

LEARNING DISABILITY STAFF AND AGGRESSION FROM CLIENTS

by

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Abstract

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This study was designed to investigate whether provision of information, in the form of a leaflet, about issues surrounding aggression and violence at work would lower anxiety about aggression and increase confidence in dealing with aggression, in care staff working in learning disability. A brief evaluation of the leaflet was carried out, and measures taken to establish whether information was assimilated from the leaflet. Also investigated were other feelings that care staff had about aggression at work. An information leaflet entitled "Preventing and coping with an aggressive incident involving a client in your care", and a questionnaire entitled "Aggressive incidents involving a client at work" were constructed. The questionnaire incorporated a scale for measuring 'Confidence in dealing with aggression'.

53 care staff, working in residential homes for people with learning disabilities, completed pre and post-intervention Spielberger State-Trait Form Y-1 questionnaires, and "Aggressive incidents involving a client at work" questionnaires. Results were analysed using analysis of variance, t-tests and Pearson's product moment correlation. No differences were found in levels of anxiety or confidence in dealing with aggression between two experimental groups and a control group, pre and post-intervention, but a significant difference was found in levels of anxiety within the groups pre and post-intervention. The leaflet was evaluated positively, but information was not assimilated.

These and other findings are discussed in relation to present practice and implications for future research.

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Author's Declaration

At no time during the registration for the degree of Doctor of Clinical Psychology has the author been registered for any other University award.

The contents of this bound volume are identical to the volume submitted for examination in temporary binding except for the amendments requested at the examination.

This study was conducted while the author was a Trainee Clinical Psychologist in the South West Region based in Avalon Somerset Healthcare Trust, and the research was conducted in collaboration with Exeter & District Community Health Services Trust.

Signed Mary Jones

Date 1.12.93

Chapter 1

Introduction

There is a wealth of literature on nearly all aspects of the lives of learning disabled people but very little on the staff who care for them. One of the areas which has seen little research to date is that of the effects on care staff of the minority of people with a learning disability who display aggression. This project aims to explore some of the feelings staff have about aggression from clients in their care. In particular it will concentrate on finding whether giving information to staff about issues surrounding aggression at work, in the form of a leaflet, will reduce anxiety and increase confidence in dealing with an aggressive incident.

The introduction will review the literature in the following areas: The move of learning disabled people from institutions to the community; Epidemiology of aggression in learning disabled people; Theories of aggression; Reasons for aggression in learning disabled people; Aggression to health service staff; Aggression to care staff in learning disability; The effects on staff of aggression and violence; Methods of

dealing with aggression and violence; Theories of anxiety; Reducing anxiety; Reducing anxiety in care staff; Confidence in dealing with an aggressive incident; Increasing confidence in care staff.

1.1 The move of learning disabled people from institutions to the community

Until comparatively recently people with a learning disability were housed in large institutions away from the public eye. Much behaviour (aggressive or otherwise) was dealt with in brutal, degrading and undignified ways by some staff in some institutions (Ryan & Thomas, 1988). A series of enquiries exposing such practices inside many hospitals (see Martin, 1984) have led to reforms, long overdue, being slowly put into practice.

The development of the ideas of "normalisation" (Wolfensberger, 1972; Nirje, 1969) came around the same time as the government policy to close the institutions (DHSS Care in the Community: A Consultative Document. Moving resources for care in England, HMSO, 1981), and thus people with learning disabilities have been moving to community placements.

Since this widespread move there has been much research on quality of life issues (eg. Felce et al, 1985, 1986; Flynn, 1986, 1987), demonstrating that generally residential provision in small homes is likely to lead to increased family contact, an increasing number of contacts and duration of contact with non-disabled people, etc. and greatly increased participation

in activities outside the residence, although this last is not necessarily so as Bratt & Johnston (1985) found.

It is generally assumed that levels of maladaptive or anti-social behaviour fall when a move from an institution to the community is made, with the concomittent change for the better of quality of life. However, Cohen et al (1977) studying the effects on 60 people moving from a large institution to a smaller setting showed that people functioning at a lower level on discharge showed increased maladaptive and anti-social behaviour. Hemming et al (1981) found increased rates of such behaviours four months after a group of learning disabled people moved from an institution to a group home. The majority of such effects appeared to be of short duration, and consisted of what could be termed "settling in teething troubles", but Martindale & Kilby (1982) provide evidence to suggest that for some people the effects are long-lasting. Thus, although data are scarce on prevalence of aggressive behaviour in group homes in the community, it would be unwise to assume that there will be an automatic lessening of such behaviours just because the move has been made.

The acknowledgement of the three fundamental principles set out in the King's Fund publication 'An Ordinary Life': 1) mentally handicapped people have the same human value as anyone else; 2) mentally handicapped people have a right and a need to live like others in the community; 3) services must recognise the individuality of mentally

handicapped people; means that staff accept that people with a learning disability were wrongly placed in institutions and that violent procedures must never now be used against their clients, but at the same time they are having to deal with some behaviours that were learnt many years ago (probably with good reason at the time, ie. self-protection) and which may now be resistant to change. Staff rightly no longer have recourse to some of the methods which were once available to them, but have been left with the problem of curtailing or containing aggressive behaviour in some people.

1.2 Aggression

1.2.1 Epidemiology of aggression in learning disabled people

It must be made clear at the outset that only a minority of people with a learning disability display any aggressive behaviour. However, there is evidence that there is a higher proportion of people with a learning disability displaying aggressive behaviour than occurs in the general population. Epidemiological surveys have suggested that 82% or more of the learning disabled child and adolescent population may exhibit some form of severe behaviour disorder (Kushlick & Cox, 1973; Wing, 1971). The rate in the adult population is thought to be slightly lower at around 15% (Kushlick & Cox, 1973). Harris & Russell (1989) carried out a study in a health district in the south west to find the prevalence of aggressive behaviour in the learning disabled population. They found an overall

prevalence of 17.6% (n = 159), the lowest rate being in day facilities (9.7%) and the highest rate being in hospitals (38.2%). Overall proportionately more males than females were reported to present aggressive behaviour, but only in day facilities. Within hospitals there was no association of gender and aggressive behaviour.

In order to understand some of the reasons why aggressive behaviour may occur the next section will discuss theories of aggression.

1.2.2 Theories of Aggression

There are many definitions of 'aggression'. The Penguin Dictionary of Psychology defines 'aggression' as "an extremely general term used for a wide variety of acts that involve attack, hostility etc.....". Most people see a close relationship between aggression and violence, and therefore violence is included in most definitions of aggression. However, violence may be neither necessary nor sufficient for aggression. In many cases behaviour may be termed 'aggressive' but does not lead to physical harm. On the other hand behaviour may be violent without being aggressive, eg. predatory behaviour in animals. Archer & Browne (1989) view aggression as a cognitive concept with three distinct features; 1) intent; 2) actions which cause, or are likely to cause, damage; 3) appropriate emotional state, eg. anger, irritation or rage.

Freud's psychoanalytic theory of aggression first considered that rage, anger and hostility were products of frustration. Later psychoanalytic

researchers incorporated an aggressive drive. Fromm (1977) places less emphasis on innate drive and more on social and practical influences. Freud's view of frustration and aggression has survived and has been reformulated as the frustration-aggression hypothesis (Dollard et al, 1939), or drive theory. According to this theory aggressive behaviour serves the function of reducing arousal (or drive) built up through the experience of frustration. However, Dollard's theory has been displaced by more recent research (eg. Geen & Quanty, 1977) who conclude that if aggression is a drive, aggressive behaviour should be cathartic, resulting in a reduction of intensity of aggressive feelings. It appears that although aggressive behaviour does reduce physiological arousal, there is no parallel reduction in aggressive behaviour.

Theories that see general drive or arousal as an energy source for aggression predict that it will be provoked by non-specific stimuli. Stressful characteristics of the environment fall into this category and have frequently been seen as sources of aggression, eg. crowding (Mueller, 1983).

Social learning theory (Bandura, 1977) rejects the concept of aggression as an instinct or a frustration produced drive, and proposes that it is no different from any other learned response. Aggression can be learned through observation or imitation, and the more often it is reinforced the more likely it is to occur.

Some evidence for a biologically based aggressive drive comes from studies showing that mild electrical stimulation of a specific region of the hypothalamus produces aggressive behaviour in animals (Smith et al, 1970). However in humans with intact brains such instinctive aggressive patterns are controlled by the cortex and therefore are much more influenced by experience, and the activation of the neurological mechanisms that enable us to behave aggressively is under cognitive control.

Mackintosh (1990) points out that the term "aggression" is used very widely and no single theory or causal system can be expected to cover all its aspects.

1.2.3 Reasons for aggression in learning disabled people

It is impossible to know, in some cases, how much any aggressive behaviour is a product of the person's impairment or of the setting in which he/she has been living. Any of us can be driven to anxiety, depression and anger at times when we are faced with severe life stresses or losses. People with a learning disability suffer stresses throughout their lives; stresses such as failure, frustration, incomprehension, impatience from others and humiliation, and it is hardly surprising if this is expressed in aggressive outbursts, given the lack of alternatives for expression many learning disabled people have at their disposal.

There is evidence of an association between behavioural disorders and the following: low level of ability and self-help skills in both children and adults with a learning disability (Bell & Marlett, 1986; Quine, 1986); poor communication skill (Carr & Durand, 1985); poor social interaction (Wing, 1981). Aggressive behaviour usually happens for a reason and is often a way of communicating such things as anger, frustration, pain, boredom, etc. It is recognised that aggressive behaviour may be maladaptive, but that it is also successful at some level for the individual. A number of writers have stressed this point and emphasised that many of the goals attained by problem behaviours may well be 'legitimate' goals, but achieved by what are, in the long run, unsatisfactory means (Goldiamond, 1974; Carr & Durand, 1984). A complete understanding of any behaviour needs to take into account not only the present circumstances in which the behaviour is happening, but events which happened in the recent or distant past and which may have contributed to establishing the present pattern of behaviour.

Harris and Russell (1989), in a study on the nature of aggressive behaviour in learning disabled people, showed that it was more likely to occur when the individuals concerned were experiencing difficulty with a wide variety of triggering events and situations. The authors reduce these events and situations to the following coping conditions: 1) coping with demands from others; 2) coping with environmental changes; 3) coping

with physiological needs; 4) coping with too much stimulation; 5) coping without the attention of others.

Ghaziuddin (1988) found that nearly half of 65 consecutive referrals for behavioural disorder were associated with life events sustained in the previous twelve months, and that these clients tended to be mildly learning disabled. Those who had a behaviour disorder but no history of recent life events tended to be more severely learning disabled. There was an increased occurrence of epilepsy in this latter group which can also affect behaviour, not only by seizures but by the effects of long-term medication (Trimble & Reynolds, 1976).

Perkins (1991) in a study of violence against clinical psychologists notes that there were marked differences between the various client groups in terms of aggression and violence experienced. 80% of psychologists working in neuropsychology, 50% of those in psychiatric rehabilitation, and 38.5% of those working with people with learning disabilities experienced physical violence in the year prior to the study. What is noteworthy is that people in these client groups often have impaired cognitive abilities, and, in addition, verbal communication may be a problem.

Ghaziuddin stresses the fact that apparently commonplace life events, which would not necessarily have a great effect on a non-handicapped individual, may have immense psychological meaning and significance in

some learning disabled people. Brain damage can bring about changes and abnormalities in the fields of perception, discrimination and the ability to abstract. Under emotional stress learning disabled people have a tendency to become disorganised (Menolascino, 1983), a process described as cognitive disintegration (Sovner, 1986). Thus, handicapped as they are by organic deficits and concrete coping mechanisms, any stress can then cause a deterioration in behaviour and intellectual functioning.

1.2.4 Aggression to health service staff

There is a growing body of research to show that health care employees are at higher risk of assault than ever before. In Britain Rogers & Salvage (1988) suggest that there has been a 47% increase in violent attacks on health service staff in the last few years, and Breakwell (1989a) concluded that "health service workers are at least 26 times more likely to be seriously injured than the general public".

Mackay (1987) analysed three thousand questionnaires from a random sample in five health authorities, and the results indicate a particularly high risk of assault to Accident and Emergency staff, ambulance workers and trainee nurses. Higher than average rates were also experienced in psychiatric facilities. Overall 11% of respondents had received minor injuries requiring first aid, and 0.5% received injuries necessitating medical assistance.

Data on the seriousness of assaults on staff are often conflicting and ambiguous, eg. Fottrell (1980) reported that fewer than 2% of staff who were assaulted received severe injuries, while 90% received minor injuries. Lanza (1983), on the other hand, found that 36% of staff who had been assaulted sustained severe injuries and 64% received minor injuries.

Data on numbers of reports made may not be correct. Lion et al (1981) showed that in a state hospital with 1500 patients and 800 nursing staff, 203 assaults on staff were reported in one year. However, the authors estimate, based on daily ward reports, that almost five times as many assaults occurred as were reported. The authors speculated that the reasons for this were a) the effort required to complete an incident report, b) because they were accustomed to violence, and c) because they felt that being assaulted represented a performance failure.

1.2.5 Aggression to care staff in Learning Disability

There is little direct evidence from research that staff working with learning disabled people suffer attacks. That they do is shown in studies that have attempted to find the sources of stress in care staff. One recent report in Britain, that of Allen et al (1990), showed that violence and behaviour problems caused concern to staff. Browner et al (1987) in a study in an American hospital found that 52% of staff mentioned violent outbreaks as a significant source of job stress, and that violence was the

only aspect of work actually with the residents that caused stress. Other research, eg. on behaviour modification procedures to lessen aggression (eg. Foxx et al, 1989; Bird et al, 1989), have serendipitously shown that staff do suffer attacks of an aggressive nature from some clients. Hill & Spreat (1987) evaluated staff injury rates with regard to type of restraint used in a 284 bedded hospital for people with mild (16.6%), moderate (15.5%), severe (37.2%) and profound (30.7%) learning disabilities, and over two six month periods there were 868 staff injuries reported, most of which were of a minor nature.

It is likely that the reasons for attacks on care staff in learning disability are different from the ones which are the causes of attacks against health service staff generally, merely because the client group is different and has its own particular problems. However, as the effects on victims have been shown to be universal (Janoff-Bollman & Frieze, 1983), in the absence of much research on the effects of aggression on staff in learning disability, it is possible to extrapolate from findings in the literature of the effects on staff in psychiatric nursing and other hospital departments.

1.2.6 Effects on staff of aggression and violence

Until comparatively recently attacks against nurses and care staff by clients in their care were not acknowledged to be a problem, with the attitude "it's all part of the job" being perpetuated by management (Engel & Marsh, 1986). However, whether incidents are of a minor or major

nature, or involve physical or emotional abuse, they have a significant impact on the victim. As Scott & Whitehead (1981) point out "Incidents can result in physical injury and emotional trauma and can affect job performance and relationships between patients and staff. Staff time is lost to patients due to injury. Overtime is increased to replace absent staff. Morale is lowered, fear increases and issues of control can begin to take precedence over treatment. Staff limit their interaction with certain patients. People no longer look forward to coming to work. Turnover and sick leave increase".

Dawson et al (1988) discuss two concepts that can be used for understanding how staff are likely to feel if they are assaulted at work. The first relates to a basic set of expectations and assumptions that individuals have about their world. The second relates to the role conflict that staff experience when they are attacked. To take the first concept, Janoff-Bollman & Frieze (1983) have identified three basic assumptions which most people hold about their environment and themselves. These are: 1) the belief in personal invulnerability, 2) the perception of the world as meaningful and comprehensive and 3) the view of ourselves in a positive light. Because people believe the world is an orderly and predictable place they feel safe enough to function. They assume that by being worthy and good people, they will be immune from things going wrong. "Victimization calls into question each of these primary postulates

of our assumptive world, and by doing so destroys the stability with which we are ordinarily able to function" (Janoff-Bollman, 1983).

When an assault occurs, the victim's assumptions are shattered. The world no longer feels safe and orderly. Some experience heightened feelings of vulnerability (eg. preoccupation with fear of recurrence), feelings of responsibility for the incident and feelings related to negative self-image; eg. weak, unworthy, frightened (Janoff-Bollman, 1983).

Dawson et al (1988) have shown how attacks in a clinical setting also challenge a person's basic assumptions. As a result the member of staff may employ strategies such as minimising the assault, denying their feelings and/or accepting blame for the assault.

The second concept explains the additional problem that because the violence is perpetrated by a person in their care, staff do not accept the assault as a work-related incident, but view it as part of the job. As Engel & Marsh (1986) point out, caregivers have a self-image of being strong and in control; they must not show weakness. Thus, the normal victims' responses are in conflict with the professionals' belief that they should be able to handle violence at work. Lanza (1983) found indications that some staff felt they would be overwhelmed if they allowed themselves to admit their feelings. Some stated that if they allowed themselves to experience feelings about the likelihood of assault they would not be able to function. Thus staff often deny the very feelings that are so normal to

victims, and they become isolated. In addition, role conflict occurs as the assaulted member of staff (the victim) has to care for his/her assailant again.

There is evidence that even minor assaults, ie. those that result in a small bruise or no visible signs of injury can produce severe psychological consequences (Engel & Marsh, 1986; Lanza, 1983; Whittington & Wykes, 1989; Wykes & Whittington 1991), and can in some cases be classified as post-traumatic stress disorder with people suffering symptoms such as insomnia, eating disturbances, anxiety, an exaggerated startle response etc. Whittington & Wykes (1992) state that "there is an assumption both in the literature (eg. Haller & Deluty, 1988) and on the 'shop floor' that the relatively trivial incidents which many psychiatric nurses are subjected to on a very frequent basis and which they themselves dismiss as insignificant, are not important and that research should concentrate on the occurrence of physically serious incidents." However, they go on to report that a few subjects in their study reacted very badly to these physically insignificant incidents. Campbell & Mawson (1978) have described the problems and anxieties created by violence in a psychiatric unit. The authors identify the unpredictability of an attack as creating the biggest problem. Conn & Lion (1983) found that the victims of an attack at work agreed that the emotional impact of having been attacked far exceeded the impact of physical injury.

The present author had some informal talks to some staff working in Exeter's Learning Disability Service and it became evident that a number of staff had suffered an attack at work and that that aspect of their work can create anxiety. This led to the author carrying out a piece of research into the effects of a violent incident on a few staff working in the learning disability service (Ivens, 1991). This work showed that some of the people who had suffered an attack by a client were markedly affected by the incident. The attacks included being bitten, hit, scratched, strangled, kicked and having a knife held against their throat with 6 (54%) of people requiring treatment for their injuries. Of the 11 respondents 10 (90%) developed symptoms of stress following the incident, including anxiety, increased smoking, irritability, changed eating habits and sleeplessness.

It became apparent from this initial report that some staff felt unprepared for aggression and violence at work. This research did not attempt to find how much training staff had had about preventing or dealing with aggression, but it was recommended that that should be an area for future research.

Sharrard (1992), in her study on job stress and satisfaction of direct-care staff in a learning disability service, found that there is a significant turnover of staff working with people with a learning disability and that it is related to job stress. In that context she highlights the need for supportive schemes including in-service training and social support such as discussion groups, and states "it is likely that staff will suffer less

anxiety about residents' behaviour or lack of progress if they are given adequate information, or a chance to express their concern without the fear that they will be seen to have failed."

Thus the research points to the need for ways to be sought to help staff feel less anxious and more confident in their ability to deal with clients' behaviours, and the next section outlines the main ways in which this may be done.

1.2.7 Methods of dealing with aggression and violence

In order to be able to successfully deal with aggression at work people must have specific training. The methods fall into two main categories; physical methods, eg. control and restraint or Breakaway techniques, and talking methods in which a member of staff will, by non-confrontational means, attempt to empathise and calm the person.

A DHSS Health Circular (HC7611) was issued in March 1976, recommending that all hospital staff, both professional and non-professional are entitled to, and should receive, information and instruction on the principles and practice of dealing with violence. Since the move to care in the community there has been a growing literature on staff training in the physical management of violence and aggression (eg. McDonnell et al, 1991).

At the time of writing a growing number of care staff employed by Exeter Community Trust have had training in 'Breakaway' techniques. The full course, "Management of Aggression and use of Control and Restraint Breakaway Techniques" emphasises avoidance and diversion of violence, and is an eight day course plus two refresher days. There is also a one day course being taught which deals purely with releasing oneself from simple clothing holds to hair pulling and ultimately life threatening situations, eg. strangleholds etc. However, the number of staff having done either course is still a small proportion of the total number of staff. These courses are expensive and it is unlikely that all staff who would like training in 'Breakaway' techniques will get it.

As many writers have pointed out it is better to prevent an aggressive incident from happening if at all possible, rather than having to deal with an incident that could have been defused (eg. Lally, 1988; McDonnell et al, 1991).

Ways to defuse a potentially violent situation are varied and include knowing the client well so that astute observation may pick up changes of mood and behaviour which may presage an aggressive incident. This may then be followed by sensitive management using empathic and non-threatening communication and non-threatening body language.

As discussed earlier it seems that of the many possible consequences to staff of aggression at work, anxiety is a prevalent one. The theories to account for this will be discussed.

1.3 Anxiety

1.3.1 Theories of Anxiety

There is little agreement on a precise definition of anxiety, but it is widely taken to mean the unpleasant emotion characterised by terms such as 'worry', 'apprehension' and 'dread'. Common sources of anxiety are conflicts, threats of physical harm, threats to self-esteem and pressure to perform beyond one's own capabilities. Thus any situation that threatens a person's well-being is assumed to produce a state of anxiety.

Ever since Freud's pioneering work (1926, 1959) a number of theoretical models of anxiety have been proposed. Freud differentiated between 'primary anxiety' which could be traced to somatic sources, often the birth process and later 'subsequent anxiety' resulting from separation from either mother or other significant object, castration fears, or other crises in psychosexual development.

Social learning theory focuses not on internal conflicts but on ways in which anxiety becomes associated with certain situations via learning. However it is now clear that the basic learning theory paradigm can not explain all cases of anxiety and there is increasing emphasis on cognitively

based theories (see eg. Carr, 1979; Reiss, 1980). Initially these emphasised the importance of mental events as intervening variables between an environmental event and the reaction of the individual to this event. There is a continuing debate about whether mental events can be seen as causal or moderating variables or whether they are merely one component of an anxiety response. Much recent theorising has emphasised the importance of particular patterns of thinking as causally implicated in the generation of anxiety.

It is suggested that anxiety is experienced when people encounter a situation that seems beyond their control (Mandler, 1966). The feeling of being helpless and not in control of what is happening is central to most theories of anxiety.

As anxiety appears to be such a common reaction to aggression at work, ways need to be found to reduce this anxiety. The following section will discuss theories of anxiety reduction.

1.3.2 Reducing Anxiety

Much of the research into effective ways of reducing anxiety has been applied to patients in hospital in preparation for unpleasant medical procedures. Many reviews of such work are available (eg. Anderson & Masur, 1983; Melamed et al, 1988). Studies have employed a range of techniques, including informative, psychotherapeutic, modelling, behavioural, cognitive-behavioural and/or hypnotic procedures. The aim

has been to reduce one or more of the following: pre-operative anxiety, complications during surgery, post-operative distress and recovery time. The research suggests that these approaches can be effective.

There are three theories which provide slightly different explanations as to why provision of information could reduce anxiety.

The first is Janis's (1958) emotional drive theory which conceptualises that some optimal level of preparatory communication is effective because it results in a moderate level of anticipatory fear, which in turn leads to the constructive 'work of worry'. Too much or too little fear is thought to be detrimental. The rationale is that information influences cognitive factors such as the individual's expectations, which then allows them to enhance their own sense of control.

In the second theory, that of self-regulation, Leventhal & Johnson (1983) argue that information provision influences the way the patient thinks about the impending experience, and helps in the facilitation of coping strategies.

The third theoretical concept is based on Lazarus & Folkman's (1984) cognitive appraisal model. The coping process is seen as consisting of problem-focused and emotion-focused coping which involves modifying, avoiding or minimising the problem, or attempting to control the situation. Problem-focused interventions will be mainly obtaining factual information with a view to problem-solving. Emotion-focused coping will entail

reducing emotional distress by relaxation and attention redirection, or by denial or wishful thinking.

A feature which links all three models is the part played by the perceptions of control in reducing psychological distress (Janis, 1958; Lazarus, 1966). Providing coping techniques serves to generate such perceptions of control. Information provision operates in a similar manner and people may use that information to develop their own ways of controlling events. It has been shown that notions of control have formed the central tenet of various explanations for the effectiveness of information provision in anxiety reduction. These suggest that individuals should show less arousal having been given information because they can:

- 1) discriminate safe from unsafe periods (safety-signal theory, Seligman et al, 1971);
- 2) make a well-timed preparatory response (preparatory response theory, Perkins, 1968);
- 3) reduce uncertainty and conflict (information-seeking theory, Berlyne, 1960).

1.3.3 Reducing anxiety in care staff

The researcher wished to apply the above models to a different but also anxiety provoking event, that of care staff in learning disability being prepared for facing an aggressive incident at work. To the researcher's knowledge this has not been attempted before. Based on the same theoretical model it was hypothesised that information on issues regarding an aggressive incident, given in the form of a leaflet devised by the

researcher, would also influence cognitive factors so that accurate expectations could enhance personal control, facilitate coping strategies and thereby reduce anxiety about an aggressive incident. An extension to this rationale was that the same factors would operate to increase confidence in dealing with an aggressive incident.

1.3.4 Confidence in dealing with an aggressive incident

A thorough computer search for the relevant literature found only one study that has addressed the topic of confidence in coping with patient aggression. Thackrey (1987) devised a scale for clinicians in mental health called "Confidence in Coping with Patient Aggression Instrument", which includes questions such as 'How able are you to intervene physically with an aggressive patient?', 'How safe do you feel around an aggressive patient?' and 'How good is your present level of training for handling physical aggression?' As Thackrey states "the construct 'clinical confidence in coping with patient aggression' was without published empirical precedent. For heuristic purposes, it was conceptualised as self-attributed ability, preparation and comfort in safely and effectively intervening psychologically and physically with the aggressive patient for purposes of self-preservation and therapeutic intervention."

1.3.5 Increasing confidence in care staff

Based on the same rationale as that of provision of information reducing anxiety, it was hypothesised that provision of information would not only

reduce anxiety but also increase confidence in dealing with an aggressive incident by enhancing personal control and facilitating coping strategies.

1.4 Research Aims

The research aims were as follows:

1. To find out whether information about issues surrounding aggression at work, given in the form of a leaflet to care staff, will lower anxiety about aggression at work.
2. To find out whether information about issues surrounding aggression at work, given in the form of a leaflet to care staff, will increase confidence in dealing with aggression at work.
3. To see how much of the information contained in the leaflet is assimilated.
4. To evaluate the content of the leaflet.

While the previous four aims were intended as the main thrust of this research the following aims were suggested by one or more service directors in Exeter's learning disability service, as likely to provide useful information for managers.

5. To see if participants feel that their team leader regards an attack as seriously as they do themselves.
6. To find out what additional support staff would like to have to
 - a) lessen the likelihood of an aggressive incident occurring at work,

- b) help them cope at the time, and
- c) help them after an aggressive incident has occurred.

Depending on whether the above aims were successful it was thought that the information leaflet could be used as part of new staff's preparation for working in learning disability. It would be an extremely cost-effective way of providing information to large numbers of staff.

1.5 Research Hypotheses

The research hypotheses were as follows:

1. Staff who receive an information leaflet, will have significantly lower anxiety levels about aggression at work than those who do not receive the leaflet, as measured by the Spielberger State-Trait Anxiety Inventory (STAI), Form Y.
2. Staff who receive an information leaflet, will have significantly higher levels of confidence in dealing with aggression at work than those who do not receive the leaflet, as measured by the researcher-designed scale "Confidence in dealing with aggression".
3. After reading the leaflet staff will show an increase in knowledge about issues surrounding aggression at work.

Chapter 2.

Method

2.1 Design

A between and within groups nested experimental design was used to see whether the provision of information, in the form of a leaflet, made a significant difference on a number of measures.

There were three groups:

Experimental Group 1

Experimental Group 2

Control Group

Participants in all three groups were required to complete a set of questionnaires. These were the Spielberger State-Trait Inventory (STAI) Form Y-1, and the researcher-designed questionnaire called 'Aggressive incidents involving a client at work' which contains a scale to measure Confidence in Dealing with Aggression. Experimental Group 1 were then given a leaflet to read and had a discussion with the researcher about the

leaflet. Experimental Group 2 were given a leaflet to read in their own time, but had no discussion. The control group were not presented with a leaflet.

Two weeks later all three groups were required to complete a second set of the same questionnaires (STAI Form Y-1, and the researcher-designed questionnaire). Changes on scores could then be measured for all the groups.

The design was "nested", eg. only one experimental group in each home was used, because of the possibility of staff conferring with each other leading to intergroup contamination.

2.2 Participants

The sample consisted of 65 people who were each required to complete two sets of questionnaires. Of that 65 twelve did not return the second set of questionnaires. Thus, there were 53 participants used in the analysis (see Table 1). They consisted of qualified and unqualified care staff working in homes for learning disabled clients and who were a) on duty at the time the researcher visited the home, and b) willing to participate in the study. The study used two experimental groups and a control group which were matched across groups for type of home, but it was not possible to deliberately match staff across these groups in terms of age, gender etc. However, analyses applied to the data prior to

intervention ascertained that there were no significant differences in any demographic variables across groups (see Results section). For information on non-responders also see Results section.

<ul style="list-style-type: none">• 33 females, age range 19 - 48 years. (Mean = 30.6 years, SD 8.077). 20 males, age range 22 - 53 years. (Mean = 34.2 years, SD 8.407). • Time worked in the learning disability service ranged from less than one year to 29 years: Females: Mean =7.7 years, SD =5.7 Males: Mean =7.6 years, SD =7.3 • 23 participants were qualified (RNMH): 45% women (n =15). 35% men (n = 7). • 40 participants had suffered an attack by a client while at work: 76% women (n =25). 80% men (n =16). • 10 participants had undergone "Breakaway" training: 15% women (n =5). 25% men (n =5).

Table 1. Demographic data of participants.

2.2.1 Composition of Groups

Each group comprised staff working in homes matched as far as possible on the type of home, eg. each group had a local support unit (LSU), a challenging behaviour unit, one or two 3-bedded homes and one or two 6-bedded homes (see Table 2).

<u>Group 1</u>	<u>Group 2</u>	<u>Control Group</u>
(Leaflet + discussion)	(Leaflet only)	(No leaflet)
Local Support Unit	Local Support Unit	Local Support Unit
Challenging Behaviour Unit	Challenging Behaviour Unit	Challenging Behaviour Unit
6+ bed home	6+ bed home	6+ bed home
6 bed home	6 bed home	2 x 3 bed home
3 bed home	2 x 3 bed home	
Participants = 17	Participants = 17	Participants = 19

Table 2. Experimental Groups.

This composition meant that each group comprised a cross-section of staff dealing with varying degrees of aggressive behaviour. The homes ranged from those with residents who displayed little or no violence, to those with residents who may display a high degree of violence.

Homes from different localities in the health district were used (Exeter, Exmouth, Crediton, Honiton, Tiverton, Okehampton). Thus each group might typically consist of one or more homes of a different type from each of Exeter, Tiverton, Exmouth and Honiton.

2.2.2 Description of types of home

The small 3-bedded homes tended to be a 'home for life' for the residents where they were well settled and displayed little or no aggressive behaviour. Staff/client ratio in this type of home is usually 1:3.

The 6-bedded homes also tended to be a 'home for life', but there were slightly higher levels of aggressive behaviour in these homes. Staff/client ratio in this type of home is also likely to be 1:3.

The local support units (LSUs) generally take people for a short period of time (anything from overnight to a few weeks) for a variety of reasons, including respite care or the management of a particular problem. The nature of LSUs is that they take people with a range of problems, and thus aggression is more unpredictable, both in terms of the staff not necessarily knowing the client very well, and from the client's point of view it may be a stressful upheaval. In addition, admittance to an LSU may be primarily because of aggressive behaviour. Aggression may also be a concern in an LSU because of the possible presence of physically frail clients. Staff/client ratio is usually 1:3.

The challenging behaviour units are homes for people whose behaviour warrants a higher staff ratio than usual. They tend to be fairly long-term placements and the risk of aggressive behaviour is higher than in any other home setting in the learning disability service. Staff/client ratio is usually 2:3.

The levels of aggression in the different types of home were ascertained by an examination of accident reports, and the subjective impression of people working in the learning disability service.

2.3 Materials

Researcher designed information leaflet entitled "Preventing and coping with an aggressive incident involving a client in your care". (See Appendix A).

2.3.1 Construction of the information leaflet

The construction of the leaflet took place in the following way. The researcher gleaned relevant information from talking to staff in the learning disability service and from information in a previous study (Ivens, 1991), about events surrounding a violent incident, eg. the precursors to an incident, what may happen during one and the feelings staff are likely to have following one, plus some actions which staff need to take.

This information was compiled into a pilot leaflet laid out in three sections entitled 'Prevention', 'Intervention' and 'Aftermath', plus the front page had two short paragraphs to introduce the contents of the leaflet. The final page included the information that the Occupational Health and Psychology Departments both have trained staff to help people get over traumas, and provided the relevant telephone numbers for staff to seek counselling if they so wished.

The layout and content of the leaflet took into account research summarised by Ley (1988) demonstrating the best ways of providing information so that it is read and remembered. In a clinical situation,

while the majority of patients claim to have read information given to them, on average about 30% claim not to have done so (Berry et al, 1981). To improve on this figure the usual way of increasing the likelihood that something will be read is to increase the understandability of the material.

The way in which the researcher compiled the present leaflet took into account the following: using shorter rather than longer words, and shorter rather than longer sentences (Klare, 1976); using the active rather than the passive voice; using concrete rather than abstract words and sentences; using bulleting to present facts in a paragraph (Kanouse & Hayes-Roth, 1980).

The following information, summarised by Poulton et al (1970) was noted in the compilation of the leaflet: type should be at least 10 point; titles all in capitals are harder to pick out; printing in capitals reduces speed of comprehension; printing in italics reduces speed of reading; headings should be made to stand out by the use of a different type face or by the use of space.

2.3.2 Measuring the understandability of the information leaflet

The commonest method of evaluating written materials has been to apply a readability formula which yields an estimate of the reading grade required for understanding that material, and also permits an estimate to be made of the percentage of the population likely to understand the piece

of writing. One of the formulae most often used in research into the understandability of written health-related information is the Flesch formula (Flesch, 1948).

The Flesch formula uses a regression equation for predicting difficulty of text from the predictors of word length and sentence length used in the text being measured. In general, it would be expected that polysyllabic words will be harder to comprehend than words with fewer syllables. Similarly, it would be expected that longer sentences would be harder to understand than shorter sentences. Further, it would be expected that rare words would be harder to understand than words in common use.

The leaflet was subjected to the Flesch reading ease formula for comprehensibility and gave a score of 70.5 indicating that it would be easily read by 90% of the population.

2.3.3 Approval of the information leaflet

The pilot leaflet was shown to all five service directors of Exeter's learning disability service, and the liaison clinical psychology supervisor, for their comments and suggestions. The final product incorporated certain suggested procedural changes (see section 4.3) after discussion with the overall service director and psychology supervisor, who both agreed the final version.

2.4 Measures

2.4.1 Form Y-1, State Anxiety

Form Y-1, State Anxiety (see Appendix B) has 20 items measuring state anxiety, from the Spielberger State-Trait Questionnaire. The wording on the instructions was altered from

"Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you feel right now, that is, at this moment."

to

"Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you think you would feel in the event of a violent incident at work."

The handbook to the questionnaire states that "In addition to how people feel 'right now' the STAI-S Anxiety Scale may also be used to evaluate how they felt at a particular time in the recent past and how they anticipate they will feel either in a specific situation that is likely to be encountered in the future or in a variety of hypothetical situations.....Instructions for the S-Anxiety scale may be modified to evaluate the intensity of S-Anxiety for any situation or time interval of interest to an experimenter or clinician." (See Appendix C for description of the scale.)

The trait-anxiety scale was not administered (on the assumption that it would not show changes) as it is designed to reflect general levels of anxiety.

2.4.2 Researcher designed questionnaire

The researcher designed a questionnaire (entitled 'Aggressive incidents involving a client at work'; see Appendix D), the construction of which was guided by the need to obtain the following information¹:

- a) Demographic information, eg. job title, gender, age, whether qualified, length of time worked in learning disability, training courses in dealing with aggression and how useful they had been.
- b) Information on any experience of being attacked at work. (Qs. 2,3 & 4).
- c) Whether information had been assimilated after reading the leaflet. (Qs. 13,14 & 15). Thirteen points were selected as relevant from the leaflet which participants could know after reading it. These were: observation; empathy, importance of own actions; predict ahead; restraint (use minimum force); get help from other staff if possible; must avoid injury; remove dangerous items; withdraw if not exposing others to risk; talk over feelings; form filling procedures; speak to team leader or manager.
- d) Statements from staff on
 - i) anything that could be provided to lessen the likelihood of a violent incident occurring at work,

¹ The question numbers from the questionnaire appear in brackets beside the description of the relevant items.

- ii) anything which could help them to cope at the time of a violent incident occurring at work, and
 - iii) anything that could make them feel better in the days and weeks following a violent incident occurring at work. (Qs. 16,17 & 18). These questions were asked in order to be able to make recommendations for change, based on staffs' own perceived needs, to managers in the learning disability service.
- e) Eight item scale constructed to glean information about a person's confidence in being able to deal with an attack in various situations. (Qs. 5-12). This scale used a unidimensional structure and was assigned a Likert scoring method.

The eight questions were based around variations

- i) in the type of client (defined as 'typical' or 'most difficult') that the staff member had in their care;
- ii) as to whether they were on duty on their own or with another member of staff; and
- iii) as to whether the attack was directed as themselves or another person,

eg. 'If you were on duty with at least one other member of staff would you feel confident that you could deal with a violent incident directed at *them* involving a *typical* client in your care?' or 'If you were on duty with at least one other member of staff would you feel

confident that you could deal with a violent incident directed at *yourself* involving a *typical* client in your care?'

For validation purposes the scale was subjected to coefficient alpha (Cronbach, 1951) and found to have a correlation coefficient of 0.9 indicating high internal consistency. Test-retest reliability was confirmed by no changes in scores being found in the two questionnaires completed by the control group.

The questionnaire was constructed and piloted on four student nurses, two trainee clinical psychologists and three other people not connected with the health service, for comprehensibility and relevance of questions to the information required. A number of small changes were made in response to suggestions from this pilot sample. The final version was agreed by the liaison clinical psychology supervisor and the overall director of learning disability services.

The questionnaire was subjected to the Flesch reading ease formula for comprehensibility and gave a score of 65.06 indicating that it would be easily read by 90% of the population.

2.5 Procedure

Prior to the start of the project, approval for the work was sought and granted from the board of Exeter's Learning Disability service.

The collection of data was carried out between August and November 1992.

2.5.1 Selection of homes

Homes selected for the study were made in conjunction with the supervising liaison clinical psychologist and service director of the Exeter learning disability service, based on the need to match each type of home (whether small group home, local support unit or challenging behaviour unit) across the different localities within Exeter Health Authority.

2.5.2 Initial Contact

Team leaders of the selected homes were written to (see Appendix E) giving them brief details of the study, asking them to tell their staff about the proposed study and inviting their staffs' participation. The content of the letter was slightly different for each group (Appendix E.1 to E.3). The team leader was also told that the researcher would be telephoning the following week to find out if they would be willing to participate, and if so, to make an appointment for the researcher to visit.

The researcher phoned the following week and made appointments to visit the homes. No team leader refused permission for their staffs' participation.

2.5.3 Visiting the Homes

The procedure during the visit was different for each group but all began as follows:

The researcher introduced herself and gave a brief explanation as to the reason for the research (that it was part of her training in clinical psychology and that she was interested in staffs' feelings about aggression at work). The researcher explained that the participants would be required to not only complete the two questionnaires that day, but would be required to complete two more in approximately two weeks time (so that anyone who was not willing to do this would be excluded from the study at this point). All agreed to this.

At this point the procedure was slightly different for each group:

Experimental Group 1 (Leaflet plus discussion)

For Experimental Group 1 the procedure was then as follows: The researcher explained that after they had completed the two questionnaires that day she would give them a leaflet to read and would like to have a short group discussion afterwards to find out their opinions of it. She then distributed the questionnaires, explained how to complete them and gave people the opportunity to ask questions before they began if there was anything they did not understand on either questionnaire. Anonymity and confidentiality were assured.

As each participant completed their questionnaires the researcher gave them the prepared leaflet to read. When all the participants had finished reading the leaflet the researcher began the discussion with asking the following:

1. Did you find the leaflet easy to read and understand?
 2. Did the leaflet cover all the necessary information ?
 3. Would the leaflet be useful for new staff?
 4. Would the leaflet be useful for experienced staff?
 5. Is there any other information which could have been included?
 6. Could the leaflet make a new staff member nervous?
- Any other comments.

Experimental Group 2 (Leaflet only)

For Experimental Group 2 the procedure was as follows: The researcher explained that after they had completed the two questionnaires that day she would give them a leaflet to read. She then distributed the questionnaires, explained how to complete them and gave people the opportunity to ask questions before they began if there was anything they did not understand on either questionnaire. Anonymity and confidentiality were assured.

As each participant completed their questionnaire the researcher gave them the prepared leaflet with the instruction "Please read this sometime within the next few days."

Control Group (No leaflet)

For the Control group the procedure was as follows: The researcher distributed the questionnaires, explained how to complete them and gave people the opportunity to ask questions before they began if there was anything they did not understand on either questionnaire. Anonymity and confidentiality were assured. No leaflets were presented.

The procedure for all three groups ended as follows: All were thanked for their participation and reminded that they would be required to complete two more questionnaires in approximately two weeks time. Each team leader was given the second batch of questionnaires with an envelope for each participant to use to keep the information confidential, plus a large stamped, addressed envelope for all questionnaires to be posted back to the researcher.

2.5.4 Follow-up letter

At the beginning of the second week following the researcher's visit the researcher sent out a reminder letter (see Appendix F) to team leaders thanking them again for their staffs' participation, and asking them to remind their staff to complete the second questionnaires.

2.6 Procedural Issues

The procedures for Experimental Groups 1 and 2 were intended to simulate a real life situation, either of which might occur if a team leader was giving out an information leaflet to staff, eg. he/she may follow up the giving out of the leaflet with an opportunity for discussion on issues contained in the leaflet (as in Group 1) or he/she may just hand out the leaflet with no explanation other than to 'read it sometime' (as in Group 2). By having these two different experimental conditions it should be possible to tell which, if either, method of presenting the leaflet would be more effective at lowering anxiety and increasing confidence in dealing with aggression.

Incorporated in the procedure for Experimental Group 1 was a short evaluation of the leaflet. By revolving the discussion around the questions asked, it not only simulated a team leader discussing the leaflet with a member of staff, but allowed an objective evaluation of the important points in the leaflet.

2.7 Analysis

The hypotheses were tested using Multivariate Analysis of Variance and t-tests. A post hoc analysis used Pearson's Product Moment Correlation. In addition, initial demographic data were subjected to Analysis of

Variance and Chisquare tests to check for homogeneity of variables across groups.

Chapter 3

Results

Statistical analyses were carried out by computer using the Statistical Package for the Social Sciences - Personal Computer (SPSS/PC).

It had not been possible to select a truly random sample of participants because of the shift and rota system in the homes and because only one visit to each home was possible because of the risk of future participants no longer being naive if subsequent visits were undertaken. Therefore tests for homogeneity across groups of the variables of gender, whether qualified, whether undergone Breakaway training, whether been attacked, age, and length of time worked in learning disability were carried out before analysis of the hypotheses. These data were obtained from the pre-intervention questionnaires.

Analyses were also carried out to establish whether there were any significant differences across the three groups in pre-intervention anxiety scores, and pre-intervention confidence in dealing with aggression scores.

In addition, means and SDs were computed for non-responders with the second questionnaires. Data were used from the initial questionnaires. This was to establish that anxiety and confidence levels were not significantly different from that of participants who did complete both sets of questionnaires, as very high levels of anxiety or low levels of confidence may have been a factor in the non-responding.

3.1 Initial analyses to test for homogeneity of all variables

The initial analyses carried out to test for homogeneity of all variables across groups are presented below.

A Chi-square test showed no differences in any of the following:

Gender across groups:

Chi-square = 2.77; df2; p = 0.25

Whether qualified across groups:

Chi-square = 5.43; df2; p = 0.067

Whether undergone Breakaway training across groups:

Chi-square = 2.11; df2; p = 0.34

Whether been attacked across groups:

Chi-square = 1.93; df2; p = 0.38

A One-Way Analysis of Variance showed no differences in any of the following:

Age across groups:

Group 1	m = 32.9	SD = 9
Group 2	m = 34.7	SD = 8.7
Control	m = 29	SD = 6.5

$$F(2) = 1.82; p = 0.17$$

Length of time worked in learning disability across groups:

Group 1	m = 6	SD = 5.2
Group 2	m = 10.7	SD = 6.9
Control	m = 6.4	SD = 5.7

$$F(2) = 3.2; p = 0.48$$

Levels of anxiety across groups:

Group 1	m = 46.6	SD = 9.2
Group 2	m = 42.7	SD = 12.1
Control	m = 46.6	SD = 10.9

$$F(2,50) = 0.472; p = 0.63.$$

Levels of confidence in dealing with aggression across groups:

Group 1	m = 27.6	SD = 6
Group 2	m = 30.4	SD = 6.3
Control	m = 29.2	SD = 6.1

$$F(2,50) = 0.89; p = 0.42$$

Thus there were no significant differences in any of the above variables across the three groups and participants can be said to come from the same population.

3.2 Non-responders

It was thought useful to obtain some data on the twelve participants who did not respond with the second set of questionnaires, despite having completed the first set. Means and SDs were computed for these participants' levels of anxiety and levels of confidence in dealing with aggression.

Anxiety $m = 47$ $SD = 10.2$

Confidence $m = 28$ $SD = 6$

These scores are substantially the same as those of the participants, so it appears unlikely that reasons for not completing the second set of questionnaires include very high levels of anxiety or very low levels of confidence in dealing with aggression.

Five non-responders were followed up by telephone. Reasons given for not responding were:

- a) didn't have time to do it ($n = 2$);
- b) lost the questionnaire ($n = 1$);
- c) didn't realise had to complete a second questionnaire ($n = 2$).

The results of the main hypotheses are presented below:

Analysis of the three main hypotheses was carried out using data from the pre and post-intervention questionnaires.

3.3 Hypothesis 1

Staff who receive an information leaflet will have significantly lower anxiety levels about aggression at work than those who do not receive the leaflet, as measured by the Spielberger STAI Form Y.

A split plot analysis of variance to compare the differences in anxiety levels across the three groups was carried out. There was a between-subjects factor of group, and a within-subjects factor of time of test (prepost).

Pre-intervention anxiety scores

Group 1	m = 46.6	SD = 9.2	N = 17
Group 2	m = 43.0	SD = 12.1	N = 17
Control	m = 46.7	SD = 11	N = 19

Post-intervention anxiety scores

Group 1	m = 43.1	SD = 9.4	N = 17
Group 2	m = 38.5	SD = 9.3	N = 17
Control	m = 44.3	SD = 10	N = 19

Main Effects

Group $F(2,50) = 1.28; p = 0.29$
Anxiety (prepost) $F(1,50) = 19.61; p = 0.001$

Interaction

Group x Prepost $F(2,50) = 0.52; p = 0.6$

The above are illustrated in Figure 1.

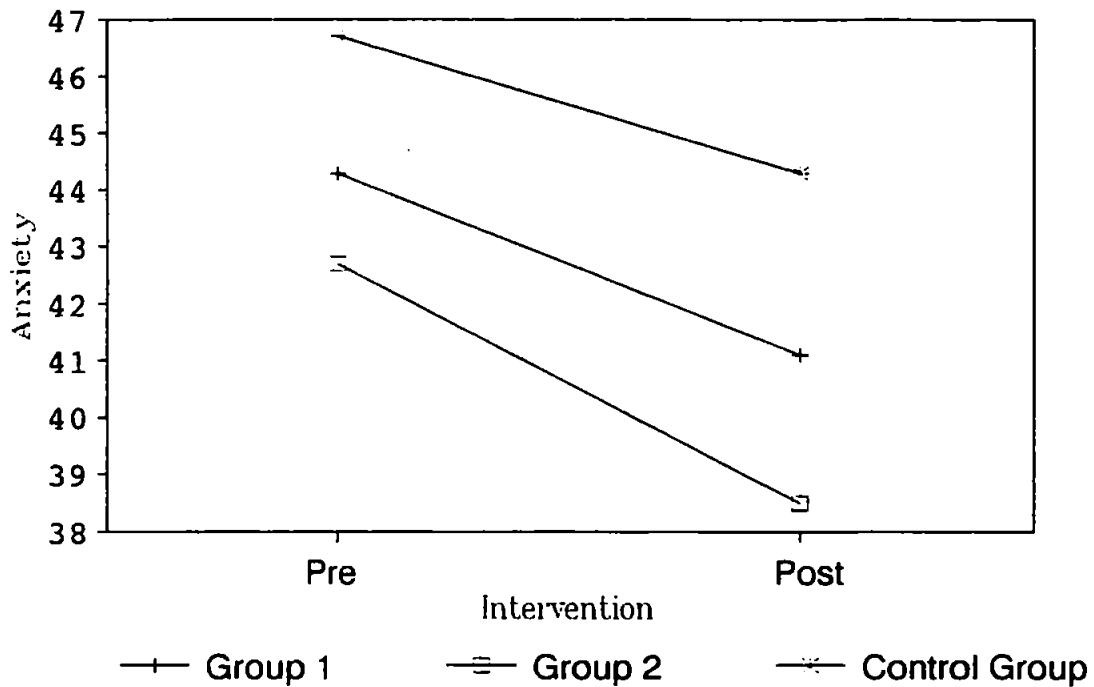


Figure 1: Pre and Post Intervention Anxiety Scores.

Thus there was a significant main effect of anxiety (prepost) with subjects scoring lower on the second Spielberger Form Y, but no significant main effect of group, nor any significant interaction. As there was no significant interaction hypothesis 1 was not confirmed.

3.4 Hypothesis 2

Staff who receive the information leaflet will have significantly higher levels of confidence in dealing with aggression than those who do not receive the leaflet, as measured by the researcher-designed Confidence in Dealing with Aggression scale.

A split plot analysis of variance to compare the differences in levels of confidence in dealing with aggression was carried out. There was a between-subjects factor of group and a within-subjects factor of time of test (prepost).

Pre-intervention confidence scores

Group 1 $m = 28$ $SD = 6$ $N = 17$

Group 2 $m = 30.4$ $SD = 6.3$ $N = 17$

Control $m = 29.6$ $SD = 6.1$ $N = 19$

Post-intervention confidence scores

Group 1 $m = 26.1$ $SD = 6$ $N = 17$

Group 2 $m = 31.4$ $SD = 5.3$ $N = 17$

Control $m = 30$ $SD = 5.4$ $N = 19$

Main Effects

Group $F(2,50) = 2.25$; $p = 0.116$

Confidence (prepost) $F(1,50) = 0.18$; $p = 0.68$

Interaction

Group x Prepost $F(2,50) = 2.05$; $p = 0.14$

The above are illustrated in Figure 2.

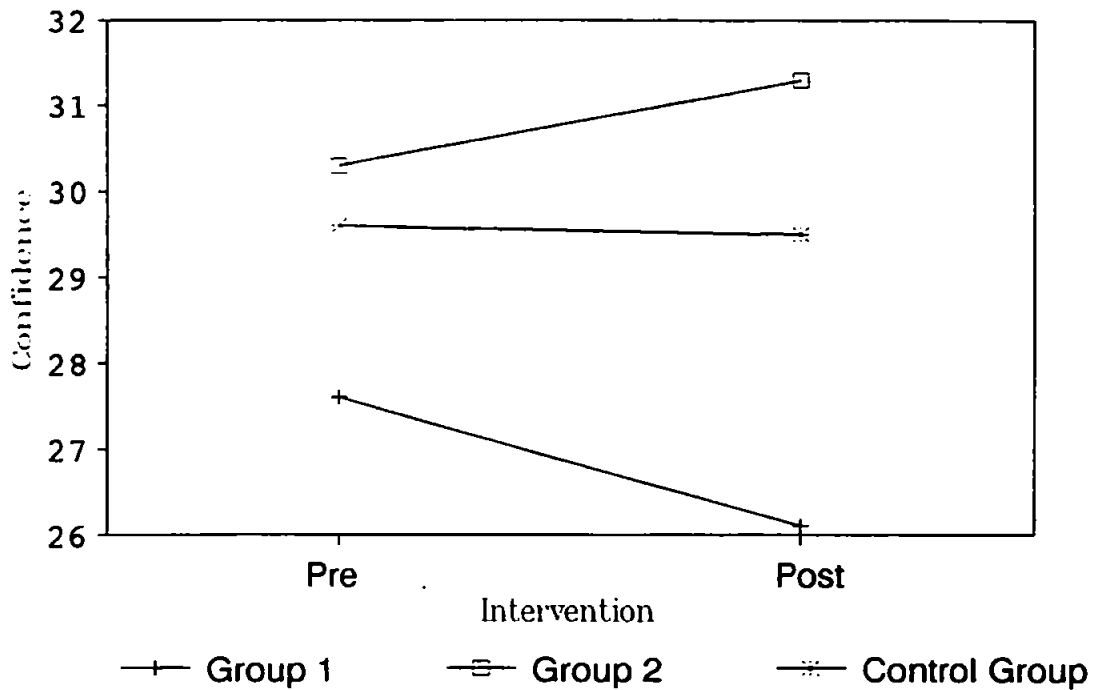


Figure 2: Pre and Post Intervention Confidence in dealing with Aggression Scores.

Thus, there were no significant main effects of confidence (prepost), or group, nor any significant interaction. As there was no significant interaction hypothesis 2 was not confirmed.

3.5 Hypothesis 3

After reading the leaflet staff will show an increase in knowledge about issues surrounding aggression at work.

A t-test comparing knowledge before reading the leaflet and knowledge after reading the leaflet was carried out to see if participants assimilated

the information contained in the leaflet. 13 discrete items of information from the leaflet were selected, knowledge of which could then be scored. Each item was assigned a score of 1. An individual's score could thus range from 0-13.

Groups 1 + 2 (n = 34):

pre-leaflet knowledge $m = 1.58$ $SD = 1.83$

post-leaflet knowledge $m = 2.11$ $SD = 2.87$

2-tail prob = 0.245

Thus, there was no significant difference in knowledge about issues surrounding aggression at work after reading the leaflet. Hypothesis 3 was not confirmed.

Having tested the main hypotheses it was then decided to carry out post hoc analysis to see whether, after reading the leaflet, there is an association between information known about aggression and

a) level of anxiety, and

b) level of confidence in dealing with aggression.

These analyses were carried out using data from the post-intervention questionnaires.

3.6 Post hoc analysis

3.6.1 Information and Anxiety

A Pearson's product moment correlation coefficient was computed between anxiety levels, as measured by the STAI Form Y, and information scores after reading the leaflet.

$$\text{Pearson } r = - 0.18; p = 0.16$$

Thus there is no significant association between information known about aggression and level of anxiety.

3.6.2 Information and confidence in dealing with aggression

A Pearson's product moment correlation coefficient was computed between levels of confidence in dealing with aggression, as measured by the researcher-designed scale, and information scores after reading the leaflet.

$$\text{Pearson } r = 0.37; p = 0.016.$$

Thus there is a significant association between information known about aggression and level of confidence in dealing with aggression, eg. the more knowledge subjects had the higher their levels of confidence. However the r-squared value of 0.13 indicates that only 13% of the variance is explained by this.

3.7 Additional aims for which no statistical analysis was carried out

3.7.1 Aim No. 4. To evaluate the content of the information leaflet.

This was carried out by discussion, and calculating percentages of 'yes' and 'no' answers to questions asked.

To accomplish a short evaluation of the leaflet, participants in Group 1 were asked their opinions of the leaflet as part of the discussion with the researcher after reading it. Although for the purposes of the analysis of the research hypotheses Group 1 comprised 17 participants, for the evaluation of the leaflet two further participants were used. These two participants completed the pre-intervention questionnaires and took part in the discussion but did not complete and return their post-intervention questionnaires in time for analysis. Thus although they could not be included in the analysis of the research hypotheses they participated in the group discussion. Hence the leaflet was evaluated by 19 participants.

Table 3 shows the six questions asked by the researcher and the percentages of participants either agreeing or disagreeing.

QUESTION	Yes	No
1. Did you find the leaflet easy to read and understand ?	18 (95%)	1 (5%)
2. Did the leaflet cover all the necessary information ?	17 (89%)	2 (11%)
3. Would the leaflet be useful for new staff ?	18 (95%)	1 (5%)
4. Would the leaflet be useful for experienced staff ?	18 (95%)	1 (5%)
5. Was there any other information which could have been included ?	1 (5%)	18 (95%)
6. Could the leaflet make a new staff member nervous ?	2 (11%)	17 (89%)

Table 3. Results of questions asked by researcher.

See 'Discussion' Section for other comments.

The following aims were carried out using information provided by participants in all three groups. These aims had been suggested by one or more service directors of the learning disability service as providing useful information for managers.

3.7.2 Aim No. 5. To see if participants felt that their team leader regarded an attack as seriously as they themselves did.

Data from the pre-intervention questionnaire were used.

Participants were asked to rate the severity of an attack (if any) that they had sustained, on a scale from trivial to very serious. (If they had sustained more than one they were asked to rate the most serious). They

were then asked to rate the severity they thought their team leader had regarded the same attack.

Overall 78% (n = 41) of participants stated that they had suffered an attack at work. Of that 78%, 75% (n = 31) rated the attack as moderately serious or worse.

The same participants estimated that 62% (n = 26) of their team leaders rated the same attacks as moderately serious or worse.

This appears to show some discrepancy between how serious staff feel an attack is, and how seriously they feel that their team leader regarded the same attack.

3.7.3 Aim No. 6. To find out what additional support staff would like to have.

Suggestions were sought to find out what additional support staff would like to have to:

- a) lessen the likelihood of a violent incident occurring at work,
- b) help them cope at the time, and
- c) help them feel better in the days and weeks afterwards.

Data from the pre-intervention questionnaire were used.

The total number of suggestions were collated and the most frequently occurring are reported below:

In answer to the question "Please state anything which you feel that could be provided which would lessen the likelihood of a violent incident occurring at work" the following suggestions were made:

	Participants
Adequate or extra staffing levels	37%
Breakaway or training	23%
Alarm or emergency call system	6%

In answer to the question "Please state anything which you feel would make it easier to cope at the time, in the event of a violent incident occurring at work" the following suggestions were made:

Extra or enough staff	28%
Breakaway or training	15%
Time away from the unit	15%
Emergency alarm system	8%

In answer to the question "Please state anything which you think would help you feel better in the days or weeks following a violent incident occurring at work" the following suggestions were made:

Talking it through with someone	34%
Support from staff or group	26%
Time off	6%

Chapter 4

Discussion

The main aims of the research were to find whether the provision of written information in a leaflet about issues surrounding aggression and violence at work would lower anxiety and increase confidence in dealing with aggressive incidents, in care staff working in learning disability. Further aims were to find out whether information contained in the leaflet is assimilated, and to carry out an evaluation of the content of the leaflet.

This research was carried out with the cooperation of Exeter's Learning Disability Service and the following aims were included in the study to provide information for managers. To see if participants feel that their team leader regards an attack as seriously as they do themselves; and to find out what additional support participants would like to have to lessen the likelihood of a violent incident occurring at work, to help them cope at the time, and what would make them feel better in the days and weeks after an incident. ◦

This discussion will consider the above aims, see whether they were achieved, and look at implications of the findings for practice and future research. It will also consider the above with regard to the particular experimental design used, and issues regarding the construction of the information leaflet.

None of the main hypotheses were proven. No differences in levels of anxiety or confidence in dealing with aggression were found, depending on whether participants had received the information leaflet or not. Neither did information appear to be assimilated by the participants who received the leaflet. However, a significant finding was that anxiety within all the groups (including the control group) was lower at the time of completion of the second set of questionnaires. The implications of this finding will be discussed.

4.1 Aim No. 1

The first aim, that of seeing whether provision of written information reduces anxiety, was based on the premise of written information reducing anxiety in hospital patients about to undergo unpleasant medical procedures (Janis, 1958). There are a number of possible reasons as to why a lowering of anxiety did not occur in the present research. Anxiety was in fact lowered within each group, but in the control group also, so it is not possible to state that the effect was due to the provision of the leaflet.

Firstly, the participants in the present research were not sick hospital patients, but presumably healthy employees of the learning disability service. The common factor between these two groups was the assumption of anxiety about a particular event that was likely to take place. It is not necessarily possible to make generalisations between the two groups.

It was then considered that maybe the assumption that learning disability staff are anxious about aggression at work is incorrect. It came from the researcher's experience of talking to staff, and from a pilot study (Ivens, 1991). This pilot study had been carried out in response to growing concern by other clinical psychologists working in learning disability that there was a problem. Certainly during the period of data collection participants made repeated comments such as "It's about time someone did something about aggression at work" and "I'm really pleased that a start is being made." Comments such as these would appear to indicate concern about aggressive situations that staff may find themselves in, but this concern may possibly not be directly translated into anxiety.

However, as stated above, anxiety was reduced over time within each group, so it would appear that anxiety was a pertinent construct to measure, but that providing written information was not necessarily the way to reduce it.

Other studies looking at staff stress (eg. Dewe, 1987a) have taken more global measures and not concentrated on anxiety about aggression per se. It would be useful to find from staff what they see as the most stressful areas in their working lives, and interesting to see what, if any, ranking that aggression from clients was given when considering stressors of all types at work.

A number of studies have pointed to denial as being a strong factor in staff when faced with aggression from patients (eg. Wykes & Whittington, 1991) and it is possible that denial was operating in the current research sample. As stated in the Introduction, care staff have an image of being in control and they may purposely have hidden or denied feelings of anxiety. But again this does not seem very likely as anxiety was not denied, at least not on the anonymous questionnaires.

The significant finding that anxiety levels were lowered in all three groups over time is interesting. As anxiety in the control group was also lowered this effect can not be due to the provision of the information leaflet. It is thought that the most likely reason for this finding is the Hawthorne Effect, ie. that any intervention works, at least for a time. The fact of the researcher going to homes, showing an interest in participants' feelings and views and possibly sparking off discussions at work or changes in working environments may have been enough to decrease levels of anxiety.

Another possibility for this finding could be the effect of repeating the completion of a questionnaire. Bendig & Bruder's (1962) paper on The Effect of Repeated Testing on Anxiety Scale Scores, shows that Windle (1954,1955) found that "subjects appear to become slightly more 'normal' or less anxious on the second administration of a personality questionnaire". The same improved finding was not shown on the researcher scale to measure confidence in dealing with aggression, but it is not known if it is reasonable to expect that subjects completing a scale such as this will appear 'slightly more normal' on the construct 'Confidence in dealing with aggression' or whether repeated testing will only affect anxiety.

It is also possible that the difference in the conditions under which participants completed the questionnaires might have affected the scores. The presence of the researcher the first time but not the second may have led to a higher estimate of anxiety whilst completing the pre-intervention questionnaire.

Anderson & Masur (1983) in summarising 24 studies of information provision with hospital patients, note that self-reports of anxiety are less affected than behavioural ratings of adjustment and discomfort. Information provision may facilitate ability to cope, or may at least modify apparent, observable coping ability, rather than being an effective way to reduce anxiety.

Finally, it must be taken into account that from reviews of various studies (eg. Ludwick-Rosenthal & Neufeld, 1988), it is clear that information provision is not always effective in reducing anxiety, and the role of individual differences in determining who will benefit from a particular type of intervention can not be ignored. This will be discussed further in the following section.

4.2 Aim No. 2

The second aim, that of seeing if written information would increase confidence in dealing with an aggressive incident was also linked to research carried out in medical situations, and it was hypothesised that provision of information would not only reduce anxiety, but also increase confidence in dealing with an aggressive incident by enhancing personal control and facilitating coping strategies.

There were no significant changes found on this measure, either between groups or within groups. It is possible that there was a tendency for participants to not consider each question thoroughly, as at first glance the questions appeared very similar, and the pressure of completing the questionnaire quickly may have affected the responses. (This issue to be discussed in the 'Methodology' section).

The present research did not consider participants' coping strategies, eg. problem-focused or emotion-focused coping, apart from the relevance that

Lazarus & Folkman's (1984) cognitive appraisal model has for obtaining factual information with a view to problem-solving. It would be useful in future research to identify those who would benefit from information provision (variously referred to as copers, sensitisers, monitors and internals). Those who habitually seek to distract themselves or avoid anxiety-provoking information (variously referred to as avoiders, repressors, blunters and externals) are not likely to benefit from information provision, but may benefit from more emotion-focused interventions. It is interesting that, in the present research, the one participant who, during Group 1's discussion with the researcher, said "I prefer not to know beforehand - just deal with aggression when it happens", was the same participant who said that the leaflet "might put new staff off" and was "too long-winded". If it were possible to identify the 'copers' as opposed to the 'avoiders', preparation for events such as aggression at work could be tailored more for the individual.

In addition, individual differences in locus of control and receptivity to information provision would be a useful area to research. Locus of control was first proposed by Rotter (1966) and is used to refer to the perceived source of control over one's behaviour, eg. an internal person being one who tends to take responsibility for his own actions and views himself as having control over his own destiny. An external person tends to see control as residing elsewhere and to attribute success or failure to outside forces. A study by Auerbach et al (1976) investigated individual

differences in locus of control and receptivity to health-care information in relation to the efficacy of information provision. The internal locus of control group who received specific information had better behavioural adjustment ratings than internals who had received general information, with the pattern reversed for the external group. This emphasises that, as above, the role of individual differences can not be ignored and must be taken into account when planning services for staff.

4.3 Aim No. 3

The third aim, to see if participants assimilated information from the leaflet, was necessary because if it was found that information was not assimilated, any changes found in anxiety levels and confidence in dealing with aggression could not be due to gleaning knowledge from the leaflet. The issues here are three-fold.

1. Establishing whether information has been read.
2. Finding if information was understood.
3. Finding if information would be reproduced on a questionnaire.

The first issue, that of establishing whether information has been read, would appear at first sight to be straightforward. Group 1 were given the leaflet and read it while the researcher was present. However, as Berry (1981) states "While the majority of patients claim to have read the information given to them, on average about 30% claim not to have done so". Thus it can not be assumed that because the participants appeared to

be reading the leaflet they actually were. Without an immediate test there is no way of knowing how thoroughly the leaflet was read. In this case it is thought that the majority of participants in Group 1 did read the leaflet and that the discussion that followed their reading of the leaflet was likely to alert them more to its content than the method which Group 2 underwent. Participants in Group 2 were given the leaflet to take away, with the instruction "Please read this sometime in the next few days." There is no way of being certain that participants in this group did read the leaflet.

The way in which assimilation of information was measured was by the researcher selecting 13 discrete pieces of information contained in the leaflet, and assigning one point to each piece of information known. Questions 13, 14 and 15 on the researcher-designed questionnaire asked for knowledge of procedures surrounding aggression at work. Thus an individual's score could range from 0-13. The pre-intervention and post-intervention scores were compared. There were a number of problems inherent in this method of testing for information assimilated.

The mean number of correct responses from people who had read the leaflet was 2.11. This would be an extremely low score for any member of staff working in learning disability, whether they had ever been given written information or not. By dint of working in the service it would be expected that the majority of staff would know a few common sense procedures in the event of an aggressive incident and what to do after it.

Again it seems likely that the circumstances in which participants completed the questionnaires may have accounted for the sparse and very poorly informed answers. It is not known how long participants took, and how considered were their responses for the completion of the second questionnaire.

It is possible that even if participants had read the leaflet thoroughly and understood the content they may not have recalled the information contained in it at the particular moment of completing the questionnaire.

It is also possible that the discrete pieces of information that the researcher selected as the ones to test for assimilation of knowledge were not the ones that participants had remembered, and that they could have assimilated some information but not the information that was being tested for. However, it is thought that the 13 items represented all the main points contained in the leaflet and that it was unlikely that this would have been a factor in the poor answers.

The participants were not given any indication that Questions 13, 14 and 15 on the researcher-designed questionnaire were testing for knowledge from the leaflet having been assimilated. Had the participants been informed that this was so, the answers may have been more comprehensive.

The layout and content of the leaflet must also be considered in a discussion of why information did not appear to be assimilated. As stated

in the Method, the usual ways of presenting information so that it is read and remembered were adhered to. As Klare (1976) states "In non-clinical contexts increasing readability has been shown to increase the probability that a piece of writing will be read".

The researcher had proposed that the original pilot leaflet would have a section of diagrams on restraint procedures. This was vetoed by the overall service director of the learning disability service as he considered it too risky in case staff incorrectly followed these diagrams and injured a client. Whilst this was understood and acceded to by the researcher, it was also felt that this omission lessened the impact of the information leaflet. Investigations carried out by Ley & Morris (1984) have shown that the use of illustrations in conveying information has mixed results. Firstly, illustrations might act as distractors, and thus divert attention from the text. Secondly, people often spontaneously develop images which help them comprehend and remember text. Illustrations provided in the text might, in some cases, be in conflict with those spontaneously produced images and thus reduce their effectiveness. Thirdly, in the case of medical information, it is possible that some illustrations might be anxiety provoking or aversive to some readers. Thus, it is not self-evident that illustrations will improve understanding or recall. However, others have shown diagrams to be infinitely superior, especially when depicting medical procedures, eg. the insertion of eye-drops and when technical terminology is involved (Wright, 1977). It is felt by the researcher that

the omission of diagrams on restraint procedures lessened the impact of the leaflet and possibly its memorability.

Ley (1988) concludes that patients do forget much of the written materials presented to them, but that by its nature written information has the advantage of being available for refreshing one's memory.

The time span of two weeks between completion of the first and second set of questionnaires was chosen to allow enough time to elapse to see if information is remembered enough to lower anxiety and increase confidence over a short space of time. It was felt that by having a longer time interval, eg. six weeks, participants would have possibly lost interest in the project and not be so likely to complete their second set of questionnaires, and also some staff may have left their job. However, the results may have been very different if the second set of questionnaires had been completed, either immediately after reading the leaflet, or after any time span thereafter.

4.4 Post Hoc Analysis

The results of the post hoc analysis of looking for an association between anxiety levels and information known, and confidence levels and information known are interesting.

As shown, there was no significant association between information known about aggression, and anxiety, but there was a significant

association between information known about aggression, and confidence in dealing with an aggressive incident, eg. those who knew the most about aggression had the highest levels of confidence in dealing with an aggressive incident.

Thackrey's (1987) research on 'clinician confidence in coping with patient aggression' used multiple methods of increasing confidence, eg. didactic teaching, selected readings, group discussion, experiential exercise, modelling/situation role play and physical practice of protection/control manoeuvres. Thackrey found an enduring gain in confidence. The present research only presented information, but, as posited earlier, it is possible that the provision of information was the trigger to provoke discussion and seek further teaching. It may be that if a participant was interested enough to thoroughly read the leaflet, and understood it, he/she may also be interested in seeking more information and strategies in dealing with aggression, and this could have led to increased confidence. However, as indicated in the Results section, of all the reasons that could contribute to participants' increased confidence, knowledge of information only explains 13% of them.

4.5 Methodological issues pertaining to Aims 1, 2 & 3

4.5.1 Design

The circumstances in which the questionnaires were completed were not ideal. Only one visit to each home was possible as participants from a

first visit by the researcher may have talked about the issues to putative participants from a second visit by the researcher. In addition, the information leaflets may have been left lying around the home so that putative participants from a second visit could have read them before they completed their first set of questionnaires. This meant in practice that participants were required to complete the first set of questionnaires in the researcher's presence and return them immediately. While it is recognised that first responses to questions are often the most valid, it could have been useful for the participants to have more time in which to consider some of their responses, in particular ideas for what they would like to help them cope with aggressive incidents.

There were also interruptions from clients/telephone calls in some homes while the questionnaires were being completed, and this probably did not lead to a high level of concentration while completing the questionnaires. The participants would also have felt under some pressure to complete the questionnaires reasonably quickly a) because the researcher was waiting to take the questionnaires, b) some participants were waiting to go home, and c) some participants wanted to get back to work.

Ideally the second set of questionnaires would have been completed in the same conditions two weeks later, but it would have been impossible to get the same staff all on duty together at a time when the researcher was able to visit. Thus, the participants were instructed to complete them in their own time, either at their workplace or at home. It is not known whether

they took more time to consider their answers without the researcher there, or if in fact they looked on them as a 'chore' and gave the answers less consideration. However, test-retest reliability carried out on the control group's first and second set of researcher-designed questionnaires indicated a high level of consistency, so it is probably possible to state that the particular circumstances of completion did not alter the results in any significant way.

As stated earlier, the time span of two weeks between completion of the two sets of questionnaires was fairly arbitrarily chosen to a) allow time for the information leaflet to be read, b) ensure that the participants are likely to still be working in the same place, and c) to ensure that interest was still high, the last two of which reasons could have been put at risk if the time span had been, for example, six weeks. However, as also reported earlier, the two participants who returned their questionnaires after six weeks had very much lower anxiety scores on their second questionnaire. Although conclusions can not be drawn from such a minority, it may be that results overall would have been different if completion of the second set of questionnaires had taken place after six weeks. It would have been useful to see changes over different time spans, eg. two weeks versus six weeks, or to have tested all participants over both time spans.

The method of testing for assimilation of information needs to be improved. As discussed earlier it is thought extremely unlikely that

participants assimilated as little information as was measured by the method used in the present study. It is thought that a more precise method of measuring information assimilated could lead to different results.

4.5.2 Sample

It would have been very useful to compare new staff (ie. those who had worked one month or less in the learning disability service) with experienced staff. Unfortunately, at the time of data collection posts had been frozen and no new staff were being taken on. The new staff who were in the sample comprised so few of the total that it was not possible to compare them with experienced staff. However, it is the researcher's subjective opinion that the new staff who did receive the information leaflet and had a discussion, welcomed the leaflet and saw it as an important reference point.

It could also have been useful to compare the effectiveness of information provision in reducing anxiety and increasing confidence in dealing with aggression, in participants across each type of home, eg. just using challenging behaviour units, or LSUs. Again the sample size in each type of home was not large enough to make any meaningful comparison.

The data collection period would need to be considerably longer if a study such as this was to be undertaken, to ensure a large enough sample. This was considered here but there was pressure to complete data collection

fairly quickly as staff were increasingly being offered the opportunity of going on a 'Breakaway' course, and it was felt that this could confound the results. In addition there would still be the problem of possible future participants seeing the information leaflet, or even just talking to current participants about the issues.

4.5.3 Measures

STAI Form Y-1

The instructions on the STAI Form Y-1 questionnaire were modified (in accordance with instructions in the handbook) to enable anxiety in a particular situation to be assessed. It is likely that participants had very different abilities in imagining their reactions in a violent situation; some may have been able to 'be there', but others may not have been able to imagine themselves in, and reacting to, a violent situation just proposed on paper. It is also possible that the participants' mood of the day affected their ability to imagine themselves in a violent situation. However, the initial pre-intervention anxiety scores were well above the norms for working adults on the unmodified STAI Form Y ($m = 35.72$, $SD = 10.40$ for working adults; $m = 44.6$, $SD = 10$ for participants), so it appears likely that the majority of participants were able to complete the questionnaires as asked.

Questionnaire 'Aggressive incidents involving a client at work'

This questionnaire, devised by the researcher, contained a scale with eight items measuring the uni-dimensional construct 'Confidence in dealing with

aggression'. The questionnaire had been piloted successfully, but the researcher observed that some participants, during the completion of this particular part of the questionnaire, appeared to complete it very quickly and did not seem to read the questions thoroughly. This may not have affected the results, but it is thought that improvements could be made to this part of the questionnaire to improve its readability.

4.6 Aim No. 4

The evaluation of the information leaflet served two purposes. The first purpose was to have a short evaluation of what participants thought of the leaflet and how it could be improved. Suggestions could then be used as a basis for improving the leaflet should it be adopted by the learning disability service to be given to staff when they join the service. The second purpose was to use this evaluation as the discussion for Experimental Group 1 to simulate a real-life situation that might occur in the workplace. While the questions asked may not have been precisely the ones a team leader may bring up, they served the purpose of drawing attention to the content.

The majority of participants rated the leaflet very highly, with negative comments being in the minority. 95% found the leaflet easy to read and understand. 89% thought the leaflet covered all the necessary information. 95% thought the leaflet would be useful for new staff. 95% thought the leaflet would be useful for experienced staff. 95% didn't

think any other information should be included. 89% thought that the leaflet wouldn't make a new staff member nervous.

The two participants who thought that the leaflet could possibly make a new staff member nervous added that it was still best to know about what could happen and be prepared for it.

In the discussion that followed the questions, the following comments were also made:

- "It could be used to stimulate further discussion and information seeking from your team leader."
- "It makes you think and reminds you, even if trained."
- "I would have liked it for myself when I was new."
- "Too long-winded."
- "I prefer not to know beforehand - just deal with aggression when it happens."

Most of the comments made during the discussion emphasised the overall positive reception of the leaflet.

While the above would appear to show that the leaflet was enthusiastically approved, it must be remembered that the researcher discussing the leaflet with the participants was also the author of the leaflet, and the participants knew this. It is possible that more negative comments would

have been made had the researcher either not divulged that she had devised the leaflet, or a different person had led the discussion.

Communicator salience has been studied by many, eg. Hovland et al (1953); Martin (1984). Shrigley (1976) surveyed 286 elementary science education students and found that to be perceived as credible the message source should exhibit a basic understanding of science, have taught science and should emphasise practical teaching. Having authored the textbook for the course was not viewed as important to students.

While the present research was not looking at communicator credibility, and not hoping to sway opinion, it could be that if the information leaflet was presented by eg. a manager who is well known to the participants (which the researcher was not), not only personally, but as an expert in the field of learning disability, this would have an effect either in reducing anxiety or increasing confidence, or in the amount of information remembered.

A further point to come out of the discussion with participants in Group 1, one that was not directly linked to the leaflet, but came up more than once, was that one of the greatest stressors of the job was admitting an unknown client (eg. to an LSU) after an aggressive situation had precipitated the admission, but being given no background information about him/her. Staff agreed that this might occur in a crisis situation, a time when important information commonly gets confused and missed, but

felt that at times this might be a deliberate policy so as not to influence them against a client. They felt that this put them and their other clients in a very vulnerable position and led to very high levels of anxiety until more was known about the client, and his/her particular ways of behaving.

4.7 Aim No. 5

The fifth aim - to see if participants felt that their team leader regarded an attack as seriously as they themselves did - had been discussed with the psychology liaison supervisor and thought to be a useful area to explore, as frequently it is heard from staff that aggression is looked on as part of the job and not taken seriously by senior staff. Certainly, as discussed in the Introduction, this has been a widespread view from management in the recent past (eg. Engel & Marsh, 1986), but it is felt that this view may be changing as more research is undertaken, especially in psychiatric nursing.

Participants were asked to rate the severity of an attack (if any) that they had sustained, on a scale from trivial to very serious. If they had sustained more than one they were asked to rate the most serious. They were then asked to rate the severity they thought their team leader had regarded the same attack.

It was found that there was some discrepancy between the two ratings. 78% of the total number of participants stated that they had suffered an attack, and of that 78%, 75% rated the attack as moderately serious or

worse, but only 62% of the team leaders were estimated to have rated the same attacks as moderately serious or worse.

It is not possible to establish what team leaders actually thought about the attacks, but there are two possibilities for the discrepancy between what participants rated and how they rated their team leader's reaction. One is that participants are mistaken about how their team leader would have reacted, but for various reasons feel that this is the case, eg. he/she didn't show much interest at the time. The other possibility is that participants are correct and that team leaders do not view an aggressive incident from clients at work as seriously as they might.

Two points are important here. One is that whatever the case, it is important that a number of participants feel that their team leader did not regard an attack as seriously as they themselves did, and this could indicate that some staff feel unsupported in the workplace. The second is that the discrepancy is fairly small, and that the majority of team leaders are thought to take incidents seriously.

4.8 Aim No. 6

The final aim was to find out what additional support staff would like to have, and was intended to glean information which could be useful for managers in planning services.

For the first question "Please state anything which you feel that could be provided which would lessen the likelihood of a violent incident occurring at work", the three most frequently occurring answers were 'Adequate or extra staffing levels' (37%), 'Breakaway or training' (23%), 'Alarm or emergency call system' (6%). Similar answers were given to the second question "Please state anything which you feel would make it easier to cope at the time, in the event of a violent incident occurring at work". 'Extra or enough staff' (28%), 'Breakaway or training' (15%), 'Time away from the unit' (15%), 'Emergency alarm system' (8%). In answer to the third question "Please state anything which you think would help you feel better in the days or weeks following a violent incident occurring at work", the following suggestions were made. 'Talking it through with someone' (34%), 'Support from staff or group' (26%), 'Time off' (6%).

It was not until the researcher was collating this information from the questionnaires that a flaw in the questions became apparent. It was not made clear to the participants that they were to respond with ideas for things that they would like, but which they do not have. It is likely that some of the participants gave responses of practice that already happens, eg. he/she may have undergone Breakaway training, but still have responded with 'Breakaway' as being something that would make it easier to cope at the time. Although over one third of participants stated that 'talking it through with someone' would help them cope in the days or weeks following an incident, it seems unlikely that such a high proportion

of participants would not have had the opportunity to talk it through. It is likely that they were stating an ideal for good practice that probably already happens.

This aside, it was surprising that so few participants made suggestions for change. It is felt that this, once again, may have been to do with the pressure of time during the completion of the first questionnaires. However, it is interesting that of those who did respond, their ideas were broadly similar, and it would be worth following this up to find out where there is genuine need for changes.

4.9 Non-Responders

There was a very high questionnaire return rate of 82% which is thought indicates the personal relevance and interest that this research has for staff.

However, 18% did not return the second set of questionnaires and the researcher looked at some of the reasons for this non-responding. It is possible that non-responders did not wish to reveal how they felt about aggression at work. As presented in the Results section, mean scores for anxiety and confidence in dealing with aggression were computed for the non-responders group, using data from the first set of questionnaires.

However, no differences between this group and the participants were

found so it can not be concluded that, as a group, they differ on scores of anxiety and confidence in dealing with aggression.

Five non-responders were followed up by telephone. Reasons given for not responding were: a) didn't have time to do it (n = 2); b) lost the questionnaire (n = 1); c) didn't realise had to complete a second questionnaire (n = 2).

Four participants returned questionnaires but not within the time allowed. Two participants in Experimental Group 1 from the same home returned their second questionnaires six weeks after completion of the first set. Interestingly their mean anxiety score had decreased significantly (from 49 to 36). This could either indicate that six weeks is the optimum time to allow anxiety to decrease after intervention, or the more likely reason is that some other change such as conditions in that particular home had changed for the better in the intervening period. This would seem worthy of further investigation.

It is felt that some participants did not return the second questionnaires because they had not been properly prepared for the researcher's visit by their team leader, despite team leaders having all been spoken to on the phone by the researcher, and written to with an outline of what the visit would involve, including a request that they would ask their staff if they would like to participate. It was evident in two homes that the researcher's visit had not been properly explained to the staff, and

conditions during the visit were not ideal. It was these ill-prepared participants who comprised the majority of the non-responders with the second set of questionnaires.

It is important to state here that it was a tiny minority who had not prepared their staff, and that the vast majority of team leaders and their staff were well-prepared and interested in participating in the research, and made the researcher very welcome.

4.10 Indications for future research

If this study were to be replicated the above points would need to be noted and put into practice, in particular aiming the research at new staff joining the service.

Initially it would seem that information, as provided in this study, does not reduce anxiety and increase confidence in dealing with aggression. However, these results do not mean that information provision does not work. If account is taken of participants' individual differences, information provision may indeed reduce anxiety and increase confidence in a proportion of the sample. A useful area of research which would take individual differences into account would be to identify individuals' particular coping styles (ie. Lazarus & Folkman's concept of 'copers' as opposed to 'avoiders'), as copers are likely to benefit more from written information in helping to reduce anxiety, than are avoiders. Research

could also look at information provision and locus of control, as those with internal, as opposed to external, locus of control have been found to have better behavioural adjustment ratings when provided with specific information. Preparation for working in the learning disability service could, with information such as this, be tailored more to the needs of the individual.

In the present research setting, even though anxiety scores and confidence in dealing with aggression scores appear not to have changed compared with those of participants who did not receive the leaflet, behaviour may have changed since presentation of the leaflet. It is possible that since being 'given permission' to be open about feelings around aggression at work, participants may be talking to each other more, approaching their team leader more for advice, and putting into practice the points recommended in the leaflet to avert an aggressive incident. These points could also be the basis for future research.

It would be useful to find out whether there is an effect of information provision in combination with another strategy, eg. Breakaway training.

Finally, looking at the stresses overall in care staffs' working lives, to find the relative importance that staff assign to different problem areas, would enable changes to be made in working practice in those areas that are relevant.

4.11 Recommendations for Practice

As anxiety was lowered within all three groups, this finding can not be said to have been caused by provision of the information leaflet. It will have been caused by another factor, the most likely of which is that the intervention gave permission for aggression to be acknowledged and discussed. This finding leads to the recommendation being made that discussions continue, and that efforts are made by management to endeavour that the subject remains acceptable and ongoing.

The information leaflet was rated highly by participants, most of whom wished to keep the leaflet for future reference. As Ley (1988) reports "by its nature written information has the advantage of being available for refreshing one's memory." It is recommended that the leaflet be used in conjunction with other methods of learning to cope with aggression, eg. Breakaway courses, as it is a good source of information to refresh one's memory at any time.

A point to come out of the discussion that the researcher had with participants in Group 1 (and which was outlined in section 4.6 Aim No. 4) was that one of the greatest stressors of the job was, on occasions, having to admit an unknown client to a unit, with no background information about him/her, other than that he/she was aggressive. It is recommended that, where possible, this practice does not continue, and that as full information as possible accompanies a client on admission.

It is also recommended that managers take note of the information provided by participants on additional support that they would like to have to prevent and cope with an aggressive incident, such as extra staff or Breakaway training. This would need to be done locally as needs will differ from unit to unit.

4.12 Conclusions

In concluding the discussion this research has shown that provision of information, in the form of a leaflet, does not reduce anxiety or increase confidence in dealing with aggression, in care staff working in learning disability. Anxiety was reduced in all the groups, but in the control group also; therefore this effect can not be said to be due to the provision of the leaflet. It is likely that this was due to the Hawthorne Effect, ie. any intervention, whatever it is, will work, at least for a while. It is thought that the visits by the researcher, which provoked interest and discussion, accounted for the reduction in anxiety.

However, as discussed above, future research may show that if account is taken of participants' individual differences, information provision may be useful in reducing anxiety and increasing confidence in a proportion of participants. Differences in coping style, and in locus of control, are likely to determine whether information provision is effective or not.

Although participants did not appear to assimilate information from the leaflet they rated the leaflet highly in content and usefulness.

Participants' views on a number of issues relating to working in learning disability were sought. It is hoped that managers will note the recommendations made for changes in practice.

The construction of the information leaflet is considered to be an important step in tackling the problem of aggression towards care staff by clients in their care, in that it is likely that it has raised awareness of the issues that staff feel are important, leading to a further voicing of such issues to colleagues and managers. The leaflet also provides an easy to access source of information for new and experienced staff alike.

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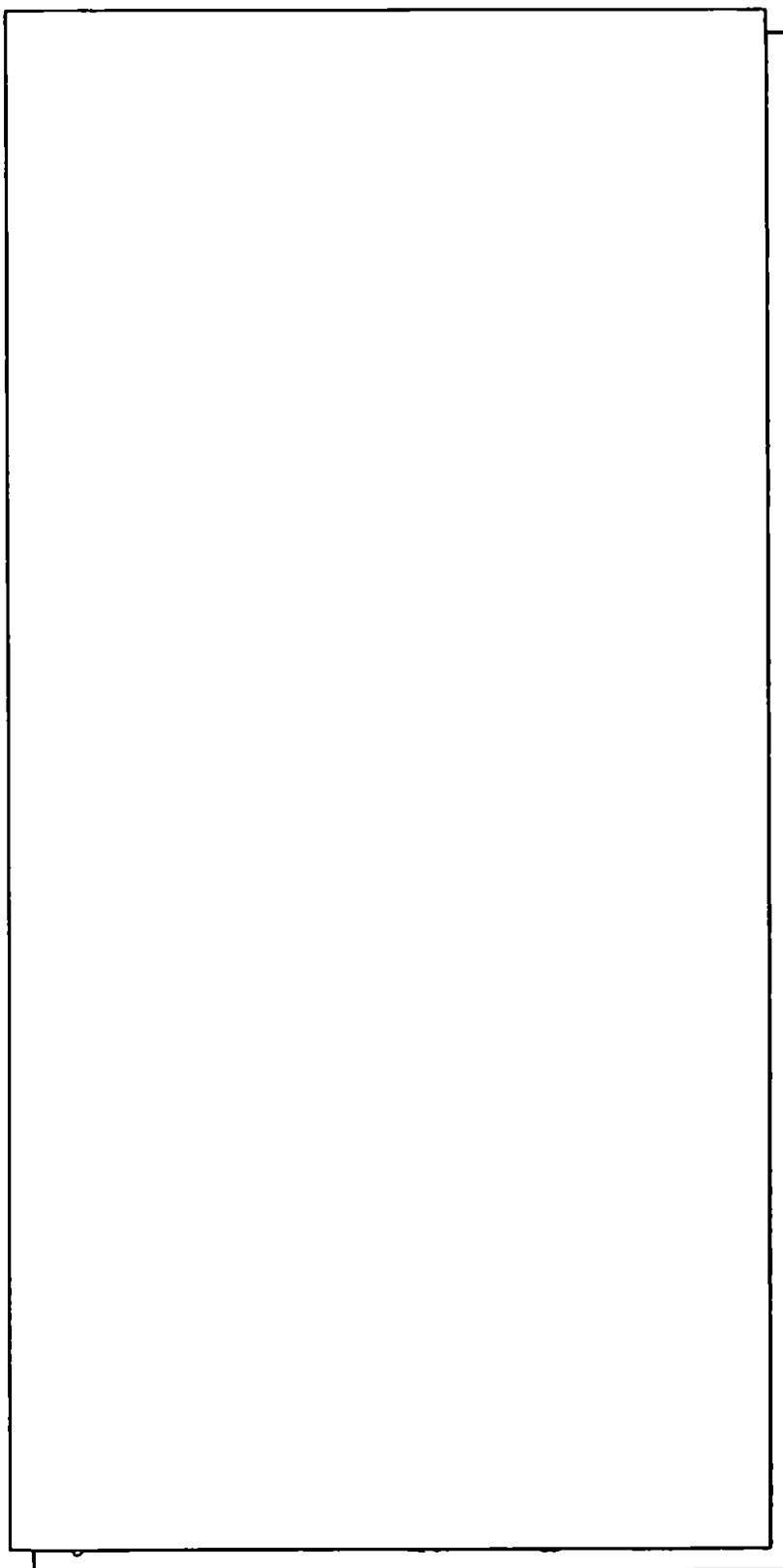
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Appendix A.

Information leaflet



Experience has shown that there have been incidents where another client or even a member of staff has produced a violent incident. In unusual circumstances this may have been done intentionally. If you think this is a factor in aggressive incidents in your place of work it should be discussed with your team leader so that the appropriate action may be taken to avoid a similar situation arising in the future.

The Occupational Health and Psychology Departments both have trained staff to help people get over traumas, and if you should wish to contact them the numbers are:

Staff Occupational Health Department - 405038.
Psychology Department - 403170.

Both services are completely confidential.

This booklet is part of a research project being carried out by Mary Ivens, Trainee Clinical Psychologist, University of Plymouth.

Preventing and coping with an aggressive incident involving a client in your care.

* * *

This booklet has been compiled to address issues that arise when a violent situation occurs with a client at work.

It is important to remember that violent incidents at work are rare. In some settings they are unlikely to happen, but in others they will be more frequent. If you are prepared you are better equipped to deal with any situation that does arise.

There are sections on:

PREVENTION - INTERVENTION - AFTERMATH

Prevention

Prevention is better than intervention. It is sometimes possible to defuse a potentially violent situation:

- **Observation** - Know your client and you will know the signs which mean he/she is getting angry.
- **Empathy** (putting yourself in the client's shoes) - We've all felt angry at times, sparked off by things such as being let down by someone, or being kept waiting by someone. This could be similar to what your client feels. It is possible for you or your colleagues to unwittingly bring about these feelings in a client. If you have empathy it can make your client's behaviour more understandable and you can act accordingly.
- **Actions** - How you behave when someone is getting angry might determine whether their anger escalates or whether it is defused. As each person and situation is different, no booklet can advise whether to withdraw or be firm. Find out, in advance, from your team leader or the relevant key worker, what is likely to be the best policy with each individual.
- **Predict Ahead** - Knowing that certain times might be difficult for a client, for example Christmas or a birthday away from their family, can help you to anticipate a client's mood change and enable you to help him/her through this.

Intervention

If, as will sometimes happen, the situation can not be defused and you get hit, it is important to know what you should do, and what are your and your client's rights.

Your manager will have explained the procedure for the service you work in. If it is necessary to restrain the client for his, your own or others' safety there are correct and incorrect ways of doing this.

It is important that minimum force is used at all times. If necessary, and if possible, get help from other staff. Dangerous items should be removed. Remember that you can cause injury by putting pressure on the middle of the long bones of the arms and legs. Carpet burns may result if a person is held on the floor. Care must be taken to avoid pressure to vulnerable areas such as abdomen and throat, and genital areas should be avoided.

If you have acted in good faith and followed the guidance you have been given to try to prevent injury you can be confident that management will support your actions.

If it is clear that aggressive incidents will happen regularly at your place of work, you *must* request further training from the senior nurse/director of your locality, and it will be arranged.

You also have rights - rights to prevent injury to yourself. The use of physical restraint to repel violence is perfectly acceptable in law, subject to the qualification that the restraint must entail reasonable force only, i.e. sufficient force to stop an attacker. If there is a choice between this and withdrawing, without exposing others to risk, then you should withdraw.

Aftermath

After an attack it is likely that you will have a mixture of feelings, which is entirely normal. You are likely to feel anger towards the client who attacked you, and perhaps fear of what might have happened if things had got more out of control. You may feel shaken for some days, or longer. You may also feel guilty that perhaps if you had behaved differently the attack would not have happened. It can also be an additional stress to have to return to work after an episode, not only to face your client but also to care for him/her as well.

These feelings will occur to a greater or lesser degree in everyone who has been attacked, and it is important to acknowledge them and talk them over with a sympathetic listener such as a colleague, team leader, manager, counsellor or psychologist.

It is also useful to ask your team leader/colleagues for feedback on any situation that occurs.

Your manager or team leader will need to know if your interaction with clients is likely to be affected by the aftermath of an incident, or if you have general anxieties in this area. There are practical things they can do to help you. Wherever possible speak to your team leader or manager.

You will also need to be aware of the reporting and form filling procedures necessary to protect yourself and your clients. Ask your team leader if you need advice on this.

Appendix B

SELF-EVALUATION QUESTIONNAIRE

Developed by Charles D. Spielberger
in collaboration with
R. L. Gorsuch, R. Lushene, P. R. Vagg, and G. A. Jacobs

STAI Form Y-1

INITIALS _____

~~Name~~ _____ Date _____ S _____

Age _____ Sex: M _____ F _____ T _____

DIRECTIONS: A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you ~~feel right now, that is, at this moment~~ ^{feel} ~~feel~~ ^{would feel} in the event of a violent incident at work. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your ~~present~~ feelings best.

VERY MUCH SO
MODERATELY SO
SOMEWWHAT
NOT AT ALL

YOU WOULD FEEL IN THE EVENT OF A VIOLENT INCIDENT AT WORK.

- | | | | | |
|--|---|---|---|---|
| 1. I feel calm | 1 | 2 | 3 | 4 |
| 2. I feel secure | 1 | 2 | 3 | 4 |
| 3. I am tense | 1 | 2 | 3 | 4 |
| 4. I feel strained | 1 | 2 | 3 | 4 |
| 5. I feel at ease | 1 | 2 | 3 | 4 |
| 6. I feel upset | 1 | 2 | 3 | 4 |
| 7. I am presently worrying over possible misfortunes | 1 | 2 | 3 | 4 |
| 8. I feel satisfied | 1 | 2 | 3 | 4 |
| 9. I feel frightened | 1 | 2 | 3 | 4 |
| 10. I feel comfortable | 1 | 2 | 3 | 4 |
| 11. I feel self-confident | 1 | 2 | 3 | 4 |
| 12. I feel nervous | 1 | 2 | 3 | 4 |
| 13. I am jittery | 1 | 2 | 3 | 4 |
| 14. I feel indecisive | 1 | 2 | 3 | 4 |
| 15. I am relaxed | 1 | 2 | 3 | 4 |
| 16. I feel content | 1 | 2 | 3 | 4 |
| 17. I am worried | 1 | 2 | 3 | 4 |
| 18. I feel confused | 1 | 2 | 3 | 4 |
| 19. I feel steady | 1 | 2 | 3 | 4 |
| 20. I feel pleasant | 1 | 2 | 3 | 4 |

Appendix C

Spielberger State-Trait Questionnaire

The concept of state and trait anxiety were first introduced by Cattell & Scheier (1961, 1963) and have been elaborated by Spielberger (1966, 1972, 1976, 1979). Trait anxiety refers to relatively stable individual differences in anxiety-proneness, eg. in their proneness to perceive a stressful situation as threatening or dangerous. State anxiety refers to an emotional state which exists at a given moment and at a particular level of intensity.

The S-Anxiety scale, used in this research, has been found to be a sensitive indicator of changes in transitory anxiety experienced by clients and patients in counselling, psychotherapy, and behaviour modification programmes, and was designed to be self-administering and may be given either individually or to groups. There are norms available for working adults, college students, high school students and military recruits.

Given the transitory nature of anxiety states, measures of internal consistency such as the alpha coefficient provide a more meaningful index of the reliability of S-Anxiety scale than test-retest correlations. Alpha coefficients (Cronbach, 1951) for the normative samples range from 0.86 to 0.95.

Appendix D

Questionnaire called 'Aggressive Incidents Involving a Client at Work'.

The questionnaire is anonymous and there are no right or wrong answers. Please answer as honestly as you can by ringing the appropriate word.

Your job title Sex

Length of time you have been working in learning disability

1. Please list any training courses/events you have had on dealing with aggression at work (eg. Breakaway, Self-defence etc.)

.....
.....
.....

In the above list please put an E beside any courses/events funded by your current employer.

Please put a tick beside the courses/events you found particularly useful, and a cross beside the ones that you did not find particularly useful.

2. Have you ever been attacked by a client at work? Yes No

3. If so, was the attack considered by yourself to be:

Very Serious, Serious, Moderately Serious, Not very Serious, Trivial

(If you have been attacked more than once please refer to the time that you considered was the most serious).

4. Was the attack considered by your team leader to be:

Very Serious Serious Moderately Serious Not very Serious Trivial

5. Do you ever feel worried about the possibility of having to deal with a violent incident at work (not directed at you).

Very Often Often Sometimes Not very Often Never

6. Are you ever worried that a client may attack you personally?

Very Often	Often	Sometimes	Not very Often	Never
---------------	-------	-----------	-------------------	-------

7. If you were on duty with at least one other member of staff would you feel confident that you could deal with a violent incident directed at them involving a typical client in your care?

Very Confident	Confident	Moderately Confident	Not very Confident	Not at all Confident
-------------------	-----------	-------------------------	-----------------------	-------------------------

8. If you were on duty with at least one other member of staff would you feel confident that you could deal with a violent incident directed at them involving the most difficult client you have at your present place of work?

Very Confident	Confident	Moderately Confident	Not very Confident	Not at all Confident
-------------------	-----------	-------------------------	-----------------------	-------------------------

9. If you were on duty with at least one other member of staff would you feel confident that you could deal with a violent incident directed at yourself involving a typical client in your care?

Very Confident	Confident	Moderately Confident	Not very Confident	Not at all Confident
-------------------	-----------	-------------------------	-----------------------	-------------------------

10. If you were on duty with at least one other member of staff would you feel confident that you could deal with a violent incident directed at yourself involving the most difficult client you have at your present place of work?

Very Confident	Confident	Moderately Confident	Not very Confident	Not at all Confident
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11. If you were on duty alone, would you feel confident that you could deal with a violent incident directed at yourself involving a typical client in your care?

Very Confident	Confident	Moderately Confident	Not very Confident	Not at all Confident
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12. If you were on duty alone, would you feel confident that you could deal with a violent incident directed at yourself involving the most difficult client you have at your present place of work?

Very Confident	Confident	Moderately Confident	Not very Confident	Not at all Confident
-------------------	-----------	-------------------------	-----------------------	-------------------------

13. Are you aware of any things you can do to lessen the likelihood of a violent incident involving a client occurring?

Yes No

If you have answered 'Yes', please state them.

14. Are you aware of any procedures (eg. on restraint etc.) which should be followed in the event of an attack on a member of staff by a client?

Yes No

If you have answered 'Yes', please state what you know.

15. Are you aware of any procedures which should be carried out after a violent incident involving a client?

Yes No

If you have answered 'Yes', please state them.

16. Please state anything you feel that could be provided which would lessen the likelihood of a violent incident occurring at work.

(Please take a moment to think about this as your comments may be very useful to service managers.)

17. Please state anything which you feel would make it easier to cope at the time, in the event of a violent incident occurring at work.

(Again, please take a moment to think about this.)

18. Please state anything which you think would help you feel better in the days or weeks following a violent incident occurring at work.

THANK YOU VERY MUCH FOR YOUR HELP.

Appendix E

Initial Letters to Team Leaders

E.1 Letter sent to Team leaders of Group 1 participants.....Page 112

E.2 Letter sent to Team leaders of Group 2 participants.....Page 113

E.3 Letter sent to Team leaders of Control Group participants...Page 114

Address.

Date.

Dear Team Leader (name),

You may know that I am carrying out a research project on the topic of violence towards care staff in the Learning Disability Service.

All the service directors are happy for the research to go ahead, and I am writing to you now to request that I may involve some of your staff in the project. If you and your staff are happy to be involved the following is the outline of what I intend to do.

I would like to visit(name the home) on a date to be agreed. I will then give out two anonymous questionnaires to each of your staff who wish to take part, and ask them to complete them. This will take approx. 20 minutes. I will then give out a leaflet for them to read and will spend a short time discussing it with them afterwards. I anticipate that the whole visit will take no more than one hour.

The second part of the study will entail the same members of staff completing two more anonymous questionnaires approx. two weeks later. This they can either do at home or at work; I do not need to be present.

I would be grateful if you could ask your staff if they would be willing to take part in the study, and I will ring you on (date) to arrange a time for me to visit. There is absolutely no obligation for anyone to take part if they do not wish to, and those that do take part can be assured that all information will be kept completely confidential.

Yours sincerely,

Mary Ivens,
Trainee Clinical Psychologist,
University of Plymouth.

Address.

Date.

Dear Team Leader (name),

You may know that I am carrying out a research project on the topic of violence towards care staff in the Learning Disability Service.

All the service directors are happy for the research to go ahead, and I am writing to you now to request that I may involve some of your staff in the project. If you and your staff are happy to be involved the following is the outline of what I intend to do.

I would like to visit(name the home) on a date to be agreed. I will then give out two anonymous questionnaires to each of your staff who wish to take part, and ask them to complete them. This will take approx. 20 minutes. I would like to leave some leaflets with you for you to give to these members of staff to read after I have gone.

The second part of the study will entail the same members of staff completing two more anonymous questionnaires approx. two weeks later. This they can either do at home or at work.

I would be grateful if you could ask your staff if they would be willing to take part in the study, and I will ring you within the next week to arrange a time for me to visit. There is absolutely no obligation for anyone to take part if they do not wish to, and those that do take part can be assured that all information will be kept completely confidential.

Yours sincerely,

Mary Ivens,
Trainee Clinical Psychologist,
University of Plymouth.

Address.

Date.

Dear Team Leader (name),

You may know that I am carrying out a research project on the topic of violence towards care staff in the Learning Disability Service.

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The second part of the study will entail the same members of staff completing two more anonymous questionnaires approx. two weeks later. This they can either do at home or at work.

I would be grateful if you could ask your staff if they would be willing to take part in the study, and I will ring you within the next week to arrange a time for me to visit. There is absolutely no obligation for anyone to take part if they do not wish to, and those that do take part can be assured that all information will be kept completely confidential.

Yours sincerely,

Mary Ivens,
Trainee Clinical Psychologist,
University of Plymouth.

Appendix F
Follow-up letter to Team Leaders of all Groups

Address.

Date.

Dear Team Leader (name),

I would like to thank you and your staff for participating in my research. I appreciate the time given in filling in the questionnaires.

I would be grateful if you could remind the staff who participated, that the second questionnaires, which I left with them, should be completed this week if possible, and returned to me in the stamped, addressed envelope provided. As I stated on my visit, it is very important that this is done, otherwise I only have limited information from the first questionnaires.

Thank you again for your help.

With best wishes,

Mary Ivens,
Trainee Clinical Psychologist,
University of Plymouth.