone having been stern with him

6 I assume John made the allegations because he was refused physical contact from the staff person

6 He might make accusations because he is bitter that when he moved here some sexual relationships ended

14 He is horrible

Sexual urges seen as deviant

6 John is looking for ways to get sexual relief with the men who work here

9 He accosts men in an attempt to satisfy his sexual urges

10 He is gay and chats up men in the toilets because he is sexually frustrated

Personality traits seen as deviant

9 He was born like this because of his genes - he can not be changed so the problem will never go away, it's part of who he is

10 I don't know why he gets depressed, it's just *him*.

10 He's gay and you can't change it - it's just the way he is

Behaviour is copied from another client

4 He may be copying someone else's behaviour - copying another tenant's occasional refusal to go to the day service

5 Some of his aggressive behaviour is copied from another client

The problem is caused by inappropriate staff and service responses to the client

Staff do not understand client's communication

1 Lack of staff understanding of client communication

2 Staff don't always learn to understand client's behavioural communication

2 Staff don't always pick up on body language or deal on gut reactions

16 It is important to watch for her communication before it becomes challenging behaviour

17 We do not share a language with her and therefore don't understand her communication

Service is not flexible enough to respond to individual needs

2 The service has restricted staffs' freedom to allow the clients to be themselves

2 The service fails the client because it is inadequately funded

16 The challenge is to respond flexibly to individuals' needs - not become a mini-institution

16 I have to mediate between the needs of the clients and the needs of the managers

Staff do not understand client's needs

1 Staff haven't understood client's current needs

3. Staff Dilemmas and Difficulties of Understanding and Responding to the Problem

How can we maintain boundaries and exert control and still be kind and respectful?

The dilemma of how to maintain boundaries and exert control and still be kind and respectful

1 Brian needs others to set boundaries on his behaviour

2 Staff either back off or go ahead pushing in their own way, rather than trying something else, because their egos get in the way

2 Brian takes advantage of people who don't police firm boundaries on his behaviour

2 Brian needs firm boundaries to be set on his behaviour by others

4 To start with the pressure from us may have stopped the problem going away

7 We are in a dilemma over how much to interfere in their relationship

8 It's hard for us to explain to Cathy about the relationship - I don't know what to say other than that Steve's not going to change

16 Sometimes we push her too hard to learn new things and forget the mental illness side

17 We are in a dilemma over how much to control her behaviour in her own interests

19 You have to strike a balance between being firm and being kind

Client did/ does not have firm boundaries in their family and wants the same treatment here

3 His mother treats him as a child

5 He wants to be mothered and have lots of attention and have things done for him as he has in the past, but we are pushing him which creates conflict

5 John wants a close relationship with an authority figure - to get things done, or as a supplement parent

5 John trashes things when he doesn't get what he wants

7 Cathy has a history of automatically having a close relationship with her parents and controlling their responses to her, she expects others to fit this mould

8 Cathy is used to being centre of attention with her parents and she finds it hard here because she's not the centre of attention

14 Perhaps Eric wants undivided attention like he gets at home - he gets everything he wants

19 She's used to her Mum giving in to her over everything - we can't do the same

20 She does all this because as a child her parents doted on her and overprotected her and now she's trying to replace them with staff and residents

We need to balance the needs of all the clients

7 Steve was losing his temper over the relationship

7 There is a lot of tension in the relationship which infects other residents and staff

8 Steve needs help to deal with Cathy's demands - we need not to take sides with either of them

18 It's hard to balance out the needs of all the residents

19 Other residents get jealous because Margaret gets quite a lot of one-to-one attention

20 Residents are jealous of the attention she gets from staff

Breaking the pattern set in family makes the behaviour worse

1 His mother treats him differently to staff

5 He wants to be mothered and have lots of attention and have things done for him as he has in the past, but we are pushing him which creates conflict

8 I may disappoint? Cathy by not comforting her as her Mum would - but I want to treat her as an adult

11 He can behave like a child having a tantrum

14 We'd get a better response from him if we could treat him like a child rather than as an adult, and gradually nurture him up to his real age

The client demands a lot from staff

2 Brian is not dealt with well by services because of his exuberance

11 He needs a lot of staff support

20 Staff see it as a problem that you have to occupy her a lot of the time -she needs supervision to do jobs for you

How can we deal with the unpleasant feelings evoked in us by working with this client?

The client evokes unpleasant feelings in the staff

6 Working with John (especially alone) makes me feel uncomfortable and at risk, sometimes I think there's no problem

11 He can be frightening to staff

12 After a particular incident I started to feel unsafe because the staff I was working with was scared - I think it's very important not to be frightened

16 She frustrates staff

17 Sometimes we take the easier option to avoid disappointment when we go out

18 Her behaviour has emotional costs for staff

19 With the best will in the world her behaviour can wear a bit thin

20 It's upsetting when you think you've made progress and then she reverts back

Fear can be overcome by getting to know the client

2 People are unnecessarily afraid of the client

12 He's not frightening when you know him and start to understand him

12 It's a problem that staff are scared of him

We need to protect ourselves with procedures

5 We have to follow procedures over these allegations to protect ourselves and John

6 We have introduced guidelines for working with John

We need to protect ourselves by "shutting off" emotionally

20 I feel angry and impotent and have to cut off from him

It is hard to understand the problem and maybe we can never fully understand.

It's hard to understand

1 Staff haven't understood Brian's current needs

1 Staff haven't found ways of responding to Brian's current needs

3 We don't know what has caused the problem

4 Andy and his problems are hard to work out

5 I'm not sure why he's making the allegations

7 We are struggling to understand how we can help them both

11 Matthew's problems are complex and multi-faceted

12 Many factors can trigger his aggressive behaviour

17 We find it very hard to work out what her problems are

18 I don't understand her routines

20 She's a worrier and we don't know why

20 Why she's like she is I don't know

Maybe we can never fully understand

17 Maybe we need to accept that we can't completely understand and solve her problems

17 I am moving towards thinking maybe we are wrong always to be searching for solution - perhaps we just need to manage the situation as much as possible

18 It's important to realise that sometimes she does it for no reason at all, but a lot f the time there is a reason

Should we understand the behaviour as a communication or as a behaviour problem?

If we respond to it as communication the behaviour will get worse

5 We need an outsider to do some careful sexual counselling with him - we could make things worse because he misinterprets things

6 We're stuck - if we try to address the problem he could make more allegations

9 We don't know how to find Bill a partner because we're ignorant - and we need to watch him in case he makes a nuisance of himself

10 It's best not to mention or deal with sexuality with him - it will only make the problem worse

10 He has a relationship with another resident, which we try to ignore

20 It's best to keep her busy and involved in things then she can't dwell on things

The dilemma of seeing the behaviour as a communication or as a behaviour problem

3 He has withdrawn from activities twice before, apparently because he wanted to make a change in his life, but this time he is anxious too, suggesting his motivations may be different

7 Cathy's difficulties are complicated and multi-faceted, involving her personality and her right to make choices - this is harder to deal with in some ways than something more tangible like Steve throwing furniture

16 We reward the behaviour by responding with attention

16 It is a challenge to keep seeing the behaviour as communication

17 The dilemma is whether or not to give in to her when she behaves in these ways (which may reinforce them), or whether to treat the behaviours as valid communications of her needs and respond to them

Appendix 9

Categories and Codes Relating to Research Question 2

CODES ALLOCATED TO CATEGORIES AND THEMES: RESEARCH QUESTION 2

Themes in bold
Categories underlined
Interview Number in Margin

Changes and Developments in Staffs' Views of Problems over Time

I Have Become More Sympathetic

I have become more sympathetic through getting to know the client

1 This changed when I got to know the client and see incidents of him hitting out
7 Later evidence from my own involvement has added weight to the relationship hypothesis
8 I have learned how to help Cathy through getting to know her
11 Since I got to know Matthew I have become more at ease with him
12 What changed my view was getting to know him by spending time with him
12 Now I see him as a nice muddled man and I feel sorry for him
18 Since working closely with her and getting to know her I understand her more and am far more sympathetic
19 I have come to know and understand her better by building up a relationship over time
20 As I got to know her I wanted to help her more and understand her

At first I thought the client was a pain

4 Initially I thought he was just being stubborn
10 At first I was disgusted and angry
18 At first I thought her behaviour was a pain, because I didn't have the relationship with her
20 Initially her problems were things we just dealt with

At first I thought the problem was in the client's nature

1 My first impression was that the client had an aggressive nature
7 Initially I saw it as Steve's problem
10 At first I thought he was a moaner
12 At first I thought he was violent and I didn't see him as a person - I saw him as his behaviour

I have become more sympathetic through changes in societal attitudes

9 My view has changed - I am less shocked by and more accepting of homosexuality
9 This reflects a societal attitude change

My Views Have not Changed

2 I have always seen the problem as external to the client
5 I have always thought he throws stuff to get attention
6 I thought from the beginning that he was making up the allegations

6 My view has remained the same throughout because three people have been accused, all investigated and found to be groundless
9 I have always thought he accosts people to satisfy his sexual urges
14 If anything I've become more frustrated by our failure to help him
14 Nothing has changed
19 I've always thought insecurity was the key

My View has Developed through Collecting Information and Input from Others

Outside professionals were helpful

7 Following input from the community nurse I started seeing it as a relationship problem
7 Today my view has been shifted by the process of this interview
8 My view changed through discussing the problem with a community nurse at staff meetings
10 My view changed when I was told he gets depressed
11 We have developed new approaches with the help of a psychologist and psychiatrist and through discussing as a team

Outside professionals were unhelpful

2 Professionals don't see the client as they really are - they just give us permission to do what we're doing already
4 The counselling he had may have made matters worse
14 The professionals don't understand what it's really like for US or for Eric

Collecting information

3 My view changed when I heard from the SW that there had been a sexual incident at the day service and they were being cagey
3 My view changed when I heard he had stopped using the communal toilet at the day service
4 I have tried to understand the problem by collecting information
14 Over time I have come to understand him a bit more - e.g. by meeting parents

My View has Developed Through Working Directly with the Client

1 An incident made me think that the client's behaviour was a means of expression
1 An incident made me think that staff responses were part of the cause of the client's behaviour
2 This view has grown stronger as I have seen the impact of his changing environment on his behaviour
5 I changed my view to thinking there was a sexual element when he made allegations and when he tried to put his arm round me
10 I have come to understand his moods more and how to deal with them
11 My first impression was that the dictatorial staff regime was aggravating the problems
16 I have learned how to redirect her by observing her

19 I didn't really have a view of her until we had experimented with different plans and seen how they affected her

My View has Changed because the Behaviour has Changed

2 I think his behaviour has "improved" over time
8 There has been a gradual change - Cathy isn't getting so upset
10 I find it less of a problem now because it hasn't happened
11 The behaviour has become far less of a problem
11 His problems have changed but I don't think the reasons have changed
12 Matthew's behaviour has improved a lot because Andrea instigated a less macho approach to him
16 Jessie has become more capable since moving from the institution

Appendix 10

Categories and Codes Relating to Research Question 3

CODES ALLOCATED TO CATEGORIES AND THEMES: RESEARCH QUESTION 3

Themes in bold
Categories underlined
Interview Number in Margin

Roles and Relationships

Amount of Contact and Involvement with Client
Support worker has more
HM
1 Keyworker is more closely involved with client
3 The support worker has more contact with the client
17 I don't spend as much time with Tina as support workers do, but I do do quite a lot of direct work with her
SW
2 The Home Manager is newer and doesn't know the clients as well as I do
6 Lee has more responsibility than me but I have a lot of experience
18 I have more contact with Tina than Wendy does and look out for Wendy's interests

Home manager has more
HM
19 I am probably more involved with Margaret than Anna is

Key Responsibilities
Hands-on work with clients
HM
1 Informal social contact with client
5 Most of my work is hands-on
7 I have done a lot of direct work with Cathy and have been very involved in planning her care
9 I had a lot more hands-on involvement and contact to start with so I know the residents very well
17 I manage personnel but also work on the shift a great deal
SW
2 As Brian's keyworker I interpret his communication and co-ordinate his activities
2 I spend a lot of time in the home with Brian
2 I do household chores with Brian
4 As Andy's keyworker I liaise with his family and day service and support him at home
4 My priority is hands on work with the tenants financial, physical, emotional and social needs
6 I am keyworker for John - I give practical and emotional support and accompany him on activities
6 I do hands-on support and spend some time on admin

8 I am a support worker and keyworker for two clients, which means supporting them in everything
8 Being keyworker for Cathy means being her advocate and her bit of security, as well as taking care of practical matters
10 I've known the residents 11 years
10 I know Bill very well and am very involved but am not actually his keyworker
12 I'm very involved in the varied day-to-day activities of the residents
14 I am Eric's keyworker
18 I have been Tina's keyworker for a year and try to meet her mental and physical needs and wants
20 I am an advocate and deal with many things in their lives

Management

HM

1 Management responsibilities
3 Administrative responsibilities fill most of my time
5 Management responsibilities
7 As home manager I spend half my time on pure management activities and half working on shift
9 I have been manager (run everything here) for 14 years - I'm not involved much in the day-to-day care now
11 As home manager I manage the care provided by meeting with staff, liaising with families and professionals and seeing residents
17 I have been promoted to managing a third of the service
17 I manage personnel but I also work on shift a great deal
19 I am deputy manager

SW

4 As a senior staff member I supervise and have some management responsibilities
10 I have recently taken on running the group home in the grounds - I run it like my own home
12 I supervise the Keyworker's work on Matthew's care plan and have a lot of close contact with Matthew
12 As one of the senior care staff I take charge of the shift, and take some responsibility for running the unit

Supervision Relationship

Formal and informal supervision

HM

3 As Helen's manager I have informal discussions with her about the work and should also have formal meetings
5 I manage Alan through formal and informal contact
7 As Melanie's manager I work alongside her and have supervision meetings
9 I have formal and informal contact with Richard to discuss the group home (which he runs)
17 I have formal supervision sessions with Kerry and work alongside her

SW

2 The Home Manager provides regular supervision sessions

4 I have formal and informal contact with the HM, who is very approachable
6 Lee and I have formal and informal discussions about problems
8 I work alongside the HM and have good supervision meetings and staff meetings
12 Andrea is my line manager, she understands the problems, we have a good relationship and I can call on her to help us out
18 Wendy is my supervisor and I have formal and informal supervision from her

Informal supervision only
HM
11 As Charlotte's line manager I liaise with her informally daily
19 Anna doesn't really need supervision
SW
20 Agnes is my superior but basically we work alongside one another

Relationship with Other Participant
Open and honest
HM
1 Open and relaxed relationship with keyworker
5 My relationship with Alan has improved over time and become more open and honest
7 We have a relationship based on honesty
SW
8 I have an open and honest relationship with the HM

Good
HM
3 Helen and I have a good supportive relationship
11 I have a very good relationship with Charlotte and have a lot of respect for her
17 I have a pretty good relationship with Kerry, we are pretty similar
SW
I get on well with Laura - I discuss things informally with her most days

Stormy
HM
9 Richard and I have a stormy working relationship

Relationship with Client
Good close relationship based on current contact
HM
1 The client likes me
9 I have a good relationship with Bill because he respects me and does what I say
SW
2 I have a good, friendly, playful relationship with the client
4 I have a very involved relationship with Andy
10 I have a good relationship with Bill, we understand each other
18 I am bonding with Tina through spending time on activities with her

20 I have a good relationship with Margaret

Good close relationship based on past contact

HM

3 Although I have far less contact with Andy than I used to, he confides in me and I am a point of security for him because I have been here a long time

11 I don't have much contact with Matthew now, but know him well from working with him in the past and have a good relationship with him

Problems in the relationship

HM

5 I work quite closely with John but there are some problems with our relationship not being as close as he wants

7 I have found it hard to get to know Cathy

SW

6 I treat John like the other residents but he has attached himself to me and Lee because we are men

Appendix 11

Participant Feedback

PARTICIPANT FEEDBACK FOR EACH QUESTION ON FEEDBACK FORM

1. To what extent do the themes in the Summary of Initial Findings reflect your views of the problem which we discussed? How could the themes be improved?

The themes, to a great extent, reflect my views - although some are new to me: (i) I've not experienced a client's hostile motivation or deviant characteristic; (ii) dealing with unpleasant feelings, perhaps another one is avoiding working with the client; (iii) changes in views - again perhaps another theme could be information gained in training (external and in house) and reading about specific conditions/syndromes/illnesses suffered by the client.

I felt the themes were clearly identified and could be related in whole or part to the problem discussed.

The themes generally reflect my views.

Themes reflect well.

I found the results interesting.

Generally, the themes applied to my understanding of the client we discussed.

The themes cover my clients challenging problems well.

They all seem to reflect the problems of challenging behaviour and seem accurate in theory.

2. To what extent do the themes in the Summary reflect how service workers understand challenges presented by residents *in general*? How could themes be improved?

I do not believe I can truthfully reply about the general understanding of service workers - it is purely my assumption that it is fairly accurate but feel probably more themes are applicable - we are all individuals and hence feelings, anxieties, understanding etc.

The extent, in my view, depends on the workers knowledge and understanding of the problems presented and their willingness to learn ways to cope and resolve challenges.

Points out the big divide between staff who are willing to understand and those who are not.

It is impossible to give a set answer to such a broad issue. Each person is an individual and each situation is unique, and so requires dealing with as such.

I believe the themes reflect the understanding of service workers. It is important to give appropriate general and specific training in the aspects of challenging behaviour relating these to the clients so that staff are equipped to approach the issues presented in a professional manner, or with confidence in their own ability.

Generally covers all except maybe good training on specific areas, i.e., residents condition (Autism) or restraining techniques, especially new staff coming into the business. Old staff need to be trained in up to date methods and techniques.

They seem quite accurate - have been understood appropriately.

3. Please add any other comments you would like to make on the content of the Summary or your experience of taking part in the research project.

I felt a bit reluctant to take part in the research project due to the confidentiality and respect of the client(s) but believe, at the same time, that the service we give will not progress unless we look at our own feelings, prejudices etc. I felt the content of the summary was very factual, concise and unbiased and could be very useful in setting up services in the future - especially in respect to recruitment and training of staff.

Taking part in the project was another welcome opportunity to discuss issues and reassess my perspective of the situation.

The points raised have lead to discussion amongst staff, in particular, staff training.

Good to see someone state that some 'challenges' could be down to staffs mishandling/misinterpretation of clients needs. Even in this summaries present form, it should be required reading for all staff and opened for team discussion.

I have enjoyed taking part in the project. Hope this is of some help to you.

It has been helpful to have an objective discussion concerning the client.

Although no answers, it was "good to talk" as BT says.

All the information prepared seems to be a reflection of the truth in theory and reality. I enjoyed taking part in the research project and would be willing to do so again if necessary.

Joint Letter from Support Worker and Service Manager

We agree broadly with your Summary of Initial Findings. Because the report is of a general nature and cannot be specific to our interviews, there are a couple of areas that we feel are not representative of our meetings. Please find our comments below.

1. Staff Explanations for Challenging Problems. It is the ethos of the home and reinforced through the induction procedure and appraisal system that staff support clients and do not 'control' them. Partners, Managers and Senior care all perform duties and work with the client group on a daily basis.
2. Similarities and Differences Between Support Staffs' and the Home Managers' Accounts of Challenges. We disagree with the assumptions made in this section.