

**STAFF RESPONSES TO CHALLENGING BEHAVIOUR: AN EVALUATION OF
BEHAVIOUR ANALYTIC CONCEPTS AND INTERVENTION STRATEGIES**

By

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ABSTRACT

This research project is divided into two studies. Study 1 considers the proposition that where the challenging behaviours of learning disabled people are sensitive to social reinforcement, the responses of unit staff may be counter-habilitative. This was investigated using a questionnaire-based self-report study involving 43 unit staff. The questionnaires covered staff emotional reactions to, attributions for and responses to challenging behaviours. In addition key aspects of the staff sub-culture were considered. Results confirmed the possible counter-habilitative nature of staff responses. These responses appeared to be influenced by both contingency effects related to high levels of stress and counter-habilitative beliefs within staff sub-cultures.

Study 2 had two aims. First, to gather qualitative data with regard to both contingency and sub-culture effects. Secondly, to evaluate a training package designed to ameliorate counter-habilitative influences upon staff responses. The qualitative data gathered was strongly suggestive of an interaction between contingency and culture effects, reinforced by aspects of the wider service culture. Key issues appeared to be high levels of stress related to challenging behaviours, highly counter-habilitative beliefs in which staff feel that they have to 'deal with anything' and a perceived lack of support from the wider service itself. For example, only a minority of staff had access to a consistent debriefing procedure. The training package proved to be largely ineffective in changing key counter-habilitative beliefs and responses. It is argued that future intervention strategies and research may need to consider wider service issues if habitative changes are to be achieved.

The implications of these findings for clinical psychologists working with learning disability services are also discussed.

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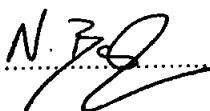
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AUTHOR'S DECLARATION

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 the 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 with the Exeter Community Health Services Trust.

Signed..... 

Date..... 3-7-97.

SECTION ONE

INTRODUCTION

INTRODUCTION

1. What is challenging behaviour ?

It is estimated that up to half of learning disabled clients living in residential accommodation engage in some form of challenging behaviour (Hill & Bruininks 1984). Defining exactly what is meant by 'challenging behaviour' is a complex issue and there are undoubtedly variations between individual services in terms of what is regarded as challenging and what is not. However, a widely accepted definition is given by Emerson et al (1988):

'Behaviour of such an intensity, frequency, or duration, that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit, or deny access to and use of ordinary community facilities'.

As Hastings & Remington (1994a) note, in practical terms this has led to the identification of three forms of challenging behaviour - stereotypy, self-injurious behaviour and aggressive/destructive behaviour.

Stereotyped behaviours may be defined as 'highly consistent and repetitious motor or posturing behaviours' (Baumeister & Forehand 1973). LaGrow & Repp (1984) identified 'body rocking' as the most commonly studied example of this form of behaviour. Self-injurious behaviour has been defined by Oliver et al (1987) as 'repeated, self-inflicted, non-accidental injury, producing bruising, bleeding or other temporary or permanent tissue damage'. Aggression would obviously cover a wide range of behaviours. However, physical aggression towards others would appear to be relatively common in this client group. Hill & Bruininks (1984) report that between 16 and 30 percent of clients in residential facilities regularly injure other people.

2. The behaviour analytic model of challenging behaviour

There is a considerable literature regarding the aetiology of challenging behaviours in learning disabled clients. Carr (1977) points out that the most influential theories have been based upon behavioural concepts, particularly positive and negative reinforcement. In terms of positive reinforcement, whilst reinforcers such as food, other tangibles and perceptual stimulation may well be important, Oliver (1991) points out that attention from others is likely to be heavily implicated. Negative reinforcement may be involved in terms of challenging behaviours enabling the individual to avoid or escape from an aversive situation e.g. a task which the individual does not wish to perform. Carr, Newsom & Binkoff (1980) report an example of this in terms of challenging behaviour leading to the termination of a teaching session. At the centre of the behaviour analytic model, therefore, is the proposition that much challenging behaviour is social in nature and as such may be sensitive to the actions and responses of others in the environment.

It is obviously not the case that all challenging behaviours can be explained in terms of this model. However, Derby et al (1992) report that in their summary of analogue assessments of 79 clients, 72% of challenging behaviours were found to relate to either attention or escape.

This has important implications for those who work in learning disability services. Rice & Rosen (1991) point out that residential staff (i.e. qualified nurses and unqualified care assistants) are at the centre of the care process. Challenging clients are likely to spend the overwhelming majority of their time with such staff. Given the behaviour analytic conceptualisation of challenging behaviours as social in nature, how such staff interact with challenging clients and respond to their behaviour may well be important

in gaining a fuller understanding of why such behaviours occur. As such, there has been an increased interest in the behaviour of direct care staff.

3. Staff interactions with learning disabled clients in residential settings.

Observational studies have indicated that learning disabled clients spend a very small proportion of their time interacting with staff. Cullen et al (1983) report that typically clients spend less than 10 percent of their time in such interactions. This may have important implications in terms of challenging behaviours. As Hastings & Remington (1994a) note, this means that where staff attention is not easily obtained by clients it may become a powerful reinforcer. This in turn may lead clients to engage in challenging behaviours as a means of obtaining attention. There is evidence to suggest that this may be an effective strategy. Duker et al (1989) found that challenging clients receive a greater proportion of staff time than non-challenging clients, even when time spent dealing with actual incidents is excluded. A further consequence of a lack of staff attention may be that clients spend much of their time on their own, thereby encouraging the development of self-stimulatory behaviours, including stereotypy.

Researchers have also focused upon the quality of staff interactions with clients. Moores & Grant (1976) report that these interactions are often very brief with up to 50 percent being of less than ten seconds duration. Hile & Walbran (1991) report that only 1.8 percent of such interactions involve staff attempting to teach clients appropriate skills. Studies of the affective dimension of these interactions have indicated that two thirds may be described as 'neutral' in nature (Beail 1985). Landesman Dwyer et al (1980) report that only 1 percent of interactions involve staff praising or rewarding clients. This is important with regard to challenging behaviours in that it would appear that appropriate client behaviour does not lead to consistent positive attention from staff.

As Hastings & Remington (1994a) point out, a global increase in staff interactions with such clients is unlikely to be effective. Whilst those clients whose behaviour serves an attentional function may show a decrease in challenging behaviours, those whose behaviour is socially avoidant in nature may well show an increase as a result of such a policy.

An increasing amount of research has also focused on the question of how staff respond to challenging behaviours. Hastings & Remington (1994a) argue that in terms of understanding how challenging behaviours develop and how they are maintained, this is the central question.

4 Staff responses to challenging behaviours.

In recent years there has been a growing awareness that if the challenging behaviour of clients is to be more fully understood and successfully treated, there is a need to understand more about how direct care staff respond to such behaviour. This is particularly relevant in terms of developing a comprehensive functional analysis of challenging behaviours. As Hastings & Remington (1994b) note, it is only in the last decade that staff behaviour has become the focus of extensive systematic research. Even now, whilst more is known about how staff respond to such behaviour, we are a long way from fully understanding why such responses take place.

Observational studies suggest that, consistent with the evidence that care staff spend little time interacting with clients (Cullen et al 1983; Abraham et al 1991; Conneally et al 1992), generally care staff rarely attend to either appropriate or inappropriate client behaviour (Beail 1989). Warren & Mondy (1971) report that staff do not respond to challenging behaviours between 62 and 79 percent of the time. The same study reported that staff respond in a discouraging way between 11 and 25 percent of the time and in an encouraging way (e.g. smiling, coaxing) between 4 and 9 percent of the

time. This study was replicated by Felce et al (1987) producing very similar results. Hastings & Remington (1994a) point out that this means that staff respond in a positive way to challenging behaviour on a variable ratio schedule of between 1:10 and 1:20, a schedule which is more than adequate to shape or maintain a behaviour (Ferster & Skinner 1957). Hastings & Remington point out that it is possible that staff ignore such behaviour up to a certain point but that when it escalates beyond a certain level of severity they intervene, thereby differentially reinforcing more severe behaviour. An additional point to consider would be that where staff attention is a scarce resource, even negative staff attention such as reprimands may become highly reinforcing.

Self-report studies, however, give a different picture. Maurice & Trudel (1982) asked staff about their responses to challenging behaviour. 44 percent of staff said that they would reprimand the client, 20.6 percent said that they would use restraint and 17.1 percent indicated that they would isolate the client. Worryingly, 2.5 percent admitted hitting clients, confirming the view that challenging clients are at risk of abuse. Bruininks et al (1988) indicate that staff report ignoring the behaviour on only 2 percent of occasions. They identify a hierarchy of staff responses, ranging from verbal reprimands to restraint and calling for assistance. Intagliata et al (1986) report that staff indicate that they are most likely to respond to violent, destructive and withdrawal behaviours.

There is, then, a large disparity between the observational and self-report studies. This is centered around the frequency with which staff respond to incidents of challenging behaviour. Hastings & Remington (1994a) suggest that this may partly be explained in terms of the questions staff are asked in the self-report studies. By asking staff what they 'usually do' the studies may bias staff to focus upon those occasions when they did respond. However, the disparity remains puzzling.

A critical insight in terms of staff behaviour comes through a series of studies reviewed by Hastings & Remington (1994a). That is, that the relationship between client challenging behaviours and staff behaviours is reciprocal and that as such client behaviour may shape staff behaviour. Carr et al (1991) demonstrate that student teachers interacted less with those clients whose behaviour served an avoidant purpose. Taylor & Carr (1992b) found that participants gave more attention to clients whose behaviour served an attention seeking function. Probably the best study in this area is Hall & Oliver (1992). They studied the behaviour of a man engaged in self-injurious behaviour. Before episodes of self-injury staff attention was low - as would be predicted from the literature. As self-injury began to occur staff attention rapidly increased. Following this attention from staff the self-injury declined and then ceased. As this process occurred staff attention to the client returned to its pre-injury levels. The authors hypothesise that the staff involved found the behaviour of the client aversive and intervened as a form of escape behaviour. Whilst this response might well reduce the self-injurious behaviour in the short term, it would also be likely to reinforce it in the longer term. As Hastings & Remington (1994a) note:

‘Staff appear to act in ways that reduce aversive experiences for them in the short term but ensure the long term survival of challenging behaviours’.

There would also appear to be an additional problem with staff behaviour. It is common for challenging clients to be referred to behavioural specialists such as clinical psychologists and nurse behaviour therapists. These specialists often construct formal behavioural programs in which staff are instructed to respond to the challenging behaviour in a particular way (Blair 1992; Bromley & Emerson 1993). Hastings & Remington (1994a) note that it is rare for these specialists to be involved in the day to day implementation of such programs and that in fact many programs fail to produce the desired results because they are not fully implemented by care staff. This is a problem familiar to clinical psychologists working in learning disability services and

represents a major problem in terms of wasting valuable clinical psychology time. It is also likely to be demoralising for those staff who have followed the program. Any comprehensive analysis of staff behaviour needs to account for this non-compliance.

There is substantial evidence, therefore, to suggest that staff responses to challenging behaviours may be counter-habilitative. Whilst this is comprehensively detailed by Hastings & Remington (1994a) one point that they perhaps fail to bring out is that this is all the more puzzling given the fact that it would be reasonable to assume that the intentions of such staff are overwhelmingly good. Nor do Hastings & Remington perhaps fully bring out the possible significance of the 'day to day' pressures of working in a residential setting with challenging clients e.g. administration, cooking, cleaning etc. However, Hastings & Remington (1994a) remains an excellent introduction to the issues involved.

Hastings & Remington's second paper (1994b) regarding staff responses to challenging behaviour is of central importance in terms of going beyond the existing literature. In this paper they look at the problems outlined above in more theoretical terms and put forward two key hypotheses which might explain the counter-habilitative nature of staff responses to challenging behaviour. It is these hypotheses that form the basis of this research project.

5. The contingency hypothesis.

This hypothesis rests on the data which suggests a reciprocal relationship between client and staff behaviour. This in turn rests upon the view that staff find challenging behaviours significantly aversive. There does seem to be considerable evidence to support the view that staff find aggressive and self-injurious behaviours particularly aversive (Quine & Pahl 1985). Indeed, Hastings & Remington (1995) found that different challenging behaviours may elicit different negative emotions in care staff.

Self-injurious behaviour and aggression seem to be particularly associated with feeling disturbed, sad and frightened, although more experienced staff seem to experience less of an affective reaction than inexperienced staff. This may lead staff to engage in non-reflective escape motivated behaviour. In this respect, the behaviour of the client can be seen as a powerful establishing operation (Michael 1982) for defensive behaviour on the part of staff. The Hall & Oliver (1982) study, referred to earlier, is a good example of how this process might work. The self-injury of the client is a significant stressor for staff, leading to negative affect. As a result of this, staff intervene and attend to the client. This quickly reduces the challenging behaviour in the short term, thereby negatively reinforcing staff to intervene in the future. However, in the longer term the client is positively reinforced for repeating the behaviour in the future. Therefore, a vicious circle is set up. The process works in exactly the same way if the challenging behaviour is avoidant in nature. Staff are quickly shaped not to intervene.

Hastings & Remington (1994b) point out that the power of this contingency effect may well interfere with the implementation of any formal behavioural programs written by specialists, especially where the program is likely to result in some form of extinction burst (i.e. the behaviour gets worse before it improves). This would seem to be a very powerful hypothesis which could, potentially, represent a major breakthrough in the field.

6. The possible importance of staff 'culture'

It is clear, however, that human behaviour is influenced by more than schedules of reinforcement. Skinner (1957) identified rule governed behaviour as being important. Rules may be defined as verbal formulations of contingencies, describing relationships in the environment which would otherwise have to be learned through experience. Catania et al (1989) argue that human behaviour is more often rule governed than

directly shaped by contingencies. In the context of an analysis of staff responses to challenging behaviours this may well be significant. Zettle & Hayes (1982) argue that there are two processes involved in terms of the degree to which a rule is followed. In 'pliance' compliance is governed by consequences mediated by the 'speaker'/source of the rule (e.g. praise, rewards, punishments). In 'tracking' compliance is based more upon the way in which the rule interacts with the environment i.e. the rule interacts with the environment in the predicted way. An example of tracking would be that the rule says that 'if you carry out action X then Y will occur' and that when the individual performs action X, Y does indeed occur. As Zettle (1990) points out, rules may be self supplied and include attitudes and beliefs. Hastings & Remington (1994b) argue that this may give an insight into why staff behave as they do.

If the proposition that such staff responses may be influenced by 'rules' is correct then it is obviously important to understand how this process works. Whilst rules may be very positive in terms of familiarising staff with their environment, they can also produce negative effects when followed unquestioningly (Lowe 1983) and where they no longer correspond accurately to the environment. As Kiernan (1991) points out, staff may be exposed to many sources of rules and these may conflict. For example, a unit mission statement may stress the need to give clients choice/individual freedom whilst at the same time emphasising the need for such clients to be protected. This in itself may lead to great inconsistencies in staff behaviour. Staff will also have their own attitudes, views and beliefs which may in fact be based upon experiences not appropriate to learning disability services - e.g. bringing up their own children. As Hastings & Remington (1994b) note, staff hypotheses about why challenging behaviours occur, especially in relation to individual clients, will inevitably influence their responses to such behaviour.

Externally supplied rules, such as formal behavioural programs written by clinical psychologists, may have a beneficial effect in terms of enhancing staff understanding of

challenging behaviours. Hastings et al (1995) note that in fact nurses seem to have a good understanding of behavioural models. However, the central theme developed by Hastings & Remington (1994b) is that these externally supplied rules may well be less salient to staff than their own sub-culture. Managers and psychologists are inevitably distant for much of the time from the 'day to day' care process. For an individual member of staff, therefore, such people may be distant figures. However, for that individual other members of staff are always present in the work setting. Managers may at best deliver rewards or punishments in relation to behaviour at work infrequently and long after the behaviour has occurred. Other staff, however, can enforce adherence to the rules of the staff sub-culture swiftly. Given the stresses involved, a common perception amongst those who have contact with such staff teams is that they are quite closely knit - a theme perhaps not fully developed by Hastings & Remington. Hastings & Remington (1994b) argue that there may be powerful influences within the staff culture to misinterpret behavioural models into a 'needs led' approach i.e. if a client's challenging behaviour is motivated by a need for attention then the most effective response is to give attention in order that the behaviour will cease. Whilst this seems plausible, it is perhaps the weakest link in the hypothesis put forward by Hastings & Remington (1994b) and clearly requires further investigation. However, once such a rule was adopted it would be powerfully reinforced through 'tracking' given that such an approach would indeed lead to the swift termination of an individual incident. Any behavioural program that appeared to contradict this would be likely to be abandoned by care staff.

The above 'culture hypothesis' could also represent a major breakthrough in our understanding of the counter-habilitative responses of unit staff. In their discussion of this hypothesis, Hastings & Remington do not perhaps put enough emphasis on the possibility of an interaction between a contingency effect and the staff sub-culture. The translation of behavioural principles into a 'meet the need' approach does not look entirely convincing. It would seem just as likely, and indeed straightforward, that

contingencies within the work environment quickly establish with staff that certain actions on their part lead to the swift termination of individual incidents. This rule would become part of the staff sub-culture and new staff would be socialised into it by more experienced staff. Processes of both tracking and pliance could be involved in maintaining it. Formal programs which contradicted this rule would be likely to be abandoned by staff, especially where the program resulted in an extinction burst.

Whatever the precise rules within the staff sub-culture that may contradict a behavioural program, it is clear, as Hastings & Remington (1994b) point out, that a central reason why such programs often fail is that they are not based upon a full functional analysis of the situation. Any full analysis of an individual client's challenging behaviour may well need to take account of the sub-culture amongst staff responding to that behaviour. In the light of this it is interesting to note that there is some evidence to suggest that learning disability services are now becoming more aware of the importance of care staff. Of some note is the 'person specification for hands on care staff' produced by Hill-Tout & Lowe (1995). This represents an attempt by a challenging behaviour service to set out clearly those qualities/skills felt to be desirable in care staff and those felt to be undesirable. Desirable aspects included ability to keep calm when under pressure, assertiveness, some insight into the difficulties in dealing with challenging behaviour, ability to talk about personal feelings in relation to work and having a realistic idea of one's own skills/abilities. Undesirable qualities were quick temper, feeling the need to retaliate and 'evangelical personal beliefs'. This is an interesting document in relation to the staff culture hypothesis put forward by Hastings & Remington (1994b). Many of the skills/qualities mentioned in relation to individuals may also relate to the staff group as a whole. For example, the degree to which an individual member of staff feels able to talk about their personal feelings in relation to work may well depend upon how this is viewed by work colleagues. It is possible, for example, to envisage a staff culture where talking about one's feelings in relation to the challenging behaviours encountered is actively

discouraged and seen as 'weak'. Alternatively, a staff culture might actually encourage individuals to talk about their feelings. This difference in staff sub-culture could possibly have a significant impact on the levels of stress experienced by individual staff and this in turn could affect the way in which they respond to challenging behaviours.

It is clear that the recent work of Hastings & Remington represents a major theoretical contribution to the understanding of challenging behaviours amongst clients with learning disabilities. Indeed, the hypotheses put forward might also be equally relevant to other client groups. As Hastings & Remington (1994b) note, care staff sub-culture has not been widely investigated and there is a lack of both qualitative and quantitative data with regard to how such cultures may operate and what sort of rules may develop within them. If staff sub-cultures are indeed implicated in the development and maintenance of challenging behaviours, then an understanding of such cultures may have great significance in terms of treatment strategies.

7. An investigation of 'staff culture' in a learning disability service.

Hastings (1995) seeks to remedy this lack of data in a study which interviewed 19 care staff working with challenging clients in a learning disability service. These interviews focused upon staff definitions of challenging behaviour, the training they had received, their involvement with formal behavioural programs, their hypotheses as to why challenging behaviours occur, how they responded to such behaviour, their emotional reactions to the behaviour, the stressful aspects of their work and their view of what an ideal service to such clients would look like. The results of this study have a direct bearing upon this research project and are discussed below.

7.1: **Staff Beliefs:** Care staff clearly identified self-injury, aggression, destructive behaviour and inappropriate behaviour (e.g.: sexual) as challenging. However, stereotyped behaviour was not seen as challenging. In terms of defining challenging

behaviour a majority of staff, 53%, saw it as 'challenging to others' with a further 42% defining it in terms of behaviour outside of the accepted norm. 32% saw it as an extreme reaction to normal events.

Perhaps the most significant aspect of this part of the study was that staff appeared to possess a rich conceptual framework with regard to the possible causes of challenging behaviours. 79% mentioned social reinforcement (i.e. attention) as a factor, 68% felt that challenging behaviour could be a means of the client communicating, 58% mentioned problems with the immediate physical environment, 58% felt that the behaviour might relate to emotional distress, 47% mentioned medical/biological factors (including sexual frustration) and 37% saw it as an adaptive response to the environment. All of these factors would be congruent with current models of challenging behaviour. There were, however, some significant omissions from staff replies. For example, escape from task demands was not mentioned. This data would suggest that if there is a problem with staff responses to challenging behaviour it is not the case that staff do not possess adequate models of why such behaviour might occur. Hastings notes that 74% of his sample saw challenging behaviours as intentional. Hastings hypothesises that this might lead staff to blame clients for their behaviour and thereby lead to punitive responses (which in the context of an environment where staff attention is scarce, might well be reinforcing).

7.2: Responses to challenging behaviour: Hastings asked staff how they would normally respond to challenging behaviours. Replies indicated that these staff seldom responded to stereotypy. Combined with the view that such behaviour is not challenging, Hastings points out that staff may regard stereotypy as a 'special case' and as such behavioural programs designed to ameliorate it might be regarded with little enthusiasm. However, staff reported that they did respond to aggression and self-injury. These responses seemed to be mainly concerned with stopping and controlling the behaviour. In the case of self-injury 74% reported this as their

response. As Hastings notes, what is striking about this is that the responses do not seem to be congruent with staff hypotheses about why such behaviour occurs. For example, whilst the overwhelming majority of staff had mentioned attention as a factor in such behaviour, none mentioned removal of attention as a response to the behaviour. None, for example, mentioned communication training as an option. Indeed, constructive approaches to the behaviour did not seem to be favoured by this staff group. Interestingly, when Hastings asked staff about their 'ideal service' staff did appear to draw upon their hypotheses with regard to the behaviour, indicating for example that they would favour greater input from outside professionals. This would seem to lend strong support to the hypotheses put forward by Hastings & Remington (1994b) that there are powerful forces at work within the working environment that interfere with staff's ability to work with challenging clients in a habilitative way.

7.3: The formal and informal staff culture: Hastings found that with regard to the training staff had received, this was mainly concerned with management and control issues e.g. 'breakaway' courses which train staff to physically breakaway from a client who is assaulting them. Hastings notes that this may well have the effect of both focusing staff attention onto aggressive behaviour and contributing to the view that such behaviour needs to be controlled and managed rather than understood.

Given the earlier work of Hastings & Remington (1994b) the aspects of this study dealing with the informal staff culture are of some interest. A key finding was that inexperienced staff tend to look to more experienced staff for help and guidance in terms of challenging behaviours. Hastings points out that new staff may not receive their formal induction until some time after they have joined the service. This means that their first few, possibly formative, weeks are spent learning from existing staff. A key aspect of this will be, therefore, how more experienced staff feel certain challenging behaviours should be responded to. It is clear from this study that staff do appear to develop their own 'rules' and that formal programs that contradict these

may well be viewed negatively e.g. as 'complicating things unnecessarily'. This study would also indicate that staff do not feel sufficiently involved in the construction of formal programs and feel that they have important information which is not acknowledged. Staff also indicated that they saw the main purpose of such programs as eliminating or controlling challenging behaviours. Hastings notes that as a result of this, programs that do not explicitly state this as an aim or in fact focus mainly on reinforcing positive behaviours, may well be abandoned by staff. It would also mean that programs which result in extinction bursts would quickly lose credibility with the staff sub-culture.

It is interesting to note that whilst constructive intervention strategies seemed to be more favoured by qualified staff, it was also qualified staff who indicated that the intrusiveness of such programs (eg. filling in record forms, attending meetings) is a key reason why they are abandoned.

This part of the study does seem to lend considerable support to the hypothesis put forward by Hastings & Remington (1994b) that responses to challenging behaviour may well be influenced by the staff culture. This research would suggest that experienced staff have a key role to play in this and that such responses are mainly concerned with stopping and controlling the behaviour. In addition, the formal service culture reinforces this by emphasising control and management in formal training.

7.4: Emotions and stress: The reasons why a culture of control and management might emerge relate to the stressful nature of challenging behaviour. Staff in this sample clearly indicated that they find challenging behaviours (particularly self-injury and aggression) aversive. For example, 58% found self-injury upsetting with 26% mentioning anger. Of considerable importance to the contingency effect hypothesis is that 53% of staff indicated that their emotional response to the behaviour had affected the way in which they had responded to it. It is interesting to note that Hastings found

that in the case of self-injury this reaction appeared to lessen over time, confirming the findings of Hastings & Remington (1995). This in itself may have important implications. It may mean, for example, that staff only respond to more severe behaviour, thereby differentially reinforcing it. It may also mean that staff are less motivated to implement programs that address behaviour which they no longer find aversive. Given the important role that experienced staff may play in the staff sub-culture, it may also be that more experienced staff socialise newer staff into a 'detached' view of certain behaviours. In the light of this it is interesting to note that in terms of coping with the stress of challenging behaviours 42% mentioned 'detachment'. In terms of the strength of the staff sub-culture it is also of note that 42% of staff mentioned receiving support from other staff. This is important in that it would indicate that whilst staff sub-culture may be implicated in counter habilitative responses to challenging behaviours it may also be an important factor in helping staff cope with stress. It could also mean that staff culture could be used to weaken the power of the contingency effect.

8. Discussion

Hastings (1995) is clearly an important study, providing some evidence for both contingency and 'staff culture' effects. Perhaps the most interesting finding is that lack of knowledge with regard to the causes of challenging behaviour is not the issue. Staff seem to be aware of the role which social reinforcement may play in the maintenance of challenging behaviours for example. What does emerge from this study is that the two hypotheses put forward by Hastings & Remington (1994b) may in fact be combined. That is that staff do find challenging behaviour aversive, producing negative affect. As a result their motivation to swiftly terminate individual episodes of challenging behaviour is high and the contingency effect, whereby staff and client become locked in a vicious circle, is quickly established. Actions on the part of staff which achieve a swift termination of individual incidents may then become part of the

sub-culture. New staff would then be socialised into this by experienced staff. Such a rule would be extremely powerful in that it would be supported by both pliance (the power of other staff to enforce adherence) and tracking (adherence resulting in the swift resolution of individual incidents).

There are, however, some difficulties with this study. As Hastings points out, it is based upon one learning disability service and a limited sample size of 19. It is by no means clear that the service used in Hastings (1995) can be regarded as representative of other services. For example, it is of note that 9 of the 19 participants were qualified nurses. This would certainly seem to be a higher proportion than in many such services (including the one that forms the basis of this research project). It is not clear, therefore, to what extent the finding that staff have a good knowledge of current models of challenging behaviour relates to this factor. It is also of note that the two units used in the study may not be entirely representative of more community-based challenging behaviour services. For example, Hastings indicates that between 10 and 15 clients lived in each unit in his study. It is possible, therefore, that staff in these services are unrepresentative of those who work in smaller units.

Hastings (1995) is clearly a very important study and gives some support to the view that both contingency and staff sub-culture effects may be implicated in the counter-habilitative nature of staff responses to challenging behaviours. In providing empirical evidence for the hypotheses put forward by Hastings & Remington (1994b) it represents an important contribution to research in this area.

RESEARCH AIMS AND OBJECTIVES

Clearly, the work of Hastings & Remington (1994b) and Hastings (1995) raises some important issues for those involved in learning disability services. Challenging behaviour represents one of the most difficult issues facing such services. Research that enhances our understanding of such behaviour and enables us to develop more effective strategies to tackle it is likely to be of great benefit. In human terms, the development of such strategies could represent a significant advance in terms of improving the quality of life for learning disabled clients with challenging behaviour needs i.e. reduced injuries, potential reductions in medication, reduced isolation and enhanced opportunities to access ordinary community facilities. This in turn would be likely to reduce both injuries and stress to staff, potentially leading to an increase in the amount of time spent by staff in constructive interactions with challenging clients. For the service as whole this process could also result in financial benefits in a number of areas. For example, reducing the levels of stress encountered by staff would be expected to have some impact on sickness rates. Reductions in the amounts spent on repairs related to challenging behaviours and additional staff would also be predicted.

As mentioned in the main introduction, one of the central issues facing clinical psychologists working in this area is that formal behavioural interventions are not always fully implemented by care staff. Hastings and Remington (1994b) suggest that this may be partly because these interventions are often not based upon a full functional analysis of the situation which would include staff attitudes, beliefs and sub-culture. An enhanced understanding of these factors should, therefore, enable clinical psychologists to engage more productively with care staff thereby increasing compliance and increasing the effectiveness of behavioural interventions generally.

The potential benefits in terms of increased research in this area are, therefore, considerable. Hastings & Remington (1994b) have provided a theoretical basis upon

which such research can be based. Hastings (1995) has provided some empirical evidence to support the existence of both the contingency and staff culture effects. Having reviewed the findings of Hastings (1995) I have argued that there is, in fact, evidence to suggest that there may well be an interaction between these two effects i.e. that the aversive nature of challenging behaviour leads staff to adopt strategies that swiftly terminate individual incidents of such behaviour and that these strategies become part of the staff sub-culture, reinforced by both pliance and tracking.

However, as Hastings & Remington (1994b) and Hastings (1995) point out, research in this area is still very much in its early stages. Hastings (1995) represents the first attempt to gather empirical evidence specifically related to the contingency and culture hypotheses. As has been discussed earlier, whilst Hastings (1995) represents an important contribution to research in this area, it has yet to be established that the results can be generalised to other challenging behaviour services. Quite clearly, more research is needed in terms of staff culture in such services. In particular, as Hastings & Remington (1994b) argue, an essential element in this will be staff self-report methodology. Given the central role which care staff have in the lives of clients with challenging behaviours, it is striking how little research has been devoted to them. Hastings (1995) represents an important first step in developing research in this area and this research project seeks to continue this process.

Research Aims

1. To establish to what degree the results obtained by Hastings (1995) may be generalised to other challenging behaviour services.
2. To gather further quantitative and qualitative data with regard to staff culture in challenging behaviour services.

3. To further evaluate the hypothesis that staff responses to challenging behaviours are influenced by both contingency and culture effects.

4. To develop a training package designed to ameliorate counter-habilitative influences on staff responses to challenging behaviours.

5. To evaluate the effectiveness of this package.

6. In the light of the results of this research project to suggest future intervention strategies and avenues of research.

Given the above aims and objectives, this research project is divided into four further sections:

Section Two

Section Two takes as its starting point the contingency and staff culture hypotheses put forward by Hastings & Remington (1994b) and the supporting data contained in Hastings (1995). Using a community-based learning disability service it seeks to investigate staff culture in such services in more depth, drawing in particular upon themes from the work of Hill-Tout & Lowe (1995). It seeks to establish to what degree the hypotheses put forward by Hastings & Remington (1994b) may be regarded as valid and to what extent the findings of Hastings (1995) may be generalised to other challenging behaviour services.

Section Three

Section Three documents the first phase of a quasi-experimental intervention study designed to ameliorate counter-habilitative influences within staff sub-cultures. In

particular it documents the development and delivery of a training package based upon the hypotheses of Hastings & Remington (1994b) and the data gathered in Section Two. Qualitative data gathered concerning counter-habilitative influences within staff sub-cultures is also documented and discussed.

Section Four

Section Four sets out the results of a quantitative evaluation of the effects of the training on the attitudes and beliefs of participating staff. These results are discussed in the light of the qualitative data gathered.

Section Five

Section Five is a general discussion of the main findings of this research project. Implications of the findings are discussed and suggestions made for future research.

SECTION TWO

STUDY ONE

RESEARCH PROTOCOL

A full proposal for this research project was submitted to the University of Plymouth clinical teaching team and the Exeter Community Health Services Trust Ethics Committee for approval. In addition, ethical aspects of the study were discussed with Mr. D McDermott, Principal Clinical Psychologist based with the learning disability service in Exeter. Mr. McDermott agreed to supervise the research project.

In discussions with the University course team attention focused mainly upon the quasi-experimental study, which contains a control group ie. one residential service which does not receive any training as part of the study. Concern was expressed that should the training provided prove to be successful in producing habilitative changes in the attitudes and beliefs of participants, those who did not receive training would not benefit from participation in the study. Given that such positive changes would also be expected to improve services to clients, this could also mean that residents of the control group service would not benefit from an improved service available to clients whose service had received training. In the light of this it was agreed with Mr. McDermott that the training package would be made available to all participants who had not received it at the end of the study.

Following course team approval, the researcher & Mr. McDermott met with the Exeter Ethics Committee where the above point was again discussed. On this basis the research was approved by the committee & the Medical Director, Dr R Ayres.

Appendix A contains a) Approval from the Exeter Ethics Committee, b) Approval from the Medical Director, c) A consent form filled out by all participants, d) An information form sent to all participants.

STUDY ONE

1. INTRODUCTION

This study takes as its basis the theoretical propositions put forward by Hastings & Remington (1994b) and the supporting empirical evidence of Hastings (1995), as outlined in the main introduction. The main points may be briefly summarised as follows:

a) That staff find challenging behaviours aversive, leading to negative affect. Staff responses to challenging behaviours may serve, therefore, an escape function. Staff appear to cope with this negative affect by 'detaching' themselves from the situation and by seeking support from other staff.

b) That different challenging behaviours may be associated with different negative emotions.

c) That staff attributions for, attitudes towards and beliefs about challenging behaviour are likely to influence their responses to such behaviour.

d) That the staff sub-culture within such services may also be an important influence on staff behaviour ie. what Hastings (1995) refers to as 'unwritten ways of working'. Younger and more inexperienced staff may be greatly influenced by older, more experienced staff and particular attributions for and responses to challenging behaviours encouraged through strong peer pressure. As such it would appear that staff groups develop a collective view with regard to challenging behaviours and that adherence to this view is highly valued within the staff culture.

e) That care staff have a good knowledge of current models of challenging behaviour and that as such lack of knowledge cannot account for counter-habilitative staff responses.

f) That staff responses to challenging behaviour do not reflect their understanding of these models, being mainly concerned with managing, controlling and eliminating such behaviours.

g) That whilst stereotypy is included in formal definitions of challenging behaviour, staff do not classify it in this way. Stereotyped behaviour does not seem to be associated with significant stress or negative affect. As such, Hastings (1995) argues that this behaviour may be seen as a 'special case', to be considered separately from aggression, self-injury and destructive behaviours.

h) That particularly with self-injury, there may well be a 'tolerance' effect in which negative affect diminishes as staff are exposed to more incidents.

i) That where formal behavioural programs are constructed to ameliorate challenging behaviours, they are not fully implemented by care staff. This may be due to an interaction involving both contingency and culture effects.

This study seeks, therefore, to examine these factors in more depth using a larger and more community-based sample than Hastings (1995). Should the results obtained by Hastings (1995) and the theoretical propositions put forward by Hastings & Remington (1994b) be confirmed, this would have important ramifications. In particular, it would give a firm foundation for interventions, based upon the behaviour analytic approach, with staff groups as a means of reducing incidents of challenging behaviour amongst clients.

2. HYPOTHESES

Given the above, the following hypotheses were made:

1. That participants will associate self-injurious and aggressive behaviours with high levels of stress and negative affect.
2. That in relation to hypothesis (1) those staff who are exposed to the highest levels of self-injurious and aggressive behaviour will show the least emotional response to it.
3. That stereotyped behaviour will not be associated with high levels of stress and negative affect.
4. That different types of challenging behaviour will be associated with different types of negative affect.
5. That talking to others about feelings in relation to work will be highly valued both by the staff culture as a whole and by individuals.
6. That participants will demonstrate a good understanding of current models of challenging behaviour. In particular, participants will show an awareness of the role which social reinforcement might play in the development of challenging behaviours.
7. That an analysis of participants' attributions for different challenging behaviours will indicate to what extent staff associate particular behaviours with particular causal factors.

8. That staff responses to self-injurious and aggressive behaviours will be concerned with controlling, managing and eliminating the behaviours. There will, therefore, be an incongruence between the theoretical understanding possessed by staff and their responses to challenging behaviours.

9. That stereotyped behaviour will not be associated with the responses outlined in hypothesis (8).

10. That team leaders will indicate poor compliance by staff with some behavioural programs.

11. That participants will indicate that agreeing with colleagues is highly valued within the staff culture.

12. That an analysis of staff sub-culture, based upon the work of Hill-Tout & Lowe (1995), will reveal both habilitative and counter-habilitative influences within that culture.

3. METHOD

3.1: Participants:

Four residential units in the Exeter area were approached with regard to participation in this study. All indicated that challenging behaviour was an issue for their service and that they were interested in receiving training in this area. In each case the researcher had discussions with team leaders with regard to the study and following this, individual staff were approached with regard to their participation. Across the four services 43 staff agreed to take part in the study of whom 26 were female and 17

male. All were employees of the Exeter & District Community Health Service Trust. 6 were qualified nurses and 37 were unqualified. Length of experience working with challenging clients ranged from 6 months to 26 years with an average of 8 years 11 months. 45.2% of staff had at least 10 years experience. A high proportion of these staff would appear to have been previously employed at a local mental handicap hospital which was closed about 10 years ago. Once the hospital was closed many staff transferred to the new community-based residential services. A brief description of each service is set out below:

UNIT A: - this is a community residential home for 5 clients. Although not specifically set up as a specialist challenging behaviour service, all its residents exhibit challenging behaviours as well as having moderate to profound learning disabilities. The home is in an ordinary residential area in a town just outside Exeter. All clients have their own room and day service activities are provided by the home itself. In recent years the level of challenging behaviours encountered by staff has been of concern to the team leader and management. The average length of experience of participants working at this unit was 5 years and 9.75 months, ranging from 6 months to 18 years. 10 out of a possible 14 staff agreed to participate (2 staff were absent due to long term sickness).

UNIT B: - this is a residential facility built in the grounds of a closed psychiatric hospital. It has 6 residents, all of whom have moderate to severe learning difficulties. The unit was not established as a specialist challenging behaviour service but in recent years staff have reported increasing difficulties with challenging behaviours from some residents. Each resident has their own room. No day service is, as yet, available to residents of Unit B, although negotiations are continuing with social services. The average length of experience of participants working at Unit B was 8 years and 1.5 months, ranging from 6 months to 22 years. All 12 staff agreed to participate.

UNIT C: - this is a specialist facility for challenging clients whose placement in ordinary residential facilities has broken down due to their behavioural needs. It normally has 3 beds but currently has 2 residents. A team of health service professionals, including a senior nurse, occupational therapist and clinical psychologist provide input to the unit. The unit aims to swiftly return clients to ordinary community placements. However, with the current clients, this has not been possible and they have now lived at the unit for 2 years. 4 staff are on duty at all times. The home is adjacent to a hospital but is part of a residential area. Residents have their own rooms. The average length of experience for participants was 7 years and 4 months, ranging from 9 months to 19 years. 11 staff agreed to participate out of a possible 16.

UNIT D: - this is a residential facility in an ordinary residential area of Exeter. It was not established as a challenging behaviour service but in recent years staff have reported increasing incidents of challenging behaviour from some residents. There are currently 8 residents with a variety of needs, the majority of whom receive a day service from a local social services resource centre. The average length of experience for participants working at this unit was 14 years and 4 months, ranging from 3 years to 26 years. 10 staff agreed to participate out of a possible 12.

The length of services figures are of some interest and are examined further in the discussion section. It is of note that 85.7% of the participants were unqualified, a figure that would be typical of this service as a whole. One possible criticism of Hastings (1995) is that his sample contains a rather high proportion of qualified staff, possibly biasing results. By using a sample based more upon unqualified staff it was hoped to eliminate any possible bias.

3.2: **Measures:**

This study is based largely upon self-report measures rather than direct observation by the researcher on the units themselves. Direct observation was considered. However, such an option presents considerable difficulties from both the ethical and practical points of view. First, the units concerned are long term residential services, where many residents have lived for a number of years. It was felt that the presence of an observer would be a considerable intrusion on the privacy of the clients concerned. In addition, many would be unable to give informed consent for this. From the practical point of view team leaders indicated that many of their clients reacted strongly to the presence of strangers with new staff being a particular focus for challenging behaviours. A 'participant observer' approach (Vetere & Gale, 1987) was not, therefore, felt to be ethically acceptable or practical. In terms of attempting to gain an accurate picture of the 4 units concerned, it was also felt that the presence of an observer would inevitably lead to some changes in behaviour by both staff and clients. Given that a key aspect of this research was to investigate staff views with regard to challenging behaviours, self-report methodology seemed to be both the most practical and ethical approach.

Given the numbers of staff involved, a structured interview approach, as used by Hastings (1995), was not felt to be practical in terms of the timescale of this project. As such, it was felt that a questionnaire-based approach would be the most effective and practical means of gathering a large volume of self-report data.

3.2.1: **Measure A: - Staff and challenging behaviour questionnaire.**

a) **Construction:**

This questionnaire was designed to examine staff emotional reactions to, attributions for and responses to stereotypy, self-injury and aggression. Each of these behaviours was represented on the questionnaire by a vignette, describing the behaviour of a fictitious client called 'James Robinson'. This approach was based upon that used by Hastings & Remington (1995) in their analysis of staff emotional reactions to challenging behaviours. Hastings & Remington (1995) based their three vignettes on a topographical definition of each behaviour derived from relevant research studies concerning challenging behaviours. Given the successful use of these vignettes by Hastings & Remington, it was decided to use them for this questionnaire (the author's permission having been obtained). A small addition was made to the vignette concerning self-injury, with the phrase '...or other temporary or permanent tissue damage' being added. This addition, taken from the definition of self-injury given in the main introduction (Oliver et al 1987), was intended to emphasise the potential damage to the client that might result from such behaviour. The vignette used by Hastings & Remington (1995) mentions 'bruising' and 'bleeding' only and does not mention the possibility of permanent harm.

In relation to their emotional reaction to challenging behaviours, following each vignette, participants were asked to indicate how stressful they would find being involved in the incident described on a 7 point Likert scale (Likert, 1932) anchored at 'Not at all' and 'Extremely Stressful'. Likert scales were used throughout the questionnaire as a visual and straightforward means by which staff could indicate their responses. In addition, participants were asked to list any emotions they felt that they would experience in the situation described. This part of measure A was specifically related to hypotheses (1), (2), (3) and (4).

In relation to their attributions for the behaviour described in each vignette, staff were asked how likely they felt it was that the behaviour could be attributed to each of the following factors, reflecting current models of challenging behaviour. These were : a) 'Individual' (ie. factors related to the physical and mental state of the client such as personality, pain, illness), b) 'Environmental' (ie. factors related to the client's environment such as noise, bullying, other residents), c) 'Communication' (ie. a way in which the client might be attempting to communicate with others) and d) 'Past Experiences' (ie. particularly the results of past learning experiences resulting in material or other gains or removal of something the client finds aversive). For each of these items the participants were asked to indicate their view on the likelihood of it being a cause of the behaviour described in the vignette, using 7 point Likert scales anchored at 'Not at all Likely' and 'Extremely Likely', and to give possible further examples of how this factor might have led to the behaviour. This section of the questionnaire was designed to a) establish whether participants had different attributions for different behaviours, b) establish the degree to which past reinforcement (covered by the 'past experiences' factor) was identified by staff as a causal factor in challenging behaviours and c) by considering, in particular, the examples given by staff themselves, to assess to what degree participants understood current models of challenging behaviour and were able to translate these into practical examples from their own experiences. As such, this part of Measure A relates specifically to hypotheses (6) and (7).

With regard to responses to the challenging behaviours described, the questionnaire attempted to address the difficulties described by Hastings & Remington (1994a) in which questions that ask staff what they 'usually do' might bias participants towards focusing on those occasions when they did respond, neglecting those occasions where the behaviour was ignored. For each vignette staff were given the following options as responses: a) Physical restraint, b) Ignore the behaviour, c) Distract the client, d)

Reprimand the client, e) Communicate with the client (specifically to talk to the client in an attempt to find out what had led to the behaviour) and f) Other responses - allowing staff to indicate any other responses they might consider, not covered by the other options. By asking staff to indicate the likelihood of each option and including an 'ignore' option, it was hoped that any possible bias might be eliminated. For each vignette staff were asked to rate each of these options on a 7 point Likert scale anchored at 'Not at all Likely' and 'Extremely Likely'. For the 'Other' option participants were asked to describe the action they would take. The final section of Measure A was, therefore, designed to test hypotheses (8) and (9).

In order to facilitate the piloting of the questionnaire, an additional set of questions were included with regard to the questionnaire itself. First, staff were asked to indicate on a 7 point Likert scale anchored at 'Not at All' and 'Extremely' how representative the vignettes were of the challenging behaviours that they had encountered. Secondly, they were asked to indicate how easy the instructions given were to follow, with the scale anchored at 'Extremely Easy' and 'Extremely Difficult'. Thirdly, they were asked how representative their replies were of their actual views, feelings and attitudes. Here the scale was anchored at 'Not at all' and 'Extremely'. In constructing the questionnaire a key concern had been that staff replies might not reflect their actual views/actions ie. for example, staff might not use the 'Reprimand' scale for responses because this might seem to be 'incorrect' or incongruent with service values and good practice. Finally, in relation to this, staff were specifically asked to give details of any factors that might have led them to give responses that did not in fact reflect their actual views or practice. Feeling that replies had to be ones that would be approved of by the learning disability service was given as a specific example. Staff were also asked to comment upon the questionnaire generally.

A sample questionnaire is contained in Appendix B.

b) Piloting Procedure:

The questionnaire was initially piloted with a group of 8 staff who were not taking part in the main study. Some difficulties were encountered in recruiting participants for this procedure, given that a large number of staff were already taking part in the main study. All worked within the Exeter Learning Disability Service and had regular contact with learning disabled clients with challenging needs. Each was asked to fill in the questionnaire, including the section regarding the questionnaire itself.

With regard to the suitability of the vignettes used, the average score on the 7 point Likert scale was 6.33, indicating that staff found them to be highly representative of the behaviours they had encountered. With regard to the instructions, the average score on the 7 point Likert scale was 2.16, indicating that staff felt that they had not encountered significant difficulties in following the instructions.

With regard to the validity of the questionnaire the key question was whether staff had given answers that reflected their actual views and responses to challenging behaviours. On the 7 point Likert scale provided the average score was 5.5, indicating that they had broadly answered the questionnaire in a manner congruent with their actual views. No replies were received to the question on the form with regard to possible factors that might have led to incongruent replies. When approached by the researcher, staff indicated that they had given replies congruent with their views. However, participants did also indicate that since they did not know the client concerned personally, it had been difficult to say precisely what action they would take. Hence they felt there might be some incongruity between their responses on the questionnaire and their actions in 'real life' had they known the client.

Staff replies to the attributions section of the questionnaire also indicated that they had interpreted the factors (ie. 'Individual', 'Environmental' etc) as intended by the

researcher. The 'Individual' item attracted examples concerned with the clients individual physical and emotional well-being (particularly epilepsy and emotional distress). Typical replies for the 'Environmental' factor included lack of stimulation and lack of privacy. In terms of the 'Communication' factor, replies were mainly concerned with the expression of emotion, particularly sadness, anger and frustration. The 'Past' factor replies centered around social reinforcement/learning and past abuse.

This initial pilot gave encouraging results in terms of the validity of the questionnaire. It was recognised that this was based upon a small sample size. It was not felt appropriate to pilot the questionnaire with staff working with non-challenging clients. Piloting the questionnaire with staff from another challenging behaviour service (ie. outside Exeter) would not have been satisfactory given the number of variables in which these staff might differ from the main sample in this study (eg. different induction, training experiences, management policies, access to staff support services etc). Given this, it was decided to incorporate the validity questions section as a permanent feature of the questionnaire. This would enable the question of validity to be monitored throughout the study.

As part of a test-retest reliability procedure each participant of the pilot study was asked to complete the questionnaire again, 2 weeks after filling it in initially. All agreed to do so. A gap of 2 weeks was felt to be adequate for this, given the length and complexity of the questionnaire. It was also noted that a number of the participants were due to attend training courses, meaning that had the retest been further delayed the training might have confounded results. Each participant contributed, therefore, two scores for each scale. These data pairs were categorised in terms of a) Those that were identical, b) Those where there was a difference of 1 point only and c) Those where there was a difference of more than 1 point. Data pairs in categories (a) and (b) were considered to be acceptable in terms of reliability whereas

data pairs in category (c) were indicative of unreliability. Reliability ratings for the questionnaire as a whole and its 3 parts were then calculated by dividing the number of data pairs in categories (a) and (b) by the total number of data pairs. The results are set out in Table 1:

TABLE 1

Questionnaire	Reliability
All Scales	0.899
Stress Scales	0.958
Attribution Scales	0.822
Response Scales	0.917

Table 1: Reliability Ratings for Measure A

On the basis of this pilot procedure it was decided to use the questionnaire in the main study.

3.2.2: **Measure B: - Staff Culture Questionnaire**

a) **Construction:**

This questionnaire was designed to investigate staff sub-culture in more depth. Eight possible influences were identified from the work of Hill-Tout & Lowe (1995). This work is of particular interest in that it represents an attempt by a learning disability service to define more precisely what skills and attributes are desirable in unit staff. These attitudes and attributes are interesting with regard to this project in that they may be applied to both individuals and staff groups as a whole i.e. attributes identified as positive factors in individuals are also likely to be positive when applied to staff groups. For each of the eight factors, a statement was formulated to describe it. The statements were:

1. 'Is able to talk about their personal feelings in relation to work' - given that Hastings (1995) found that support from other staff was an important means of coping with challenging behaviour, this was included as part of the questionnaire. As such it was included as part of the evaluation of hypothesis (5).

2. 'Feels confident they can deal with any situation' - this was felt to be an interesting variable within the staff culture. If the staff culture values and adopts this sort of attitude it could have important consequences for staff and clients. For example, inexperienced staff may feel under pressure to cope and deal with situations beyond their abilities. It may mean that asking for assistance is seen as a weakness, resulting in loss of status within the staff team. For clients it may mean that incidents are handled poorly. This part of measure B relates, therefore, to hypothesis (12).

3. 'Has a good understanding of the principles of normalisation' - this was included in order to determine how far the official service philosophy has become part of staff cultures. This would relate to hypothesis (12).

4. 'Readily agrees with other colleagues' - this was included as a measure of the cohesion of the staff group and the degree to which 'having a united view' is valued by staff. This would relate to hypothesis (11).

5. 'Follows detailed instructions/written guidelines completely' - this was included as a measure of to what degree compliance with formal programs was valued by participants. This was included as part of the evaluation of hypothesis (10).

6. 'Feels strongly that when someone has done something wrong they should be punished' - given the finding by Hastings (1995) that staff tend to opt for control-based strategies in response to challenging behaviours, staff attitudes towards

punishment were felt to be an important variable. This was included as part of hypothesis (12).

7. 'Quick to recognise small changes in the behaviour of others' - this was included as a measure of one possible reason why behavioural programs may be abandoned by staff. If staff fail to notice small positive changes in client behaviour they may quickly become discouraged and cease to implement the program. This was included as part of the evaluation of hypothesis (10).

8. 'Has strong personal beliefs and seeks to persuade others of these' - this was included as a measure of how staff who seek to influence the attitudes/beliefs of other staff might be regarded. This part of measure B related to hypothesis (12).

For each of these statements staff were asked 3 questions. First, how much they felt this was valued where they worked. This was included as a measure of the degree to which the attribute described was perceived as being a part of the staff culture. A 7 point Likert scale was used anchored at 'Not at all valued' and 'Extremely valued'. Secondly, staff were asked how much they valued it personally. The 7 point scale was anchored at 'Not at all' and 'Extremely'. Finally, staff were asked to what degree they possessed the attribute. The 7 point scale was anchored at 'Not at all' and 'To a very great extent'.

As with measure A an additional sheet was included asking staff to comment upon the questionnaire itself. With the exclusion of the 'vignettes' question, this was identical to that used in measure A.

b) Piloting Procedure:

The 8 staff who had taken part in the pilot procedure for questionnaire A participated in this pilot study. Two weeks after having completed Measure B for the first time they were asked to do so again. All agreed to do so.

With regard to the instructions provided, the mean score using the 7 point scale provided was 2.38, indicating that staff did not have significant difficulty with them. The mean score for the question regarding the degree to which replies were congruent with participants actual views was 5.38. Staff indicated that they had replied in a manner that did reflect their views but, as with measure A, also indicated that some questions were difficult to answer precisely without being given a specific context.

The test-retest procedure was carried out as described for measure A. Results are set out in Table 2:

TABLE 2

Questionnaire	Reliability
All Scales	0.95
Question 1	0.91
Question 2	1
Question 3	1
Question 4	0.92
Question 5	0.95
Question 6	0.95
Question 7	0.92
Question 8	0.96

Table 2: Reliability Ratings for Measure B

On the basis of this pilot procedure the scale was used in the main study. As with measure A, the sheet asking participants to comment upon the questionnaire was retained, enabling aspects of the validity of the measure to be monitored throughout the study.

3.2.3: **Measure C: - Unit Measures.**

Measure C, filled out by unit leaders, was designed to examine 3 unit-based variables.

First, the number of incidents of challenging behaviour recorded at the unit during each month. Recording of incidents is part of the administrative routine of units where challenging behaviour is an issue and is in fact a requirement of the Trust. In practice this entails the recording of incidents where aggressive, destructive or self-injurious behaviours were involved. It was recognised that there were some weaknesses to this measure. First, it does not include incidents of stereotypy. Secondly, there might be some variation between units as to at what point an incident was considered to be serious enough to record. However, in discussions with team leaders (and from the past experience of the researcher) it was felt that the interpretation of the Trust guidelines was broadly similar. This measure was included for the following reasons. First, it is not clear from the literature how much challenging behaviour is typically encountered by staff. Secondly, given the finding that increased exposure to challenging behaviours may lead to a decline in emotional response (Hastings & Remington 1995), the number of incidents encountered by staff in each service was clearly an important factor when considering their replies to the first part of measure A (ie. stress and emotion). This measure also related, therefore, to hypothesis (2).

Secondly, measure C asked team leaders to record on a monthly basis the number of their clients for whom a formal behavioural program/guidelines existed. This was intended to ascertain to what degree these programs are used within this service.

Thirdly, for each of these programs, unit leaders were asked to rate to what degree staff had complied with the instructions given. Unit leaders were asked to indicate their view using a 7 point Likert scale anchored at 'Not at all compliant' and 'Extremely compliant'. It had been hoped to complement this rating with a second rating, on the same scale, given by another independent person connected with the program (eg. the clinical psychologist or nurse behaviour therapist who had written it). However, this proved to be impractical in that those approached indicated that they had too little day to day contact with the unit to give a rating and that in practice they would rely on the view of the team leader. This measure was included as part of the evaluation of hypothesis (10).

Measure C is contained in Appendix B.

3.3: **Procedure:**

Measures A and B were distributed to all participants. At this point a number of participating staff raised concerns with regard to confidentiality, indicating a concern that team leaders might be provided with information regarding individual replies. Further discussions were, therefore, held with a number of staff. Measure C was distributed to team leaders with a request that it be filled out on a monthly basis over a period of 3 months. Measures A and B were returned to the researcher over a 4 week period.

4. RESULTS.

4.1: Validity Data - Measures A & B:

For measure A the average rating for the vignettes provided was 5.63, indicating that staff had found the examples of challenging behaviours given representative of those they had encountered. The rating for the instructions provided was 2.75, indicating that staff had not encountered significant problems with the questionnaire. For the question regarding to what degree their replies had reflected their actual views, the average rating was 5.31, giving encouraging evidence for the validity of the questionnaire. As with the pilot sample, some staff did indicate that without knowing the client personally it had been difficult to say precisely how they would respond in a given situation.

For measure B the average rating for the instructions provided was 3.2, again indicating that staff had not encountered significant difficulties with the instructions. In terms of replies reflecting actual views, the average score was 5.33. Very few comments were made about the questionnaire by staff. It is of some interest, given the nature of this study, that 2 of the 10 participants who did make comments, indicated that their views at any particular time would, to some degree, be affected by the levels of stress they were encountering.

4.2: Incidents of Challenging Behaviour:

The average number of logged incidents of challenging behaviour are set out below:

TABLE 3

UNIT A	UNIT B	UNIT C	UNIT D
253.33	6.33	26	9.33

Table 3: Average Monthly Frequency of Challenging Behaviours

Clearly, therefore, there was a substantial disparity in terms of logged incidents of challenging behaviour between Unit A and the other units. It is of note that all 5 residents in this service are considered to have considerable challenging behaviour needs and, as such, were involved in incidents. In addition, since these clients do not receive a day service, they are with unit staff 24 hours a day. It is of interest that as this is a community residential facility and not a specialist challenging behaviour service, the overwhelming majority of staff are unqualified.

In terms of this study, the large disparity between units provides a clear test of hypothesis (2) ie. if there is a 'tolerance' effect to challenging behaviours, then this should be most evident at Unit A.

4.3: Emotional Responses to Challenging Behaviours:

With the scales relating to emotional responses, for each unit results are presented in terms of the mean score and standard deviation. The standard deviation was included as a measure of the level of agreement between participants for that item ie. a small standard deviation would indicate a high level of agreement. For each vignette details are also given of the negative emotions associated with it by participants.

4.3.1: **Stereotypy:**

TABLE 4

	UNIT A	UNIT B	UNIT C	UNIT D
MEAN	2.1	1.75	1.545	2.4
STAN DEV	1.71	0.87	0.82	1.17

Table 4: Average Stress Ratings for Stereotypy

In terms of specific emotional responses to stereotypy, 8 staff said that they would have no emotional response, 5 said that they would feel frustrated, 5 said that they would feel worried, 4 said that they would feel sad, 3 said that they would feel sympathy for the client, 2 said that they would feel bored and 1 said that he/she would feel uncomfortable.

These results would appear to confirm hypothesis (3) ie. that stereotyped behaviour was not seen as being particularly stressful by staff. However, it would be overstating the case to say that there was no emotional response. A minority of staff did indicate that they would experience negative affect in relation to the behaviour eg. frustration and worry. This could indicate that whilst a contingency effect may be less strong with stereotyped behaviour, it may well still operate with some staff, especially when stressors other than the behaviour itself are also present.

4.3.2 : **Self-Injurious Behaviour:**

TABLE 5

	UNIT A	UNIT B	UNIT C	UNIT D
MEAN	3.4	4.5	4.9	4.3
STAN DEV	1.71	1.62	1.62	1.56

Table 5: Average Stress Ratings for Self-Injury

Clearly self-injurious behaviour was associated with a greater degree of negative affect than stereotypy. It was also notable that participants working at Unit A indicated the least emotional response to it. The prediction that these staff would show a significantly lesser response (Hypothesis 2) to self-injury was tested using a one way analysis of variance comparing unit A with the other units. The prediction was confirmed ($p=0.042$, $df=39$). The negative affect associated with self-injury was illustrated by the examples given by participants: 9 mentioned feeling upset, 7 said that they would feel worried, 6 said that they would feel sympathy for the client, 5 said that they would feel afraid, 5 mentioned frustration, 2 said that they would feel helpless and anger, discomfort and mental exhaustion were each mentioned once.

4.3.3: **Aggressive Behaviour:**

TABLE 6

	UNIT A	UNIT B	UNIT C	UNIT D
MEAN	4.4	4.75	5.27	5.1
STAN DEV	1.897	1.54	1.49	1.45

Table 6: Average Stress Ratings for Aggression

Although participants in Unit A gave the lowest average stress rating for aggression, a one way analysis of variance did not reveal a significant difference between Unit A and the other units ($p>0.05$). Hypothesis (2) was not, therefore, confirmed for aggressive behaviour. It is clear from these results that aggressive behaviour was associated with significant stress amongst this sample.

In terms of specific examples of negative affect, the following were cited by participants: 11 said that they would feel afraid, 8 indicated that they would be worried, 5 said that they would feel frustrated, 4 said that they would feel anger, 4 indicated that they would feel generally 'stressed' and 2 indicated that they would feel sad. It is interesting to note that whilst 6 participants mentioned sympathy with regard to self-injurious behaviour only 1 did so for aggression.

These results would indicate support for hypotheses (1) and (3). Hypothesis (2) would appear to be confirmed for self-injurious but not aggressive behaviour. This disparity is commented upon in the discussion section. These results would also give some support to hypothesis (4). Stereotyped behaviour appeared to elicit the least emotional response, with frustration and worry being the most cited examples of negative affect. Self-injury would appear to elicit a much stronger emotional response, leading staff to feel 'upset'. Self-injury would also appear to elicit some feelings of sympathy in staff. Aggressive behaviour produced the strongest emotional response in this sample. This response was mainly centered around feelings of fear and worry. Aggression did not appear to elicit feelings of sympathy in this sample.

4.4: **Attributions for Challenging Behaviours:**

As with the scales concerned with emotional responses, results for the attribution scales are presented in terms of both the mean score and the standard deviation.

4.4.1: **Stereotypy:**

TABLE 7

	INDIVIDUAL	ENVIRON	COMM	PAST
MEAN	4.9	5.32	5.17	5.28
STAN DEV	1.41	1.297	1.14	1.38

Table 7: Average Attribution Ratings for Stereotypy

Participants gave, therefore, high probability ratings for each of the categories. In terms of specific examples of possible causes of the behaviour results are set out in Table 8, overleaf. It can be seen from these examples that staff made a strong association between stereotypy and lack of stimulation. However, they also generated a wide range of other possibilities congruent with current models of such behaviour.

4.4.2 : **Self- Injury:**

TABLE 9

	INDIVIDUAL	ENVIRON	COMM	PAST
MEAN	5.43	5.02	5.38	5.11
STAN DEV	1.447	1.237	1.14	1.525

Table 9: Average Attribution Ratings for Self-Injury

As with stereotypy participants gave each of the categories a high rating. Specific examples were again both numerous and congruent with current models of self-injurious behaviour, focusing mainly upon lack of stimulation, the expression of distress and the result of past learning experiences related to attention. Details of the examples given by staff are set out in Table 10.

TABLE 8

CAUSE OF BEHAVIOUR	FREQUENCY
Lack of Stimulation	19
Lack of Skills to Interact with the Environment	6
Communication of Boredom	6
Living Space too Small	6
Poor Interaction from Unit Staff	6
Specific Examples Related To Attention	5
Client Frustration	5
Communication of Hunger	4
Client Stressed	4
Communication of Thirst	3
Client Feeling Threatened	3
Result of Past Abuse	2
Client Feeling Happy	2
Communication of Frustration	2
Institutionalised Behaviour	2
Client Distressed	2
Lack of Sleep	1
Impatience	1
Gives Client Sense of Security	1
Dislike of Other Residents	1
Communicating Pain	1
Communication of Contentment	1
Needs the Toilet	1
Result of Past Losses	1
Staff Not Keeping Their Promises	1
Childhood Experiences	1

Table 8: Frequency of Specific Possible Causes Given for Stereotypy

TABLE 10

CAUSE OF BEHAVIOUR	FREQUENCY
Communication of Distress	11
Unstimulating Environment	9
Examples Related to Attention	7
Medical Factors eg: Epilepsy	6
Environment too Small	5
Client Angry	4
Sexual Frustration	4
Lack of Skills in Interaction	2
Conflict with other Residents	2
Lack of Control over his Environment	2
Communication of Excitement	2
Communicating a need for Help	2
Past Abuse	2
Past ECT	1
Past Punishment	1
Past Bullying	1
Communication of Fatigue	1
Communication of Feelings of Security	1
Poor Interaction from Staff	1
Dislike of a Meal	1
Confusion	1

Table 10: Frequency of Specific Possible Causes Given for Self-Injury

4.4.3: **Aggression:**

TABLE 11

	INDIVIDUAL	ENVIRON	COMM	PAST
MEAN	5.17	5.15	5.1	5.01
STAN DEV	1.45	1.41	1.64	1.34

Table 11: Average Attribution Ratings for Aggression

Participants gave, therefore, high ratings for each of the categories. Details of specific possible causes given by participants are set out in Table 12.

TABLE 12

CAUSE OF BEHAVIOUR	FREQUENCY
Conflict With Other Residents	11
Examples Related To Attention	8
Communication of Emotional Distress	8
Lack of Skills to Interact	7
Lack of Stimulation	5
Client's Frustration	4
Dislike of the Environment	4
Communication of Pain	2
Effects of Medication	2
Communicating a Need for Attention	2
Past Abuse	2
Sexual Frustration	2
Client Confused	1
Client Afraid	1
Result of Past Restraints	1
Communicating a Lack of Control	1

Table 12: Frequency of Specific Possible Causal Factors for Aggression

Aggression was, therefore, associated with conflict with others, learned behaviour in which attention was the main factor, emotional distress and lack of communication skills. These factors are all congruent with current models of such behaviour.

In terms of participants' attributions for challenging behaviours a number of points are worthy of note. First, hypothesis (6) would appear to be confirmed. Participants generated an impressive range of possible causes for each of the behaviours, congruent with current models of challenging behaviour. Particularly with self-injury and aggression, social reinforcement linked to attention was one of the most frequently cited examples given by participants. It is, however, interesting to note that as with

Hastings (1995), participants did not give examples of the role which avoidance might play in the development of challenging behaviours. Whilst a lack of understanding of the major causes of challenging behaviour amongst learning disabled clients would not appear to be a central issue with these staff, their apparent lack of awareness of the possible role of negative reinforcement is of some note.

In terms of hypothesis (7), the specific examples of possible causes given by staff would seem to indicate that particular behaviours are associated with particular causes within this sample eg. stereotypy and lack of stimulation, aggression and conflict with others.

4.5: **Responses to Challenging Behaviour:**

Results are given in terms of the average rating of likelihood for each response and the standard deviation.

4.5.1: **Stereotypy:**

TABLE 13

	Restrain	Ignore	Distract	Reprimand	Commun
Mean	1.55	3.26	5.71	2.06	5.9
Standard Dev	1.15	1.71	1.64	1.23	1.23

Table 13: Average Ratings for Responses to Stereotypy

In addition to the above, 7 participants indicated that they would request an additional assessment of the client, 3 indicated that they would attempt to meet the need that had led to the behaviour and 1 mentioned teaching James constructive communication skills. These results would confirm hypothesis (9) in that stereotyped behaviour was

not associated with 'control'-based responses. Participants strongly favoured distraction and communication as responses, which would be congruent with their attribution of the behaviour to lack of stimulation.

4.5.2: **Self-Injurious Behaviour:**

TABLE 14

	Restraint	Ignore	Distract	Reprimand	Commun
Mean	3.67	1.46	5.9	2.76	6.03
Stan Dev	1.4	1.11	1.23	1.87	1.03

Table 14: Average Ratings for Responses to Self-Injury

In addition to the above, 4 staff said that they would give immediate attention, 2 indicated that they would request a further assessment, 1 indicated that he/she would initiate a program to improve the client's communication skills and 1 mentioned gentle teaching. Hypothesis (8) was not, therefore, confirmed for self-injury, with staff strongly favouring responses based upon distraction and communication. Whilst these responses would be congruent with attributions based upon the client communicating distress or reacting to an unstimulating environment, it is noticeable that responses consistent with staff viewing the behaviour as attention related were not favoured by staff. Despite the fact that staff had given 'Past Factors' a high rating in the attribution section of the questionnaire and that learned behaviour related to attention was the third most popular specific attribution given, this did not appear to be reflected in staff responses to the behaviour. Indeed, the most frequently cited response given in the 'Other' category was to increase levels of attention. It would appear, therefore, that with regard to self-injury participants did not translate their understanding of the role attention might play in the behaviour into responses based upon this understanding.

4.5.3: **Aggression:**

In addition to the responses given below, 4 staff indicated that they would segregate James from other clients, 2 indicated that they would call for help, 2 indicated that they would give the client more attention, 1 indicated he/she would use P.R.N medication and 1 said that he/she would do anything to stop the behaviour.

TABLE 15

	Restraint	Ignore	Distract	Reprimand	Commun
Mean	4.1	1.81	5.45	3.45	5.89
Stan Dev	1.48	0.96	1.4	1.81	1.18

Table 15: Average Ratings for Responses to Aggression

Although the ratings for restraint and reprimand did increase for aggressive behaviour, staff again favoured distraction and communication in terms of responses to the behaviour. Hypothesis (8) was not, therefore, supported for aggressive behaviour. The use of communication and distraction based responses would appear congruent with attributions concerned with conflict with others and emotional distress. Again, however, it is notable that participants apparent connection between aggression and learned behaviour related to attention was not reflected in their responses to the behaviour.

These results would appear to indicate that whilst this sample differs from that of Hastings (1995) in terms of the use of control-based strategies, it is similar in terms of the incongruence between staff attributions that apparently recognise the role which social reinforcement might play in the development of challenging behaviours and responses to the behaviours which do not apparently draw upon this understanding.

These results suggest that in instances where challenging behaviours are sensitive to social reinforcement, staff responses may indeed be counter-habilitative.

4.6: Guidelines and Formal Programs:

All 4 of the units taking part in this study had formal behavioural programs instructing staff on how to respond to the challenging behaviours of certain residents. For units A and C all residents had an individual program regarding their behaviour incorporated into their care plan. Units B and D each had 1 resident covered by a formal program. This would confirm the findings of previous research (Blair 1992) that such programs are relatively common in learning disability services. However, unit leader ratings did not confirm hypothesis (10), in that compliance ratings for these programs were consistently high. Table 16 sets out the average monthly compliance ratings for each unit:

TABLE 16

	UNIT A	UNIT B	UNIT C	UNIT D
Average Rating	6	5	5.66	5

Table 16: Average Monthly Compliance Ratings for Behavioural Programs

Results from Measure B also indicated that compliance with formal instructions is generally valued within this staff culture:

TABLE 17

	Valued at Work	Valued by Self	Possessed by Self
Average Rating	4.9	5.28	5.16
Stan Dev	1.39	1.27	1.16

Table 17: Average Ratings for Following Detailed Instructions

There was, therefore, a considerable measure of agreement between the view of team leaders and the views of unit staff. In terms of recognition of small changes in behaviour, the results are set out in Table 18:

TABLE 18

	Valued at Work	Valued by Self	Possessed by Self
Average Rating	5.57	6.1	5.67
Stan Dev	1.29	0.85	1.1

Table 18: Average Ratings for the Recognition of Small Changes in Behaviour

It would appear, therefore, that within the service that forms the basis of this study compliance with formal behavioural programs is not a key issue either from the perspective of management or staff.

4.7: **Talking About Personal Feelings in Relation to Work:**

In relation to hypothesis (5) participants clearly valued this on a personal level with a very high degree of agreement (Table 19). It is interesting, however, that despite this the average rating for their view of the staff culture as a whole was a full point lower. A t test confirmed a significant difference between the 'valued at work' and 'personally valued categories ($t=-3.98$, $df=42$, $p<0.01$). These results would appear to indicate that whilst staff individually value talking about personal feelings, there are

factors at work within the staff culture which discourage this. Given that talking to others would appear to be a useful way of coping with stress related to challenging behaviours this is a potentially very significant result. It is also interesting to note that staff gave a high rating to the 'possessed by self' scale. The difficulty in this area would appear to lie, therefore, with factors related to the staff culture.

TABLE 19

	Valued at Work	Valued by Self	Possessed by Self
Average Rating	4.86	5.86	5
Stan Dev	1.42	1.04	1.1

Table 19: Average Ratings for Talking About Personal Feelings in Relation to Work

4.8: Dealing with 'Any Situation':

This question, based upon the work of Hill-Tout & Lowe (1995), also produced a very interesting and potentially highly significant set of results from participants. Results are set out in Table 20:

TABLE 20

	Valued at Work	Valued by Self	Possessed by Self
Average Rating	5.19	5.67	5.12
Stan Dev	1.1	0.82	1.08

Table 20: Average Ratings for Confidence in 'Dealing With Any Situation

It would appear, therefore, that staff not only highly value, but also feel they personally possess, 'confidence that they can deal with any situation'. Such a strongly held belief within the staff culture could have profound implications for the way in which staff respond to incidents of challenging behaviour, their ability to request

assistance when required and their ability to admit to serious difficulties in dealing with a particular client, for example. This may, indeed, be a factor that might lead staff to highly value talking about personal feelings in relation to work but also on occasions be reticent about doing so.

4.9: **Attitudes Towards Punishment:**

In response to the statement ‘Feels strongly that when someone has done something wrong they should be punished’ participants gave the following results:

TABLE 21

	Valued at Work	Valued by Self	Possessed by Self
Average Rating	4.16	4.3	3.6
Stan Dev	1.53	1.26	1.22

Table 21: Average Ratings for Attitudes Towards Punishment

Congruent with the results with regard to staff responses to challenging behaviours, punishment did not appear to be highly valued by this staff group, although there was some individual variation in this. It would, however, be overstating the case to infer from these results that favourable attitudes towards punishment have little or no influence on staff responses in individual situations. In this sample the average ratings indicating agreement with the statement are by no means insignificant. Staff attitudes in this area are considered further in the discussion section.

4.10: **Normalisation:**

Results in this section, as set out in Table 22, would appear to indicate that participants both highly value normalisation and feel that they possess a good knowledge of it:

TABLE 22

	Valued at Work	Valued by Self	Possessed by Self
Average Rating	4.7	5.51	5.6
Stan Dev	1.6	1.31	1.09

Table 22: Average Ratings for Normalisation

It is interesting to note, however, that as with talking about personal feelings, there was a disparity between the personal views of staff and how they perceived the staff culture. A t test confirmed a significant difference ($t=-2.58$, $df=42$, $p=0.013$). This would again suggest that there are factors within the workplace which prevent staff from putting their views into practice.

4.11: **Agreement with Colleagues:**

TABLE 23

	Valued at Work	Valued by Self	Possessed by Self
Average Rating	4.26	4.1	4.15
Stan Dev	1.32	1.56	1.15

Table 23: Average Ratings for Agreement with Colleagues

These results would not tend to support Hypothesis 11. The results would indicate that whilst participants did to some degree value agreement between colleagues, it is

certainly not the case that this is a highly valued and central part of the staff culture. This result may have important implications if it is typical of such services as a whole.

4.12: **Strong Beliefs:**

TABLE 24

	Valued at Work	Valued by Self	Possessed by Self
Average Rating	4.45	4.3	4.37
Stan Dev	1.53	1.82	1.56

Table 24: Average Ratings for Attitudes Towards Strong Beliefs

These results would appear to reflect those outlined in the last section ('Agreement with Colleagues') indicating that those who do seek to change the opinions of others within the staff culture are not necessarily regarded with hostility by other staff.

5. **DISCUSSION.**

The sample used for this study contained a high proportion of staff with over 10 years experience working with challenging clients - indeed some had over 20 years experience. It is interesting to note that the sample used by Hastings (1995) also had considerable experience in this area. This would suggest that in localities where a mental handicap hospital has been closed, large numbers of staff have transferred to community-based units. This may have a number of important implications given the questions raised by this study. First, these staff represent a tremendous resource in terms of knowledge and experience, especially with regard to the behaviour of individual clients. The finding of Hastings (1995), confirmed by this study, that staff

groups appear to possess an impressive knowledge with regard to the possible causes of challenging behaviours, may relate to this length of experience.

It would also seem reasonable to assume that these experienced staff may exert a powerful influence within the staff culture, leading potentially to both positive and negative effects. Newer staff may be socialised into a number of 'rules' that help them interact positively with clients. However, this process of socialisation might also mean that counter-habilitative beliefs and responses, developed within an institutional setting, may be passed on to new staff. This would suggest that interventions involving staff groups would need to take particular account of the attitudes and beliefs of experienced staff. For example, a behavioural program that seeks to change the way in which staff respond to a particular challenging behaviour, may well encounter significant resistance from experienced staff who have been responding in a different way for many years.

Even if Unit A is regarded as an exceptional case, with all 5 clients having challenging needs, it is clear that staff in these services frequently encounter challenging behaviours. Measure C did not give any indication as to the severity of incidents. However, given that participants rated the vignettes supplied as highly representative of the behaviours they had encountered, it would seem likely that some incidents are serious in nature. The ratio of qualified to unqualified staff in these services would suggest that many of these incidents are dealt with by unqualified staff. For the newest staff, their only training may have been their induction. This in itself must be of some concern in terms of the welfare of both staff and clients.

This study clearly indicates that self-injurious and aggressive behaviours have a significant emotional impact upon staff. Aggressive behaviour would seem to elicit the strongest emotional response, centered around feelings of fear and worry. Without substantial emotional support this may leave many staff at least temporarily, and

potentially in the longer term, in distress. It would certainly support the proposition that staff motivation to swiftly terminate individual incidents will be high. In such circumstances the potential for a contingency effect to become established is clear.

The apparent habituation of staff to self-injurious but not aggressive behaviour is of some interest. It would suggest that these behaviours are viewed/experienced by staff in different ways. Two possible explanations may account for this effect. First, aggressive behaviour frequently involves actual physical danger to the staff member encountering it. Indeed, the behaviour may be directed at the member of staff. With self-injury the behaviour is undoubtedly distressing but seldom involves any immediate danger to staff. It may be that the element of personal danger involved in dealing with aggressive behaviour prevents any tolerance effect developing. Secondly, it is interesting to note that staff made different attributions for the two behaviours, linking aggression particularly with conflict. In the light of this it is of note that self-injury elicited more expressions of sympathy from staff than aggression. This may link to Hastings (1995) in terms of the possible importance of 'intentionality' in staff evaluations of challenging behaviours. It is possible that aggression is viewed more negatively by staff in that it potentially damages others and is perceived to relate more to factors directly under the control of the client. It may be, therefore, that staff see aggression in a particularly negative light and, as such, incidents continue to elicit powerful negative emotions.

Whatever the precise mechanism involved in this tolerance effect it may well have important ramifications in terms of client behaviours sensitive to social reinforcement. Where client behaviour is at least partly maintained by staff responses (i.e.: attention) and staff responses diminish due to staff finding the behaviour less aversive, an extinction burst may occur i.e.: the client may increase both the frequency and severity of the behaviour until staff resume responding. This may lead staff to differentially reinforce more severe self-injury with potentially serious consequences.

Although, staff clearly do not experience the same degree of negative emotional response to stereotypy, it would not appear to be entirely justified to regard it as a 'special case'. It may well be that emotional reactions to stereotypy are more context dependent than other challenging behaviours. Whilst aggression and self-injury produce strong negative emotions in themselves, the emotional response to stereotypy may be more dependent upon other situational stressors i.e.: the extent of other pressures in the environment at that time. The connection made by some staff between stereotypy and frustration would tend to support this view.

It is notable that in line with other self-report studies e.g. Maurice & Trudel (1982), participants in this study indicated that they do respond to challenging behaviours, although they differed from the Hastings (1995) sample in terms of the nature of that response. This study did not support the finding of Hastings (1995) that staff tend to adopt control-based strategies. The disparity between self-report and observational studies is clearly a stable effect and remains unexplained. This is an area that requires further research. This study would tend to support the findings of Duker et al (1989) in that challenging behaviours would appear to be a highly effective means of gaining staff attention. Where challenging behaviours are sensitive to social reinforcement, these results would suggest that staff responses may be highly reinforcing i.e. communication or engagement in an activity. As such, although effective in quickly terminating individual incidents, staff responses may well be counter-habilitative in the longer term.

The counter-habilitative nature of staff responses would not appear to result from a lack of understanding with regard to the role attention might play in the development and maintenance of challenging behaviours. This study clearly confirms the finding of Hastings (1995) that, with the exception of negative reinforcement, staff have a good understanding of current models of challenging behaviours. Staff responses broadly seem to be congruent with these models (eg. lack of stimulation leading to

communication and distraction) with the exception of social reinforcement. Given that staff are clearly aware of the role which attention or other gains may play in challenging behaviours, it would seem odd that this understanding does not appear to lead to responses congruent with this awareness eg. reducing attention in response to the behaviour or reinforcing positive behaviours. Nor did participants apparently seek to associate the behaviour with aversive social outcomes for the client (eg. reprimands). Indeed, in relation to self-injurious behaviour it was notable that four participants cited 'give attention' as a specific response. There would appear to be, therefore, a problem in staff putting their understanding into effect. In the short term strategies based upon reducing attention in response to challenging behaviours, would be likely to lead to an increase in the behaviour i.e. an extinction burst. This in turn would lead to increased negative affect in staff. This emotional cost to staff may be a key reason why they do not tend to opt for strategies that reduce attention. This may also be a case where contingency effects become part of the staff culture. The observation that reducing attention as a response leads to an increase in challenging behaviours and increased stress for staff may become a powerfully established rule within the staff culture, maintained by both pliance (i.e. advice from experienced staff) and tracking (staff who do attempt to reduce attention experience an increased level of behaviour). The incongruence between staff understanding of the role which social reinforcement may play in challenging behaviours and their lack of responses which reduce such reinforcement provides, therefore, additional evidence for the possible existence of a contingency effect. The contingency hypothesis may also explain why staff do not appear to adopt a strategy of reinforcing appropriate behaviours (or, indeed, of constructive interventions generally). If staff responses to challenging clients are largely motivated by a desire to reduce negative affect, then their motivation to intervene at times when negative affect is not present may be low. Hence, appropriate client behaviour may be largely ignored.

The results with regard to adherence to formal programs are of interest in that they are not in line with previous research eg. Hastings & Remington (1994a). Compliance with programs was not seen as an issue by either team leaders or staff. A possible explanation for this would be that team leaders in particular gave an overly favourable view of the situation. However, it would seem unlikely that all 4 would have replied in this way. In addition, staff replies to Measure B indicated that adherence to such programs is valued within this staff group. It may be, therefore, that the results were in fact congruent with the actual situation and that there are factors within this service that particularly encourage compliance eg. a positive aspect of staff culture. This issue is considered further in the second part of this project.

A number of important issues arose from the investigation of staff culture in these services. The results would certainly suggest that particular attitudes/beliefs embedded within the staff culture may well have a significant impact upon the way in which staff respond to challenging behaviours. The high ratings given to the 'feels confident that they can deal with any situation' statement would be a key example of this. Such an attitude could well lead to a number of counter-habilitative effects. First, it would suggest that there is a pressure within this culture to cope and deal with whatever situations arise. Given that the majority of staff are unqualified this may very well lead to individuals becoming involved in situations for which they possess inadequate training and/or experience, increasing the risk of non-reflective escape motivated responses. This could have serious consequences for all involved. Secondly, it might well mitigate against the development of more positive/habilitative attitudes within the staff culture. For example, this study confirmed the finding of Hastings (1995) that staff do value talking to others about their feelings in relation to work. However, the results also indicated that staff gave a significantly lower rating for how this was viewed by the staff culture as a whole. This would suggest that individual staff may well experience a conflict between their desire to talk about their emotions in relation to challenging behaviours (eg. fear and worry) and a feeling that if they do so they will

be seen in a negative light ie. as 'not coping' by other staff. This in turn would be likely to lead to increased stress for the individual concerned and might also strengthen any contingency effects operating. The belief that staff should be able to deal with anything might also lead to a reluctance to call in outside help.

It is clearly not possible at this stage to gauge to what degree the 'feels confident they can deal with any situation' view is applicable to services in general. It may be something associated with this service alone. However, if it was found to be prevalent amongst staff working with challenging clients this would be significant. It would, for example, suggest that interventions designed to change key staff beliefs might well have a positive impact in terms of staff responses to challenging behaviours. At this stage the main significance of the finding is that it demonstrates that staff cultures may well exert counter-habilitative influences.

The picture that emerges of staff culture from this study is of interest. A central question in terms of considering possible interventions designed to modify counter-habilitative influences within staff cultures will be the degree to which such cultures are receptive to possible change. For example, should these cultures be highly cohesive and resistant to change, then interventions aimed at the staff culture might well be problematic. The evidence from this study would suggest that staff groups may, to some degree at least, be open to new ideas. Results from Measure B would indicate that 'agreement with colleagues' is valued but by no means to the same degree as factors like being able to 'deal with anything'. Those who put forward views that contradict existing attitudes and beliefs within the staff culture may not necessarily be regarded with hostility. This would suggest that a key means of addressing counter-habilitative responses to challenging behaviours may well be to become involved within staff cultures with the aim of modifying certain aspects of those cultures. This could involve traditional approaches such as training and discussion

groups for example. It could also involve clinical psychologists becoming more directly involved in residential care services.

Results from this study would also suggest that staff cultures may be extremely complex with various influences, internal and external, interacting. For example, the fact that the official service philosophy of normalisation was highly valued by individuals but significantly less valued in terms of participants' view of the staff culture is of interest. It would certainly indicate that staff cultures are influenced by more than the views of staff. In this case it would appear that whilst staff broadly agree with normalisation as a philosophy, there is a difficulty in terms of putting it into practice. This clearly requires further investigation and is considered in the next section of this project.

Attitudes towards punishment are clearly an interesting variable in terms of staff working with challenging clients. Challenging clients are at risk of abuse (Maurice & Trudel 1982) and staff cultures that value punishment as a principle may well be of particular concern in the light of this. Staff who highly value punishment as a general principle and who have applied it in their own lives e.g. in bringing up their children, may well see it as a legitimate strategy with learning disabled clients. Where high levels of stress are also involved, this is a potentially dangerous situation. Although this study did not find that punishment was highly valued by staff, it is clear that some value is placed on it and that there was a great deal of individual variation. Given the dangers involved and the high levels of stress encountered by these staff, punishment would appear to be an appropriate area for intervention within staff cultures.

The results of this study relate directly to a number of key issues raised by Hastings & Remington (1994a;1994b). Firstly, where challenging behaviours are sensitive to social reinforcement, staff responses would indeed appear to be counter-habilitative. Given

the often serious consequences that result from these behaviours this is clearly a major issue for learning disability services. Secondly, the study did find evidence to support the existence of a contingency effect. High levels of negative affect in staff, resulting from exposure to challenging behaviours, may well lead to counter-habilitative responses. In addition, high levels of stress would also be expected to be linked to more general problems for these staff e.g. an increased risk of health and social problems. Staff may show some habituation to self-injurious behaviour but this could potentially lead to the differential reinforcement of more serious self-injury. Thirdly, the study confirmed that staff culture may also need to be considered in terms of counter-habilitative responses. Attitudes and beliefs which are embedded in the staff culture may well have a considerable impact both on staff responses to challenging behaviours and the ability of staff to cope with the emotional impact of such behaviours.

The picture which emerges from this study would support the view that contingency and culture effects may well interact. For example, a contingency effect may be strengthened where factors within the staff culture make it more difficult for staff to ventilate their feelings with regard to challenging behaviours. The failure of staff to utilise their understanding of a behavioural analysis of challenging behaviours may also relate to an interaction of the two effects ie. the staff culture strongly discourages such an approach based upon experiences related to the contingency effect. This study would suggest that interventions aimed at ameliorating counter-habilitative staff responses will need to address both contingency and culture effects.

In terms of interventions with staff groups a number of points arise from this study. First, with the exception of negative reinforcement, training centered around increasing staff understanding of challenging behaviours would not appear to address the issues involved. Training would need to concentrate on emotional and cultural factors. Secondly, if this service is representative of services as a whole, interventions

aimed directly at the staff culture would seem to be viable. Whilst certain views may be strongly held within staff groups, there is no evidence from this study to indicate that they could not be modified. This would indicate that a key role for clinical psychologists in the future might well be the support and training of unit staff in these services.

SECTION THREE

STUDY TWO - QUALITATIVE DATA

STUDY TWO- QUALITATIVE DATA

1. INTRODUCTION

The results of Study One are clearly of relevance to learning disability services where clients have challenging behaviour needs. They would certainly confirm that a comprehensive functional analysis of challenging behaviours needs to take account of both staff responses to those behaviours and staff culture. Interventions that do not take account of these factors may well be ineffective.

Whilst Study One provided quantitative data with regard to staff culture it did not gather qualitative data. Qualitative data might well be extremely useful both in terms of enhancing our knowledge of staff cultures (particularly in terms of how staff view their work and the behaviours they respond to) and in relation to a number of points raised in Study One. For example, it might give indicators as to processes by which newer staff are socialised by more experienced staff, the way in which particular beliefs within the staff culture may interact (eg. 'talking about feelings' and 'dealing with any situation'), why compliance with programs did not appear to be an issue in this service and why there might be a problem for staff in applying the principles of normalisation. The first aim of Study Two was, therefore, to gather qualitative information with regard to staff culture from participants.

Secondly, an important aim of this research project was to investigate possible means of ameliorating counter-habilitative staff responses. Whilst a theoretical understanding of the processes that may be involved in such responses is clearly useful, in terms of practical benefits this needs to be translated into intervention strategies that can be implemented by learning disability services. If these strategies were successful, the benefits to all involved could be considerable. Training has been a frequently used method of intervention with unit staff. The results of Study One would suggest that a

training package based upon both contingency and culture effects might well be effective in terms of both reducing counter-habilitative responses and promoting habilitative attitudes within staff cultures. Study Two documents, therefore, the development of such a training program and outlines a pilot study in which this package was evaluated.

This section of the research project sets out the method and design for Study Two. In addition it reports upon the qualitative data gathered from participants. Section Four of the project sets out and comments upon the results of an evaluation of the effectiveness of the training package.

2. HYPOTHESES

In relation to Study Two, the following hypotheses were made:

1. That qualitative data gathered from participants would provide further information with regard to both positive and negative aspects of staff culture.
2. That a training package based upon both contingency and culture effects would result in habilitative changes in the attitudes, beliefs and responses of participants.

3. METHOD

3.1: Participants:

Staff who had taken part in Study One were approached with regard to their participation in Study Two. Of the original participants 39 agreed to do so. 25 were female and 14 male. 9 were from Unit A, 12 from Unit B, 10 from Unit C and 8 from Unit D.

3.2: Training Package Construction:

In constructing a package based upon the work of Hastings & Remington (1994b) and the results of Study One a number of points had to be considered. First, the package had to be practical in terms of the time commitment involved for staff. It was agreed that a 2 day workshop was the maximum length practical if the package was to be affordable for services in the future (ie. in terms of the cost to the service of paying for relief staff whilst unit staff were attending training). Secondly, given the amount of material that would be covered in the training it was felt that staff would benefit from having written information to take away. Two booklets were, therefore, written outlining the main points of the training, the first covering day one of the workshop and the second day two. It was hoped that these booklets would also be a useful resource in the future. The booklets are contained in Appendix C. Thirdly, the style of training was considered. Given the need to gather qualitative information as well as deliver training, an interactive/discussion-based approach was used. This involved brief presentations from the researcher followed by discussions around particular issues and (fictitious) case vignettes. Fourthly, in order to further facilitate the gathering of qualitative data, specific time was set aside for general discussion of the issues raised by the workshop and the questionnaires.

3.2.1: Day One: Issues For Staff Working With Challenging Clients:

This section of the training was largely based upon an attempt to intervene at the level of the staff culture, seeking to enhance staff understanding of the importance of their responses to challenging behaviours and to modify counter-habilitative factors identified in Study One. The following elements were included:

1. A Basic Introduction To Behavioural Terms: Although Study One had revealed that staff were aware of the role which social reinforcement might play in challenging behaviours, it was thought that a brief introduction might be useful for newer staff. In particular the role of avoidance/negative reinforcement was included in this section.

2. The Contingency Effect: This section outlined for staff how the negative affect which they might experience in relation to challenging behaviours might lead them to respond in ways to the behaviour which reinforced it in the future. In particular the way in which staff behaviour might be shaped by client behaviour was stressed.

3. Responses to Challenging Behaviour: Ways of responding to challenging behaviour based upon a behaviour analytic approach were outlined including the use of positive reinforcement for appropriate behaviour and giving minimal attention in response to challenging behaviours. The role which outside professionals might play in working with challenging clients was also included in this section.

4. Programs and Guidelines: The purpose of programs was explained and the importance of consistency in their implementation discussed. Participants were asked to identify and discuss possible reasons why staff might not follow a program.

5. **Punishment:** This section involved a brief presentation from the researcher followed by a discussion on punishment. The presentation set out to establish the ethical and practical problems with punishment, it's inappropriateness with learning disabled clients and the adverse consequences that might result from it.

6. **'Coping With Anything':** This involved a discussion between the researcher and staff with regard to the answers given on Measure B. The researcher asked staff to consider how such an attitude might have arisen and what effects it might have on individuals. The researcher then outlined some possible negative aspects of this belief.

7. **The Views And Feelings Of Staff:** The final section was designed to encourage further debate within staff groups. It stressed the importance of the information held by unit staff alone (ie. with regard to individual clients), the importance of views being shared and discussed and the relationship between unit staff and outside professionals. This then led into a general feedback session in which staff were able to give their views on both the training and the questionnaires.

3.2.2: Coping With The Stress Of Challenging Behaviours:

The second day of training was aimed more at individuals, attempting to both increase staff awareness of the problems associated with high levels of stress and enhance their ability to cope with stress related to challenging behaviours. The day was divided into the following sections:

1. **A General Introduction To The Effects Of Stress:** This section aimed to look at stress in general terms, including it's positive and negative effects. Participants were encouraged to become more aware of their own individual reactions to stress and their current coping strategies.

2. **The Risks Of Stress:** This section, based upon a presentation by the researcher, sought to broaden the issue of how stress might have damaging effects. In particular it concentrated upon the risk of non-reflective escape motivated responses leading to inappropriate and counter-habilitative responses to challenging behaviours.

3. **The Stress Of Challenging Behaviours:** This section, based upon a discussion with staff, sought to identify particular reasons why being exposed to challenging behaviours might lead to stress and negative affect. Whilst the researcher put forward a number of points based upon the existing literature and personal experiences, most of the time set aside for this section was taken up with staff discussing their own experiences.

4. **Coping With A Stressful Incident:** Given the high levels of negative affect reported by staff in Study One this section aimed to enhance staff coping skills. It included some basic relaxation techniques, advice on reducing the long term effects of stress and a discussion centered around the value of talking to others about feelings in relation to work. It concluded with participants giving the researcher further information with regard to how they were 'debriefed' after an incident.

5. **Time Management:** The final section sought to establish to what degree other pressures in the environment might lead to increased levels of stress in staff. The researcher gave a brief presentation suggesting ways in which day to day pressures might exacerbate the problems outlined in the rest of the day. This then led into a general discussion on the issues raised during the day and the questionnaires used in Study One.

3.3: **Design:**

A quasi-experimental design was used in this study. Each of the four participating services was randomly assigned to 1 of 4 conditions:

(1) - Full Package: This staff group received both days of training and both booklets. Unit B was allocated to this condition.

(2) - Control: This group received no training (or booklets). This condition was included in order to control for any general change in the attitudes/beliefs of staff working in the Exeter Learning Disability Service which might have occurred during the time between Study One and Study Two (8 weeks). Unit D was allocated to this condition.

(3) - Culture Package Only: In order to gauge the effect of this component of the training in isolation, this staff group received Day One training only (plus the corresponding booklet). Unit A was allocated to this condition.

(4) - Stress Package Only: this group received Day Two training only plus the corresponding booklet. Unit C was allocated to this condition.

It is stressed that all participants will receive the full training package once this project is completed.

It was recognised that the quasi-experimental design used has significant limitations and these are discussed in section four of this thesis which considers the evaluation of the training package.

3.4: **Measures:**

Measures A and B were used to evaluate any changes in participants attitudes, beliefs and responses following the training. Participants replies to these measures from Study One were used as baselines against which any change could be gauged. It had been hoped that the 'number of incidents' section of measure C might also be used as a measure of outcome with the prediction that in the longer term the number of incidents would fall as a result of a decrease in counter-habilitative responses from staff. However, it quickly became clear that this was not possible due to the number of other possible factors which might lead to a change in the number of incidents. These would include changes in medication, effects of other treatments, changes in routine (e.g. day services) and the introduction of new staff. Too many extraneous variables would, therefore, be involved in terms of attributing any decrease in the number of incidents to the effects of the training. Issues concerned with a long term evaluation of this study are considered in the final discussion contained in Section Five of this thesis.

3.5: **Procedure:**

Given the need to maintain adequate staffing on the units it was only possible for each unit to release 3 or 4 staff for training on any one day. In order for all staff to attend the training allocated for their unit, therefore, the 2 day package had to be repeated 4 times over an 8 week period. Considerable logistical problems were experienced in organising this due to factors such as staff sickness, annual leave and a shortage of relief staff. Some aspects of these difficulties are relevant to issues raised in Study One and are considered further in the Results and Discussion sections below. During and after the training sessions the researcher (with the permission of participants) kept notes on comments made by staff. In the two weeks following their completion of the training each participant was asked to complete Measures A and B again, enabling the researcher to gauge whether the training had had any initial impact. At this point

questionnaires were also sent to participants in the control group. Team leaders were also asked to give their view in terms of how the training had been received by staff.

4. **RESULTS - QUALITATIVE DATA.**

4.1: **Stress:** Participants made a number of interesting comments with regard to the stress they had encountered in working with challenging clients. The unpredictability of events was cited several times. Staff indicated that working with clients whose behaviour can become challenging very rapidly can result in additional stress because it leads to an atmosphere of tension. Many staff also indicated that this could lead to a particularly stressful combination of periods of uneventful routine (e.g.: cleaning, cooking, administration) interspersed with episodes of having to cope with quite severe challenging behaviours, involving the possibility of personal injury. There was a high level of dissatisfaction with the level of support provided to staff in relation to this distress. Staff reported that in the majority of cases where challenging behaviour had occurred the member of staff involved was expected to continue their shift without a debrief. Only 1 of the units (Unit C) had a formal debrief system in place. This occurs at the end of the shift where the staff involved discuss what has happened and send a formal incident sheet to the team leader. Any member of staff can then request a further debrief from the team leader. Staff felt that the problem with this was that since it occurred at the end of the shift there was a strong motivation to complete it quickly. The team leader involved voiced the same concern i.e.: that the member of staff involved might not receive adequate initial support. On the remaining units whether a member of staff was debriefed or not appeared to depend largely on the seriousness of the incident and the immediate availability of the team leader. Participants also indicated that they felt that even when injuries had occurred support was often very limited.

In terms of coping with this stress participants confirmed the findings of Hastings (1995) and Study One. Support from fellow team members was repeatedly mentioned with participants indicating that they generally relied upon one or two other people within their team who they felt they could talk to. On a day to day basis many participants indicated that they found short informal breaks very useful. Many of these staff appear to be on duty for long periods - e.g.: working during the evening, sleeping at the unit at night (where they may be woken at any time in order to deal with a problem) and then working the next day. At times when duties are light it is possible for individual staff to take a short break away from clients. These breaks appear to be very highly valued by staff.

When asked what sort of support would be most helpful, three themes emerged from participants. First, that support needs to be confidential and not shared with team leaders. Many staff expressed a fear that admitting to feeling stressed as a result of challenging behaviours could lead managers to see them in a negative light. Secondly, that support needs to be immediate. Currently, when debriefs do occur they may be some considerable time after the incident has taken place. Thirdly, that the person giving the support needs to be a 'good listener'. One of the criticisms staff had of the current system was that emotional issues and practical issues (i.e. what happened in the incident and how it was handled) were often dealt with in the same interview/debrief. There was a strong feeling that emotional and practical issues should be dealt with separately.

4.2: Culture: The valuing of 'Feels confident they can deal with any situation' was again affirmed by staff. A number of factors appeared to underpin this view. First, some male participants indicated that they felt that they were under particular pressure to be seen to be able to cope with aggressive behaviour. They felt that if they asked for help they would be seen as 'a weak link' by managers and other team members. Interestingly, experienced staff also expressed this view, feeling that newer staff

expected them to be able to cope and that to admit to needing help would result in loss of status within the staff group. Some participants expressed the fear that although initially other staff might not criticise them for asking for help, at a later date they would do so. However, the majority of staff indicated that they would feel guilty if they had to ask for help from other staff. The prevailing view was that everyone (team leaders included) was under a great deal of stress and that to ask for help would be to add to the stress of another member of staff. The primary motivation for this potentially counter-habilitative belief appeared to be, therefore, protecting other staff from stress. This would also certainly potentially account for the fact that whilst staff value talking to others about their feelings in relation to work, they see this as less valued within the staff culture as a whole.

The finding of Study One that staff cultures might well be open to debate and change was certainly confirmed by the training. On many issues staff expressed a united view (e.g. in terms of feeling that current support systems are inadequate in terms of meeting their needs) but on others there was considerable disagreement and debate (see below). It was certainly not the case that the views of more experienced staff were always adopted by newer staff, although they clearly were influential.

4.3: **Experienced Staff:** As indicated above, experienced staff clearly had a substantial influence within these services. However, it also emerged that at times there was quite significant disagreement between experienced and newer staff. For example, some newer staff felt that older staff were 'too set in their ways' whilst more experienced staff indicated that their greater experience was not fully taken account of, despite the fact that, especially in terms of dealing with incidents of challenging behaviour, they were expected to take the lead. It would appear to be in relation to responding to the behaviour of individual clients that the influence of more experienced staff is at its strongest. Newer staff indicated that they did tend to follow the advice of experienced staff in this respect, especially where these staff had known

a client for many years. Counter-habilitative responses, developed in an institutional setting, may well, therefore, be passed on to newer staff. Team leaders confirmed that on occasions tension between experienced and newer staff has been an issue.

4.4: Challenging Behaviours: Discussions with participants confirmed the findings of Study One in that staff appear to possess a good understanding of the possible causes of challenging behaviours. The role which social reinforcement might play in the development and maintenance of challenging behaviours was frequently mentioned by participants. Staff may also potentially provide a considerable insight into how challenging behaviour is experienced by those who come into contact with it. For example, one group of staff gave an example of a client with whom they had come into contact who often regurgitated food at the meal table. This group of staff eat their meals with clients. Staff indicated that this had had a substantial impact upon them - as great as any of the aggressive behaviours they had encountered. Many staff felt that whilst much attention had been focused upon aggression and self injury by managers and researchers, other behaviours which caused them substantial stress were largely ignored. They pointed out that behaviours like regurgitation do not fit readily into current incident sheets (i.e. no injuries, no immediate danger to others, no damage) and as such often go unrecorded.

The impression of the researcher was that Hastings (1995) was correct in his speculation that 'intentionality' might have a bearing on how staff view and respond to certain behaviours. This linked into staff views on punishment. A substantial minority of staff expressed the view that where a client had deliberately behaved in an anti-social way it was part of the role of staff to teach that client 'right from wrong'. In this view, therefore, punishment (typically involving the client being sent to their room) was not only justified but habilitative. Behaviour seen as not under the control of the client was not felt to merit punishment. The majority of staff appeared to oppose punishment in terms of most incidents of challenging behaviour but did express

some sympathy with the view that punishment was justified where others had been harmed. This would be congruent with the finding from Study One that whilst self-injurious behaviour may elicit some feelings of sympathy in staff, aggressive behaviour does not.

4.5: Formal Programs And Guidelines: This issue led to a considerable debate amongst staff. Congruent with the findings of Hastings (1995), these staff strongly indicated that they did not feel sufficiently involved in the construction of formal programs. A frequent complaint was that programs did not take account of the views of staff and that staff were often not invited to program reviews. There was considerable criticism of outside professionals for not fully liaising with staff. Given this it seemed puzzling that compliance had been rated so highly by both staff and team leaders. The researcher asked staff about this. The overwhelming majority of staff indicated that despite the lack of consultation they saw it as their duty to carry out the guidelines given. The only exception to this was where the program was seen as contravening the personal principles of a staff member. A small minority of staff strongly disagreed with this view indicating that where there had been inadequate consultation with staff there could be no obligation on them to carry out the instructions. A clear majority of staff indicated that they felt that non-compliance should result in disciplinary action.

Participants also indicated that where a number of residents had a formal program written for them this could cause confusion (in the case of Unit A all 5 residents have a formal program related to challenging behaviours). They indicated that where staff were under pressure it could be difficult to remember and fully implement the instructions of a particular program.

4.6: Team Leaders: In their feedback to the researcher team leaders made a number of interesting comments about their work that are relevant to Hastings & Remington

(1994b) and Hastings (1995). The researcher's contact with these services had indicated that the role of team leader is central to all aspects of the care process. Team leaders indicated that they felt that this was the case and that they acted as a link between the management system and the unit staff system. They reported that this in itself often resulted in considerable stress e.g. where the team leader was responsible for communicating a management decision to staff which was likely to be unpopular. In addition, as the most qualified person working at the unit, the team leader has responsibility for all staff and clients, program implementation and finances. Team leaders indicated that they also maintain direct 1:1 contact with clients, including dealing with incidents of challenging behaviours. Whilst team leaders appeared to have a greater access to supervision than unit staff, specific support in relation to the emotional effects of challenging behaviours was extremely limited. In addition, team leaders are largely responsible for debriefing and supporting unit staff, leading to an additional emotional demand upon them. Overall, team leaders clearly saw their role as being highly stressful and participating staff strongly agreed with this view. Given that the effectiveness of clinical psychology input (and indeed the whole care package) rests to some extent on team leaders, this high level of stress is of some concern. This is commented upon further in the discussion section below.

4.7: Normalisation: Congruent with staff replies to Measure B there was clear support for the general principles of normalisation and an associated concern for quality issues. However, frustration was expressed that, particularly in working with clients with profound learning disabilities, there were insufficient resources to provide the sort of service that staff would want. Staff clearly expressed the view that they felt that staffing levels were not adequate to provide each client with the stimulation and opportunities needed in order to fulfill the service philosophy. For example, going out into the community on a 1:1 with a client was a greatly valued activity. However, staff indicated that this was often not possible because it would leave only 1 member of staff on the unit working with the other clients. A number of staff indicated that they

felt that the incongruence between the service aims and what was actually possible was a significant source of low morale amongst staff.

4.8: Staff Responses To The Training: Staff reaction to the training program was extremely positive. On further enquiry, however, it became clear that two different aspects of the training had to be distinguished - the experience of staff coming together to discuss issues related to their job and the formal training offered by the researcher. Staff were generally positive about the formal training with a number of participants commenting that they felt it had been very helpful to focus upon staff issues and the needs of more profoundly disabled clients. However, it was clear that staff were most positive about being able to meet together away from their units and discuss their work. Team leaders confirmed this impression. Staff explained to the researcher that opportunities for staff working at the same unit to meet to discuss their work were often very limited, due to logistical and financial constraints, and that it was very unusual for staff from different units to meet. As such, the sections of the training based around discussion, with the researcher acting as a facilitator, appeared to have been particularly valued by participants.

5. DISCUSSION

The qualitative data gathered during the training sessions both confirmed and enhanced the findings of Study One.

As this project has progressed the stress and negative affect experienced by staff in relation to challenging behaviours has become increasingly central both in relation to the contingency and culture hypotheses. The qualitative data gathered in Study Two would not only confirm previous research in the finding that unit staff experience high levels of stress in relation to challenging behaviours, e.g. Hastings & Remington

(1995), but also suggest that this stress is a key factor when examining possible counter-habilitative aspects of staff cultures. Whilst research to date has concentrated mainly upon self-injurious and aggressive behaviours, it is clear from this data that in fact there are a wide range of behaviours that may lead to significant levels of negative affect in staff. Behaviours like regurgitation may lead to a great deal of stress amongst staff but not be recorded as incidents of challenging behaviour. This would indicate that formal records of the levels of challenging behaviours kept by learning disability services may well understate the number of behaviours encountered by staff which they find highly distressing.

Given the high levels of stress experienced by staff it is of some concern that they expressed such strong dissatisfaction with support systems designed to ameliorate this stress. Only 1 of the 4 participating units appeared to have developed a regular and systematic debriefing system. Both the quantitative data from Study One and the qualitative data from Study Two would indicate that unit staff value being able to talk to colleagues about the stress they experience at work. However, counter-habilitative beliefs like 'Feels confident that they can deal with any situation' may make this difficult, leaving individuals unsure as to how they will be regarded by other staff and managers if they do so. Where formal support systems are not adequate to meet staff needs, therefore, far reaching consequences may result. First, staff may continue to experience high levels of stress and negative affect, resulting in individuals encountering a range of difficulties (i.e. health, relationships). Secondly, contingency effects may develop in which staff respond to challenging behaviours in non-reflective counter-habilitative ways. This in turn would maintain a high level of challenging behaviours at the unit and lead to further stress for staff. Thirdly, these high levels of stress may have a significant impact upon the staff culture, strengthening counter-habilitative beliefs and weakening positive ones. The qualitative data from Study Two would suggest, for example, that staff fail to fully utilise a highly valued coping strategy i.e. talking to colleagues about their stress, because they feel that in

doing so they would add to the already high levels of stress in others. Where staff perception is that formal supports are inadequate, the view that both individual staff and the staff group 'have to cope with anything' may become extremely powerful, maintained at least partly by tracking. Hastings (1995) suggests that the formal service culture might reinforce negative aspects of the staff culture by emphasising control and restraint, thereby focusing staff attention away from constructive responses to challenging behaviours. These data would suggest that the service culture may indeed have a negative impact upon staff culture but not in the way described by Hastings. It would appear that if the service culture is unable to fully support the emotional needs of staff, then counter-habilitative developments may occur within the staff culture which in turn may exacerbate the stress experienced by staff. These data would suggest, therefore, that further research is needed in terms of a) the degree to which the dissatisfaction of staff with formal support systems found within this sample is typical of other services and b) what types of support staff find most effective.

In relation to (b), above, staff in this study were clear about the sort of support which they felt would be useful. In relation to this it is of note that confidentiality was a key issue. At present the overwhelming majority of debriefs would appear to be carried out by team leaders. The data from Study Two would suggest that with regard to emotional support this may not be appropriate. Staff are clearly concerned that if they fully discuss their emotions with their team leader this might lead to them being regarded as a 'weak link' and to more senior managers becoming involved. In addition, where the team leader is under significant stress (and also where unit staff are aware of this) that person may not be in a position to offer adequate support. Participants were also clear that support needs to be available relatively quickly after the incident has taken place and concentrate on the emotional rather than practical aspects of what has happened. Finally, it is also interesting to note that staff identified 'being a good listener' as the key attribute needed in someone conducting a debrief.

This might also link into the extremely positive reaction of participants to the sections of the training where the researcher acted as a facilitator.

The role which more experienced staff may play in staff cultures emerges strongly from both Hastings (1995) and Study One. However, the qualitative data gathered in Study Two would suggest a more complex picture. It is clear that such staff have a considerable influence within staff cultures. However, this data would suggest that this influence is at its strongest in relation to the challenging behaviours of individual clients but may not be so strong in relation to wider aspects of the staff culture. The influence of more experienced staff in relation to responses to challenging behaviours has already been discussed as part of Study One. The data from Study Two would confirm that newer staff tend to look to more experienced staff in terms of these responses and as such counter-habilitative responses developed in an institutional system may well be perpetuated in community-based units. It should also be emphasised again here that these staff may also socialise newer staff into habilitative and positive ways of interacting with individual clients. However, the finding that there may be a degree of disagreement between older and newer staff would confirm the finding of Study One that staff cultures may well be open to debate and change. A number of issues (e.g. formal programs and punishment) generated a considerable debate amongst staff in which the views of experienced staff were often challenged by less experienced staff. The experience of the discussion-based sections of the training would suggest that enabling staff to meet with a facilitator to discuss key aspects of their work (e.g. stress, particular clients, quality issues) might be extremely helpful and potentially lead to positive changes in staff cultures. This possibility is discussed further in the final section of this thesis.

Two issues appeared to generate disagreement between staff and these have a direct bearing on the initial work of Hastings & Remington (1994a;1994b) and Hastings (1995). Firstly, attitudes towards punishment. The data gathered in Study Two would

confirm the view that this is a key area where counter-habilitative beliefs may have a significant impact. The view that the role of staff is to teach clients 'right from wrong' may well lead individuals to adopt punitive strategies which may have serious consequences for clients. The qualitative data gathered would suggest that clients who are aggressive towards others may well be particularly associated with this, linking to the speculation of Hastings (1995) that staff beliefs about intentionality may also be important. Only a small section of the training package was set aside for this issue. Following the training sessions the feeling of the researcher was that much more time needed to be devoted to this issue, especially given the findings of Maurice & Trudel (1982), and that in fact it was an area that might merit a completely separate training package of its own.

Secondly, a number of issues arose out of the discussion concerning formal programs and guidelines. It is of note that the qualitative data gathered supported the finding of Hastings (1995) that unit staff feel that they are not fully consulted by outside professionals, such as clinical psychologists and nurse behaviour therapists, about these programs. This would suggest that part of the problem with compliance may relate to the way in which these programs are drawn up and that as such outside professionals need to ensure that unit staff have been consulted. In this service at least the dissatisfaction with the consultation process had not led to widespread refusal to comply with programs, although this was the case with some individuals. However, it would seem likely that, to some degree at least, the problem of non-compliance may relate to this dissatisfaction. A key aspect of counter-habilitative staff responses i.e. non-compliance with formal programs, might therefore be to some degree resolved by a change in approach by outside professionals. This issue also confirmed that aspects of staff culture may exert an habilitative influence, a clear majority of staff feeling that compliance with programs was an important aspect of their work.

The finding that participants feel that a lack of resources is an issue, preventing them from fully carrying out the service aims and objectives goes beyond the scope of this project. However, this concern did confirm the impression of the researcher that staff are very committed to learning disability services and the particular clients with whom they work. A number of questionnaires returned after the training contained additional comments from staff with regard to their view of the learning disability service as a whole. These comments would certainly support the finding of Hastings (1995) that when considering an 'ideal service' staff demonstrate an impressive knowledge of the needs of challenging clients.

Participation in the training program was also an extremely interesting, informative and enjoyable experience for the researcher. Whilst the formal training involved appeared to have been useful, the researcher shared the view of participants that the most valuable aspects of the program for all concerned had been those based around discussion. It was in these sessions that key issues came to the fore e.g. why staff may be reluctant to talk to others about their feelings in relation to work. Given that research into staff cultures is still very much in its early stages, qualitative data may be extremely helpful in terms of laying the foundations both for future quantitative research and intervention strategies. The approach used in this section of the project, in which the researcher acted as a facilitator in discussions with staff, appeared to be extremely successful both as a means of obtaining qualitative data and as part of the training program. It may, therefore, be a useful approach in future research.

SECTION FOUR

STUDY TWO - EVALUATION OF TRAINING

STUDY TWO- EVALUATION OF TRAINING

1. Participants:

Completed questionnaires were received from 37 participants. 9 were from Unit A, 10 from Unit B, 10 from Unit C and 8 from Unit D.

2. Aims of Evaluation:

The training package was designed to produce habilitative change in a number of key areas. The evaluation sought to establish to what degree habilitative change had occurred and which aspects of the training appeared to be responsible for this. The areas deemed to be the central indicators of habilitative change are set out below along with the relevant measures by which any change would be gauged:

Stress: A major aim of the training was to raise the awareness of staff with regard to the problems which might arise as a result of the stress of being exposed to challenging behaviours. This would be indicated by an increase, in the short term, in stress ratings given by staff for both self-injurious and aggressive behaviours ie. the stress scales contained in measure A. In the longer term it would be hoped that those who had received the 'stress' package in particular would show a decrease in this as their coping skills improved.

Attributions: Given the behaviour analytic basis of the training, it was expected that staff would show an enhanced awareness of the role which social reinforcement might play in challenging behaviours. This would also include an awareness of avoidance as a factor in these behaviours. This would be gauged by the 'past factors' scales for self-injury and aggression contained in measure A.

Responses: Following on from an enhanced awareness of the behaviour analytic model of challenging behaviours, it was expected that participants would show a reduction in immediate responses that might further reinforce such behaviours - particularly distraction and communication. This would relate to the 'distraction' and 'communication' response scales for self-injury and aggression contained in measure A. In addition it would be expected that there would be an increase in the number of staff who mentioned more long term constructive intervention strategies in the 'Other responses' section for these behaviours.

Talking to Others: It was expected that there would be an increase in all aspects of the value placed upon this coping strategy by participants, particularly in relation to the staff culture. This would be gauged by measure B - statement 1.

Dealing with Anything: It was predicted that there would be a decrease in all aspects of the value placed upon this belief by participants. This would relate to measure B - statement 2.

Punishment: It was expected that there would be a decrease in all aspects of the value placed upon this strategy by participants. This would relate to measure B - statement 6.

3. **Method of Evaluation:**

As each participant had completed measures A and B during Study One, it was possible to compare these baseline scores with those obtained post-training. Given that a quasi-experimental design had been used (the groups of participants concerned being independent) a direct comparison between units was not possible. A two factor mixed design analysis of variance was, therefore, used to analyse the results for each

of the repeated measures. In each case the interaction between the 'conditions/ unit' factor and the 'phase' factor (ie. baselines vs post-training) was examined for significance. A significant interaction would indicate that, for that repeated measure, the units had behaved significantly differently over the phases of the study. In terms of an evaluation of the effectiveness of the training package it would, therefore, be predicted that there would be a significant difference in this respect between unit B (full package) and unit D (control), with participants in Unit B showing habilitative change on all selected measures. This approach also enabled an analysis to be made of the changes which occurred in the 'culture only' (Unit A) and 'stress only' (Unit C) conditions in relation to the changes in the other two units.

The above procedure was used to analyse the data obtained from the selected Likert scales used in the evaluation. The only exception to this was the 'Other Responses' scale contained in measure A. In Study One participants used this section to indicate any responses that they would use not covered by the other options given. However, whilst participants used this option to record the nature of their responses (eg. 'give attention') they did not use the Likert scale provided to indicate how likely such responses would be. No quantitative data was, therefore, available from Study One in this respect. However, it was possible to compare the particular examples cited in Study One with those given after the training.

In terms of gauging the degree to which participants had demonstrated an increase in their awareness of the role which avoidance might play in self-injurious and aggressive behaviours, a comparison was made between the number of participants who mentioned examples related to avoidance in Study One and those who did so post-training.

4. RESULTS

For each of the selected measures results are shown in terms of: a) The mean baseline score for the participants concerned, b) The mean post-training score, c) The difference between these two means and d) The F value, degrees of freedom and level of significance for the interaction between the 'conditions' and 'phase' factors.

4.1: Stress:

4.1.1: Self-Injury:

Unit	Condition	Baseline	Post-T	Difference
A	Culture	3.67	5.56	1.89
B	Combined	4.4	5.5	1.1
C	Stress	4.8	5.4	0.6
D	Control	4.25	4.13	-0.12

Table 25: Post Training Stress Related To Self-Injury

There was, therefore, a clear trend for all those who had received training to show an increase in their ratings for stress related to self-injury. Interestingly it appeared to be those who received the culture package who showed the greatest degree of change (ie. Units A and B). The interaction was, however, non-significant - $F=2.19$, $df=3$, $p=0.108$.

4.1.2: Aggression:

Unit	Condition	Baseline	Post-T	Difference
A	Culture	4.67	5.78	1.11
B	Combined	4.8	5.8	1
C	Stress	5.4	5.3	-0.1
D	Control	4.89	3.88	-1.01

Table 26: Post Training Stress Related To Aggression

The interaction was significant, $F=3.25$, $df=3$, $P=0.034$. Again, those who had received the culture package appeared to show the greatest habilitative change, whilst the stress package in isolation appeared to be ineffective.

4.2: Past Factors:

4.2.1: Self-Injury:

In terms of the degree to which 'past factors were seen as a possible cause of this behaviour, results were as follows:

Unit	Condition	Baseline	Post-T	Difference
A	Culture	6.22	5.67	-0.55
B	Combined	4.5	5.5	1
C	Stress	5.1	5.6	0.5
D	Control	5.13	4.88	-0.25

Table 27: Post Training Ratings For Past Factors/Self-Injury

Clearly there was no significant change in the ratings for this item, although those who had received both packages did show some movement. The interaction was non-significant - $F=0.67$, $df=3$, $P=0.579$.

4.2.2: **Aggression:**

Unit	Condition	Baseline	Post-T	Difference
A	Culture	4.88	5.13	0.25
B	Combined	5	5.4	0.4
C	Stress	5	5.6	0.6
D	Control	4.88	5	0.12

Table 28: Post Training Ratings For Past Factors/Aggression

As would be predicted from these figures, the interaction was non-significant, $F=.15$, $df=3$, $P=0.926$.

A striking feature of Study One was that no participants gave examples of avoidance as a possible causal factor for either self-injury or aggression. Despite the fact that the role of avoidance was included in the 'culture' section of the training, the post-training results indicated no change in this. The number of participants mentioning attention as a factor in these behaviours remained stable.

Overall, therefore, the training did not appear to have resulted in an increase in participant's ratings for 'past factors' as a causal factor in self-injurious or aggressive behaviours.

4.3: Responses:

4.3.1: Distraction:

For self-injurious behaviour the results were:

Unit	Condition	Baseline	Post-T	Difference
A	Culture	5.63	4.12	-1.51
B	Combined	5.7	6	0.3
C	Stress	6.6	6.3	-0.3
D	Control	5.5	5.5	0

Table 29: Post Training Ratings For Distraction In Response to Self-Injury

There appeared to have been, therefore, an effect in relation to Unit A with these participants showing a marked decrease in the likelihood of using distraction. However, the interaction was non-significant, $F=2.49$, $df=3$, $P=0.078$.

For aggressive behaviour the results were:

Unit	Condition	Baseline	Post-T	Difference
A	Culture	5.33	4.13	-1.2
B	Combined	6.3	5.9	-0.4
C	Stress	6.5	6.3	-0.2
D	Control	4.88	5.38	0.5

Table 30: Post Training Ratings For Distraction In Response to Aggression.

The interaction was significant, $F=3.40$, $df=3$, $P=0.030$. Again, Unit A appeared to have shown the greatest degree of change with a marked decrease in the likelihood of using distraction as a strategy.

4.3.2: **Communication:**

For self-injurious behaviour the results were:

Unit	Condition	Baseline	Post-T	Difference
A	Culture	6.22	5.67	-0.55
B	Combined	6.33	5.78	-0.55
C	Stress	5.8	5.8	0
D	Control	5.75	5.5	-0.25

Table 31: Post Training Ratings For Communication In Response to Self-Injury

The interaction was non-significant, $F=0.41$, $df=3$, $p=0.749$. For aggressive behaviour the results were:

Unit	Condition	Baseline	Post-T	Difference
A	Culture	6.22	5.67	-0.55
B	Combined	6.3	5.9	-0.4
C	Stress	5.8	6.2	0.4
D	Control	5.75	5.5	-0.25

Table 32: Post Training Ratings For Communication In Response to Aggression

The interaction was non-significant, $F=1.22$, $df=3$, $p=0.318$.

Overall, therefore, the training did not appear to have affected the likelihood of participants using communication as a response to self-injurious and aggressive behaviours. The responses in the 'Other' sections for both self-injury and aggression revealed no increase from Study One in terms of the use of constructive intervention strategies eg. communication training or positive reinforcement for appropriate behaviours.

The results from this section would appear to indicate very little change in the responses of participants to self-injury and aggression. The only exception to this was that participants in group A (culture package only) appeared to show a marked decrease in the likelihood of using distraction.

4.4: **Talking to Others:**

In terms of participants' views of the value placed on this where they worked the results were:

Unit	Condition	Baseline	Post-T	Difference
A	Culture	4.78	5.67	0.89
B	Combined	5.2	4.9	-0.3
C	Stress	5.3	5.8	0.5
D	Control	4.5	4.25	-0.25

Table 33: Post Training Ratings For Talking To Others About Feelings

There was, therefore, some evidence of an effect in the case of Unit A with Unit C showing a more modest change. However, the interaction was non-significant, $F=1.62$, $df=3$, $p=0.203$.

The ratings for 'Personally Valued' and 'Personally Possessed' also showed little change and in both cases the interaction was non-significant ($F=0.37$ $p=.774$ and $F=0.86$ $p=0.471$).

4.5: Dealing With Anything:

For the 'unit valued' ratings the results were:

Unit	Condition	Baseline	Post-T	Difference
A	Culture	5.78	6	0.22
B	Combined	5.1	4.6	-0.5
C	Stress	6	5.4	-0.6
D	Control	4.25	4.5	0.25

Table 34: Post Training Ratings for Dealing with Anything (Valued At Work)

There was, therefore, very little change across any of the conditions. The interaction was non-significant, $F=1.31$, $df=3$, $p=0.287$. For the 'Personally Valued' scale the results were:

Unit	Condition	Baseline	Post-T	Difference
A	Culture	5.78	6	0.22
B	Combined	5	4.3	-0.7
C	Stress	6.3	5.2	-1.1
D	Control	5.63	5.13	-0.5

Table 35: Post Training Ratings for Dealing with Anything (Personally Valued)

Although the 'stress only' condition showed the greatest habitative change, the interaction was non-significant, $F=1.74$, $df=3$, $p=0.178$.

The results for the 'Personally Possessed' scale are set out below:

Unit	Condition	Baseline	Post-T	Difference
A	Culture	6.13	5.75	-0.38
B	Combined	4.6	4.2	-0.4
C	Stress	4.6	4.4	-0.2
D	Control	5.38	5	-0.38

Table 36: Post Training Ratings for Dealing with Anything (Personally Possessed)

The interaction was non-significant, $F=.20$, $df=3$, $p=0.896$.

In terms of this highly counter-habilitative belief, therefore, the training appears to have been ineffective.

4.6: **Punishment:**

In terms of changes in participants ratings for the value placed on this where they work the results were as follows:

Unit	Condition	Baseline	Post-T	Difference
A	Culture	5.33	5.33	0
B	Combined	3.4	2.6	-0.8
C	Stress	3.22	2.55	-0.67
D	Control	4.57	3.86	-0.71

Table 37: Post Training Ratings for Punishment (Valued at Work)

The training did not, therefore, appear to have produced any substantial changes on this measure. The interaction was non-significant, $F=0.32$, $df=3$, $p=0.813$.

In terms of the 'Personally Valued' scale the results were:

Unit	Condition	Baseline	Post-T	Difference
A	Culture	5.44	4.44	-1
B	Combined	3.8	3.1	-0.7
C	Stress	3.11	1.89	-1.22
D	Control	4.43	4.29	-0.14

Table 38: Post Training Ratings for Punishment (Personally Valued)

Although the interaction was non-significant, $F=.39$, $df=3$, $p=0.764$, there did appear to have been some habilitative change amongst participants who had received training. It is of interest that the greatest amount of change was observed in the 'stress only' group who did not in fact receive specific training on punishment. This is commented upon below.

In terms of the 'Personally Possessed' scale the results were:

Unit	Condition	Baseline	Post-T	Difference
A	Culture	5.22	4.67	-0.55
B	Combined	3.7	2.9	-0.8
C	Stress	3.11	2.44	-0.67
D	Control	3.86	3.71	-0.15

Table 39: Post Training Ratings for Punishment (Personally Possessed)

The interaction was non-significant, $F=0.13$, $df=3$, $p=0.94$

Overall, the training appeared to have had a very limited impact in terms of participants view of punishment as a strategy with learning disabled clients.

Taken as a whole, these results did not confirm the hypothesis that a training package based upon contingency and culture effects would lead to habilitative changes in the

attitudes, beliefs and responses of participants. Whilst condition A (culture package) did appear to result in some habilitative changes (eg. an enhanced awareness of stress, a decrease in the use of distraction as a response strategy and possibly an increase in the valuing of 'talking to others about feelings' in the staff sub-culture) these were modest. Very little change was noted in either the 'combined' or 'stress only' conditions. It was particularly notable that the key counter-habilitative belief, 'feels confident that they can deal with any situation', was not significantly affected by the training. Nor did staff show an enhanced awareness of the role which avoidance might play in challenging behaviours.

It was interesting to note that the 'stress only' group showed some habilitative movement on the 'personally valued' section of the punishment scale. Whilst punishment was not included as a part of the formal training for this group, there was a discussion centered around the dangers to clients when highly stressed staff respond to challenging behaviours. This discussion might account for this result.

5. DISCUSSION

The failure of the training package as a whole to produce significant habilitative changes was clearly disappointing and requires further analysis, especially as feedback from participants had been extremely positive. There are a number of factors which might account for these results.

First, although participants were clearly prepared to engage in discussions, many of the counter-habilitative attitudes, beliefs and responses targeted in the training may be extremely resistant to change. These factors are likely to have evolved over a number of years experience and will have been frequently reinforced through direct contact with clients and peer pressure. More experienced staff may have had over 20 years of exposure to this reinforcement. The contingency effect may, for example, be further

reinforced on every occasion where a member of staff encounters challenging behaviour. A one or two day training package may, therefore, be an insufficient response to the counter-habilitative nature of the experiences of unit staff over many years. This would suggest that clinical psychologists might make a more significant impact by intervening in the workplace itself ie. where the counter-habilitative learning is taking place.

Secondly, there may have been additional factors within the units which made it difficult for participants to benefit fully from the training. For example, at the time of the training Unit C was experiencing a significant staffing crisis, meaning that these participants were under additional stress. Whilst this might have affected the results to some degree, the striking feature of the evaluation was that in key areas (eg. 'dealing with anything') none of the training conditions appeared to be successful. It would seem unlikely, therefore, that factors within the individual units could account for the lack of habilitative results. The quasi-experimental design used clearly has weaknesses in terms of evaluating the results of the training in that the groups were not matched. Participants from Unit A, for example, clearly encounter significantly more challenging behaviours than staff from other units. This may have made the training more directly relevant to them and partially account for their more positive results in certain areas. However, the use of an experimental design would have led to a number of significant difficulties. Part of the rationale of the training was to intervene with staff groups ie. at the level of the staff culture. Constructing matched groups, each containing staff from all 4 units, would have weakened this approach. In addition, where staff from the same unit had received different training it would be expected that they would exchange information on the packages they had received, thereby making any follow-up analysis very difficult.

Thirdly, the training itself may have been inadequate in either content or style. Feedback from participants and unit leaders would not give support to this

proposition. The interactive style of the training appeared to be regarded favourably by participants and succeeded in facilitating a number of productive discussions with staff. There was no indication that either staff or team leaders felt that the training had not addressed relevant issues. Indeed, the reaction to the training would indicate that participants did feel that the training had raised issues relevant to their work.

Fourthly, the training, as an intervention strategy, only targeted unit staff. It did not seek to intervene at the level of the wider service. However, the qualitative data gathered in this study would suggest that many of the counter-habilitative factors that were targeted may in fact be heavily influenced by wider service issues. In this sense it may not be staff themselves that need to be the focus of attention but the service in which they work. For example, the training placed considerable emphasis on the value of talking to others as a means of coping with the stress of challenging behaviours. Generally staff seem to value this. However, given that only 1 of the 4 units involved has a formal regular debriefing system in place, for three quarters of the staff the opportunity to talk about feelings following an incident may be extremely limited. Where staff feel unsupported the development of beliefs like 'deal with anything' may be inevitable and training aimed at staff is unlikely to change this. This would again indicate that clinical psychology time might be most effectively used in the workplace itself. For example, a 'staff support system' coordinated by clinical psychologists might have a significant impact, enabling staff to ventilate their feelings and weakening the power of counter-habilitative beliefs. The regular presence of clinical psychologists 'on-unit' might also serve to break down barriers between outside professionals and unit staff. This might also mean clinical psychologists becoming more involved with service planners.

Both the first and fourth points in this discussion relate to the wider service culture, including team leaders, management systems and service planning. In terms of both further research and future interventions strategies these would appear to be key

areas. The possibility of clinical psychologists becoming more involved in the wider service culture is discussed in the final section of this project.

It was recognised that the above evaluation was very limited and that it only considered the initial impact of the training. A longer term follow-up of these staff was not possible given the time constraints of this project. It is possible, therefore, that over the longer term the training might have had a more positive impact. It might, for example, have led to enhanced coping skills in staff. It is also possible that discussions amongst participants in the months following the training might have led to habilitative changes. A longer term evaluation of the training is, therefore, being organised.

SECTION FIVE

CONCLUSIONS AND CRITIQUE

CONCLUSIONS

The results of this research project have a number of implications for both learning disability services and clinical psychologists who work with those services.

Where challenging behaviours are sensitive to social reinforcement the results of this study would confirm that staff responses may well be counter-habilitative. Indeed, challenging behaviours may be a highly effective means of gaining staff attention. This in itself has major implications for services given the considerable human and financial costs involved. For clients such behaviour may lead to further isolation from ordinary community facilities and potentially serious injuries. For staff this study has confirmed that high levels of stress and negative affect may result, possibly leading to considerable problems for both individuals and staff groups. Unit staff may also be at risk of injury. For services as a whole challenging behaviours may represent a considerable drain upon already scarce resources.

The reasons why staff may respond in counter-habilitative ways would appear to be complex. This project has confirmed the finding of Hastings (1995) that lack of knowledge with regard to challenging behaviours is not the key issue, although staff do appear to be less aware of the role of negative reinforcement than would have been expected. Training based upon teaching staff relevant models of challenging behaviour would not, therefore, appear to be indicated. Far more relevant would be the 'contingency' and 'staff culture' hypotheses put forward by Hastings & Remington (1994b). The results of this research project would appear to show some support for both these hypotheses and indeed suggest that there may be an interaction between the two.

As this research project has progressed, the stresses encountered by unit staff have become increasingly central. That unit staff find self-injurious and aggressive

behaviours significantly aversive would now appear to be firmly established. This study would also indicate that there are in fact a number of behaviours that staff find highly aversive which do not readily fit into official incident records. Official records may, therefore, significantly understate the levels of behaviours which cause staff distress. Where challenging or distressing behaviours are a frequent event, individual staff may be subject to high levels of stress and this in itself would be expected to affect their behaviour towards clients. Importantly, it may well predispose staff to adopt strategies that swiftly terminate individual incidents (eg. communication or distraction) whilst further reinforcing the behaviour in the future. In addition interventions based upon a behaviour analytic approach may not be used because they may lead to a temporary increase in the behaviour, thereby increasing staff stress. A striking feature of the results of Study One was that whilst staff appeared to be fully aware of the role which social reinforcement might play in challenging behaviours, this did not lead to responses congruent with this understanding. The contingency effect may well account for this phenomenon.

This study would also suggest that the high levels of stress encountered by staff may have a counter-habilitative impact upon the staff culture. Counter-habilitative responses developed as a result of contingency effects may well become firmly embedded in staff cultures, with new staff being socialised into them by more experienced staff. Processes of both pliance and tracking would make these counter-habilitative responses extremely resilient. In addition, high stress levels may lead to the development of counter-productive attitudes and beliefs. For example, this study would suggest that staff may be reluctant to use a significant coping strategy, ie. talking about their feelings to other staff, because of a desire to protect others from further stress. Highly counter-habilitative attitudes in which staff feel under pressure to 'deal with anything' may also develop. Given that many incidents of challenging behaviours are likely to be dealt with by unqualified staff this is of great concern.

The picture that emerges from this study is of a complex counter-habilitative system in which contingency and culture effects interact, each reinforcing the other. Of some note was the fact that participants did not feel that they were well supported by the wider service culture. This culture had, perhaps, not been sufficiently considered by the author when planning this study. The qualitative data gathered in Study Two would suggest that the system in which staff work may be a significant source of counter-habilitative attitudes and beliefs. Where unit staff feel unsupported and stress levels remain high, counter-habilitative consequences would seem to be inevitable. Interventions that only consider unit staff may, therefore, only make a marginal impact. The lack of habilitative change in the sample used for this project may well have been because wider service issues were not addressed. It is also notable that team leaders, whose role it is to provide support to staff, may themselves be subject to considerable stress. In addition, staff may be reluctant to talk openly about their feelings to someone who is seen as being part of the management system. For these reasons, therefore, support systems based upon team leaders may be ineffective.

This raises a number of issues for clinical psychologists. Highly stressed staff are unlikely to comply fully with behavioural programs, especially where these programs result in extinction bursts. It may well be, therefore, that scarce clinical psychology time might have a greater impact in terms of client care if it was focused more upon unit staff. Given that staff appear to have a good knowledge of current models of challenging behaviours, if supports to staff were increased then habilitative changes in terms of responses to challenging behaviours might well result. By reducing levels of stress it would also be expected that staff would be more likely to engage productively with clients when challenging behaviours were not taking place. It is also of note that this study confirmed the finding of Hastings (1995) in that staff feel that there is inadequate consultation from outside professionals in terms of behavioural programs. This would suggest that increased contact between clinical psychologists and unit staff could be highly beneficial to both parties.

The evaluation of the training used in this research project was very limited, a pilot study being the only practical approach in the time available. It is, therefore, too early to conclude that the training package was entirely unsuccessful. However, the conclusions of this project would indicate that such an approach, on its own, is not likely to produce significant change. For habilitative change to occur it is likely that all aspects of the counter-habilitative system would need to be addressed, meaning interventions with service planners and managers as well as staff. This would indicate a much wider role for clinical psychologists within residential services. Given the scarcity of clinical psychology time this might well mean a significant change in emphasis in the role of clinical psychologists working with learning disability services, involving a shift towards a more systemic approach.

An example of how this approach might produce productive results would be the establishment of a comprehensive staff support system, coordinated by clinical psychologists. Such a system would need to include some provision for debriefing, confidential counselling and, perhaps, staff support groups. The interactive-based parts of the training program would suggest that support groups might be highly successful in promoting discussion within staff cultures. Such a system would clearly require resources. However, if it was successful in reducing counter-habilitative responses amongst staff it could be a highly effective means of reducing challenging behaviours amongst clients and potentially lead to significant financial savings.

This research project poses, therefore, a number of questions for future research. First, as with Hastings (1995) it is not necessarily the case that the service that forms the basis of this project can be regarded as representative of other services. For example, whilst in some respects the results confirmed those of Hastings (1995) eg. staff knowledge of models of challenging behaviour, the possible tolerance effect to

self-injurious behaviour etc, in other areas there were striking differences. For example, whilst Hastings (1995) found that his sample opted for control-based strategies, this sample primarily opted for communication and distraction as methods of response. It is also unclear whether the 'confidence in dealing with any situation' belief is typical of other services. There remains, therefore, a need for further investigation of staff cultures in learning disability services.

A key finding of this research project was the dissatisfaction of unit staff with formal support systems. Participants also gave strong indications as to the sort of support that they felt would be helpful. Again, it is not clear to what degree this may be generalised to challenging behaviour services as a whole. There is clearly a need for research with regard to what sort of support systems are used in other services and how these are regarded by unit staff. Given that the support of unit staff is a central issue to arise from this project it would be interesting to consider whether enhanced support systems do indeed feedback into improved services to clients and lead to reductions in challenging behaviours. The work of Hill-Tout & Lowe (1995) is also interesting in this respect, reflecting an increased interest in recruitment issues. Recruitment issues were not considered as part of this study but may well be important when considering counter-habilitative factors within staff cultures. How staff are selected and the nature of their induction would certainly be expected to have an influence upon the care received by clients.

It is also of note that the disparity between self-report and observational studies remains unexplained. Given that it involves a considerable disagreement with regard to the frequency of staff responses to challenging behaviours it is clearly significant and requires further research. However, observational studies would appear to be extremely problematic both in ethical and practical terms. The structured interview approach, used by Hastings (1995), combined with information gathered in structured

discussions with staff groups, might well provide a useful means of gathering further information in this area.

Finally, although the results of this project have revealed potentially counter-habilitative factors within services to learning disabled clients with challenging behaviour needs, many positive factors emerged as well. The experience of the researcher was that at all levels of this service there was an interest in the issues raised by the research and an openness with regard to improving services. Increased involvement by clinical psychologists in these services could, therefore, be a very productive development.

Summary Of Main Findings

1. That staff responses to challenging behaviours may well be counter-habilitative, representing a major issue for learning disability services.
2. That unit staff possess a good knowledge of current models of challenging behaviours and that as such lack of knowledge would not appear to account for these responses.
3. That high levels of stress in relation to challenging behaviours would appear to be implicated in these responses.
4. That high levels of stress may lead to the development of a counter-habilitative system in which contingency and culture effects interact, reinforced by aspects of the wider service culture.

5. That clinical psychologists may well need to become more involved both with unit staff and the wider service culture if habilitative changes are to be achieved. An example of this would be an increased emphasis on support systems to staff.

6. In terms of future research a number of issues emerged:

- a) To what degree can the findings of this project be generalised to other services ?
- b) What sort of support systems are likely to produce habilitative changes ?
- c) Recruitment and induction of unit staff.
- d) The disparity between observational and self-report studies.
- e) The value of further qualitative research with regard to staff sub-cultures.

CRITIQUE

The final structure of this research project differs to some extent from that outlined in the original research proposal. In the original proposal far greater emphasis was placed upon the training packages and their evaluation, with less emphasis being placed upon Study One and the qualitative part of the project. For example, the proposal included provision for both an initial and three monthly evaluation of the training. There are a number of reasons why changes were made.

Firstly, when writing the original research proposal, the author greatly underestimated both the volume of data that would be gathered in Study One and its significance. This meant that whilst Study One was initially envisaged as being mainly a means of gathering baseline data for the evaluation section of the project, it developed into a much more significant part of the research. The potential significance of the findings of Study One, especially with regard to issues relating to staff sub-cultures, meant in turn that the qualitative data became more important. Secondly, at the beginning of this

research the researcher had no means of predicting how participants would react to the discussion-based format of the training and how successful it would be in eliciting qualitative data. This format was, in fact, more successful than had been anticipated, providing a great deal of relevant qualitative data. Thirdly, as the project progressed and wider issues emerged (eg. the perceived lack of support from the wider service system) it became increasingly clear that the data gathered was indicating that staff training was not likely to be an effective means of achieving habilitative changes. In that sense, whilst the project was originally based around the development of training packages, during its implementation it evolved away from this. This meant that in the final thesis less space was set aside for an evaluation of the training than had been initially intended. Finally, time constraints were also a significant factor. Considerable logistical problems were experienced throughout the project, especially with regard to the organisation of the training. Due to staff sickness, rota changes and annual leave the original training plan had to be abandoned, meaning that there was insufficient time to carry out the three month follow-up. This was unfortunate in that it would have been expected that if the training had had some longer term effect in terms of habilitative changes in staff culture, signs of this would have been evident after three months.

Given the timespan of this project a questionnaire-based approach was considered to be the most practical means of gathering data. However, it is by no means ideal. In particular, the questionnaires used could only cover a limited range of options and, as staff pointed out, responses to challenging behaviours may vary considerably depending upon the individual client involved. This was in fact the main criticism which participants had of measure A. The structured interview approach used by Hastings (1995) would appear to be superior, especially with regard to qualitative data. In addition, the piloting of measures A and B was extremely limited. Whilst participants for the validity part of this pilot did need to come from the Exeter service it would, perhaps, have been possible to conduct a more extensive analysis of the

reliability of the measures by using staff from another district. On reflection the researcher also felt that it would have been useful to include a 'long term strategies' section in measure A where staff could indicate how they felt the challenging behaviours might be responded to in the longer term. However, this would have further lengthened and added to the complexity of measure A.

It was also noticeable that staff were markedly less enthusiastic about filling in the questionnaires following the training (ie. for the second time). 'Questionnaire fatigue' was certainly evident and this might well have interfered with any longer term evaluation of the training. As a result of this it is not planned to use the full questionnaires in the long term follow-up to be carried out later this year. A qualitative approach based upon structured interviews is being considered.

In retrospect a major criticism of this study would be that it focused too heavily on unit staff and failed to take sufficient account of the wider service context. For example, team leaders were not initially included in the original research proposal. On completing the thesis the researcher felt that the research had only highlighted one aspect of a much wider problem. Future research might well consider the problem from other perspectives - eg. team leaders, service directors and service planners.

APPENDIX A

ETHICAL APPROVAL AND DOCUMENTS

**Exeter District
Research Ethics Committee
Dept. of Medical Affairs
Kenn Ward
RD&E (Wonford)
Barrack Road
EXETER
EX2 5DW**

In reply:

1. Please quote Study Number
2. Address to the "Chairman"

(Please do not use Chairman's name to avoid misdirection)

**Tel: 01392 402369
Fax: 01392 402067**

Our Ref: PG/SAC

29 March 1996

Mr N Bathurst
Lyndhurst
Deepway Lane
Exminster
EXETER
Devon

Dear Mr Bathurst

Study 742 Modifying Staff Responses to Challenging Behaviour

The Committee would like to thank yourself and Dr McDermott for attending the meeting on Monday 25th March. It was a great help for the Committee to be able to clarify matters with you and I am pleased to say that approval was given on research ethics grounds.

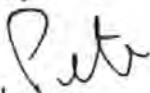
You will also need the approval of Dr Ayres on behalf of the Community Trust before the study can go ahead. I have therefore passed this file to him.

It is recommended and it would be helpful to the Ethics Committee if you would be kind enough to supply us with a report of the outcome of the study or, if it extends over a period greater than a year, interim annual reports in addition. If publications arise, we would also be very grateful for copies.

You are reminded that it is incumbent on you to inform the Chairman of the Ethics Committee of any serious adverse event that takes place during the conduct of this investigation. This notification should be made to the Chair within 24 hours of the event.

The Committee wishes you every success with this project.

Yours sincerely



Dr P H Gentle
Chairman
Exeter Medical Research Ethics Committee

Exeter District

COMMUNITY HEALTH SERVICE

■ NHS TRUST ■

Exeter & District Community Health Service NHS Trust, Newcourt House, Old Rydon Lane, Exeter, Devon EX2 7JU
Telephone 01392 449700 Facsimile 01392 445435

Mr N Bathurst
Lyndhurst
Deepway Lane
EXMINSTER
Exeter

Please ask for: **Claire Saunders**

Direct Dial Tel.: **01392 449762**

Date: **28 May 1996**

Dear Mr Bathurst

Re: Study 742 Modifying Staff Responses to Challenging Behaviour

Peter Gentle has passed the file concerning this Project on to me. I think it is a most interesting study, and I have no problems in approving it.

I hope it will go well, and I look forward to hearing the outcome.

Kind regards.

Yours sincerely



Dr R Ayres
Medical Director

RR

Working for a Healthier Community

Chairman: E S Russell Chief Executive: E C Herbert

INFORMATION SHEET

This research will be investigating ways in which the services we provide for clients with challenging behaviours can be improved. It also aims to identify ways in which unit staff can be most effectively supported in working with this client group.

As part of this you will be asked to complete some questionnaires regarding your feelings and responses to challenging behaviours. You will then receive some training with regard to challenging behaviour. Two weeks after this training you will be asked to fill in these questionnaires again. The information you provide will be treated in the strictest of confidence and only the researchers will see your completed forms. In the study you will be allocated a code number and the information that you will provide will be identified by this code number only - your name will not be included as part of the information recorded.

A number of different training packages are being evaluated as part of this study. The most successful package will be made available to all participants once the study is completed. The aim is to improve the quality of the service we provide to challenging clients.

Participation in the study is entirely voluntary. If you decide to take part but later wish to withdraw you may do so without having to give any reasons.

The researchers conducting this study are:

Neil Bathurst, Trainee Clinical Psychologist, Clinical Teaching Unit, 4/5 Rowe Street, University of Plymouth, Plymouth. Tel: 01752 233161. Home number: 01392 832782.

David McDermott, Principal Clinical Psychologist, Dept. of Community and Clinical Psychology, Royal Devon & Exeter Hospital, Exeter. Tel: 01392 403170

Please do not hesitate to contact either of us if you would like further information. This research has been approved by the Exeter District Ethics Committee. They may be contacted at the Royal Devon & Exeter Hospital, Tel 01392 402369. Should you have any concerns about the ethical conduct of this study you may speak to the committee in complete confidence. The study has also been approved by the Medical Director, Dr. R Ayres.

CONSENT FORM

Study Title: Modifying staff responses to challenging behaviour: An evaluation of behaviour analytic concepts and intervention strategies.

Please indicate your response by circling either **YES** or **NO**

Have you read the information sheet ? **YES / NO**

Have you had the opportunity to ask questions about this study ?..... **YES / NO**

Have your questions being answered satisfactorily?..... **YES / NO**

Have you received enough information about the study?..... **YES / NO**

Do you understand that you may withdraw from this study at any time without having to give reasons for doing so?..... **YES / NO**

Do you agree to take part in this study ?..... **YES / NO**

Signed:.....(Participant)

Signed:.....(Researcher)

Date:.....

APPENDIX B

MEASURES

MEASURE A

CHALLENGING BEHAVIOURS QUESTIONNAIRE

Thank-you for agreeing to fill in this questionnaire. It is important that you fill it in on your own, without reference to other staff. Your responses to the questions set out below will be treated in the strictest of confidence and be seen only by the researchers carrying out this study. Your name will not appear on the questionnaire and throughout the study you will be identified by a code number only.

In the questionnaire you will be presented with three examples of challenging behaviour. In each case you will be asked how stressed you would feel as a result of the behaviour, what you feel might have caused the behaviour to occur and what action you would take in response to it. In each case please answer the questions as if this were a real life situation where you work.

For each question you will be given a scale on which to respond eg.

[-----[-----[-----[-----[-----[-----]
Not at
All
Extremely

If your preferred answer to the question was '**not at all**' then you would place a cross on the marker on the far left of the scale. If your preferred answer was '**extremely**' you would place a cross on the far right of the scale. Where your preferred answer was between the two, you would put a cross on the marker which best represented your response on the scale provided.

Example 1:

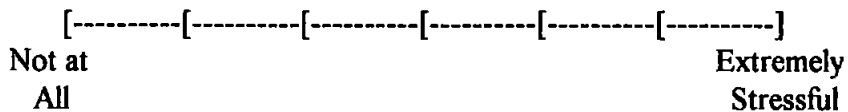
James Robinson:

James is learning disabled. Sometimes James stands in the middle of the floor and rocks his body. James' rocking always involves putting his left foot behind his right and rocking from one foot to the other. You encounter James whilst he is engaged in this behaviour.

1. STRESS

This section asks about how stressful you would find this situation.

a) How stressful would it be for you to work with James in the above situation ?



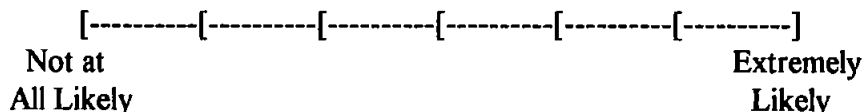
b) Please list below the emotions that you think you would feel if you were working with James.

2. REASONS FOR THE BEHAVIOUR

This section asks you what factors you feel might have led to James behaving in this way. In each case you will be asked to indicate how likely you feel the reasons given are:

a) **INDIVIDUAL FACTORS**

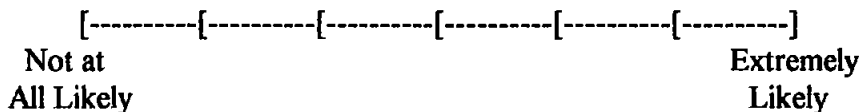
That is, reasons just concerned with James' own physical and mental world eg. his personality, pain, mental illness.



Please give any further examples of individual factors that in your experience might be relevant:

d) PAST FACTORS

That is, James has learned to behave in this way because of the results the behaviour has produced in the past eg. material or other gains, removal of something he does not like:

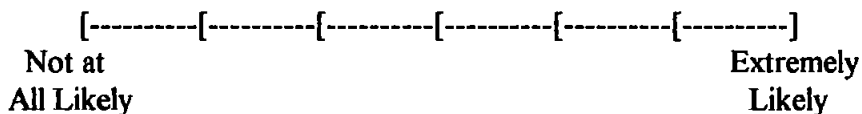


Please give further examples of past experiences that might have caused the behaviour.

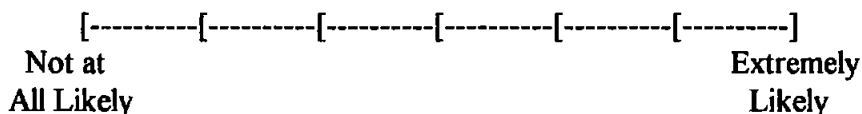
3. YOUR RESPONSE

For each of the options below, please indicate how likely it would be that you would respond to James' behaviour in that way:

a) PHYSICAL RESTRAINT

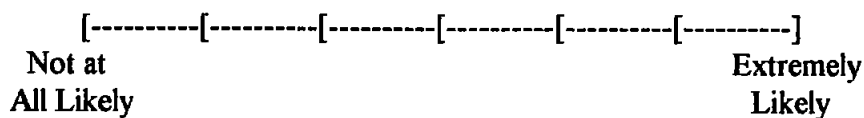


b) IGNORE THE BEHAVIOUR

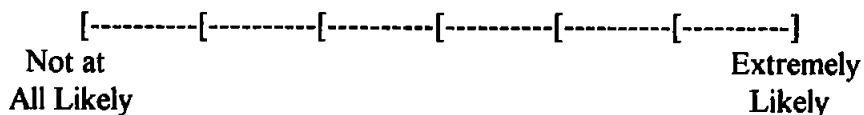


c) DISTRACTION

ie. attempt to interest James in something that will distract him from performing the behaviour:

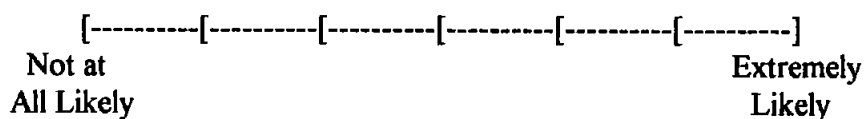


d) REPRIMAND



e) COMMUNICATION

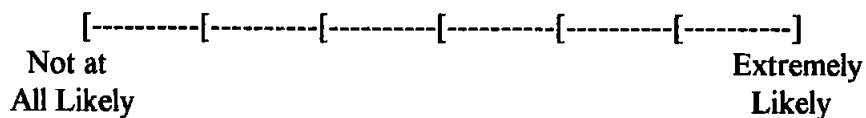
ie. talk to James to find out what has led to the behaviour and then seek to meet any need that may result from this:



f) OTHER

ie. any other course of action that you might follow. Please specify.....

.....



Example 2:

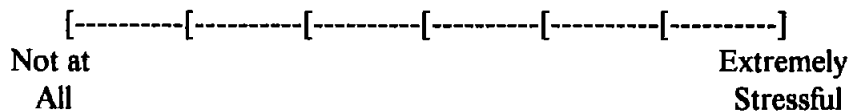
James Robinson:

James is learning disabled. Sometimes James repeatedly hits himself around the head with his fists. This often leads to bruising, bleeding or other temporary or permanent tissue damage. You encounter James whilst he is engaged in this behaviour.

1. STRESS

This section asks about how stressful you would find this situation.

a) How stressful would it be for you to work with James in the above situation ?



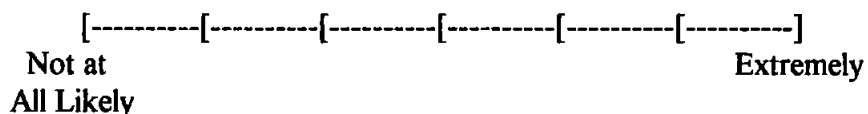
b) Please list below the emotions that you think you would feel if you were working with James.

2. REASONS FOR THE BEHAVIOUR

This section asks you what factors you feel might have led to James behaving in this way. In each case you will be asked to indicate how likely you feel the reasons given are:

a) INDIVIDUAL FACTORS

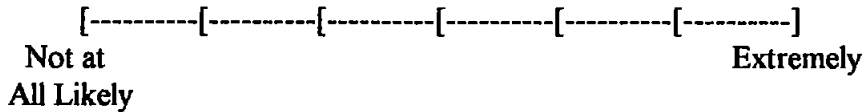
That is, reasons just concerned with James’ own physical and mental world eg. his personality, pain, mental illness.



Please give any further examples of individual factors that in your experience might be relevant:

b) ENVIRONMENTAL FACTORS

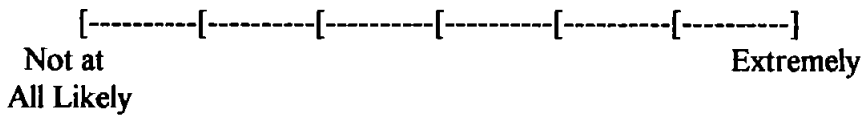
That is, reasons to do with James' environment, including other residents but excluding unit staff eg. boredom, noise, bullying.



Please give any further examples of environmental factors that in your experience might be relevant:

c) AS A MEANS OF COMMUNICATION

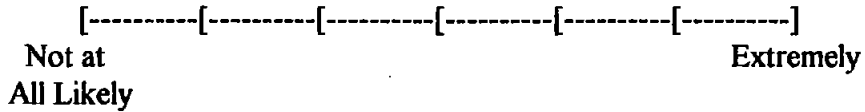
That is, as a way of James communicating with others, including unit staff eg. a desire for more attention or to communicate a need:



Please give any further examples of what James might be communicating through his behaviour:

d) PAST FACTORS

That is, James has learned to behave in this way because of the results the behaviour has produced in the past eg. material or other gains, removal of something he does not like:

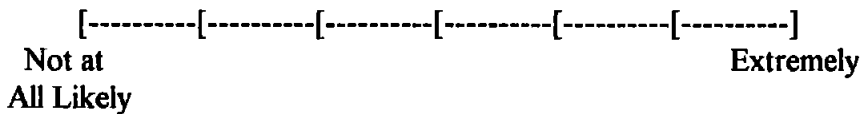


Please give further examples of past experiences that might have caused the behaviour.

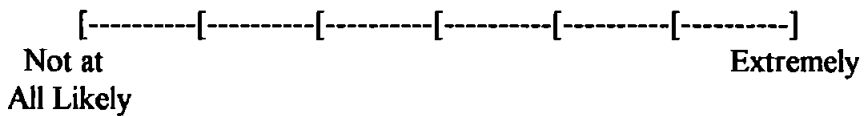
3. YOUR RESPONSE

For each of the options below, please indicate how likely it would be that you would respond to James' behaviour in that way:

a) PHYSICAL RESTRAINT



b) IGNORE THE BEHAVIOUR



c) **DISTRACTION**

ie. attempt to interest James in something that will distract him from performing the behaviour:

[-----[-----[-----[-----[-----[-----]

Not at
All Likely

Extremely

d) **REPRIMAND**

[-----[-----[-----[-----[-----[-----]

Not at
All Likely

Extremely

e) **COMMUNICATION**

ie. talk to James to find out what has led to the behaviour and then seek to meet any need that may result from this:

[-----[-----[-----[-----[-----[-----]

Not at
All Likely

Extremely

f) **OTHER**

ie. any other course of action that you might follow. Please specify.....

.....

[-----[-----[-----[-----[-----[-----]

Not at
All Likely

Extremely

Example 3:

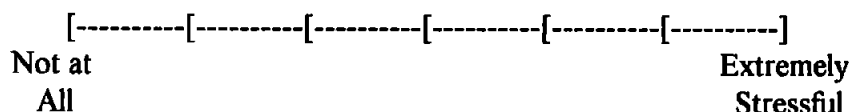
James Robinson:

James Robinson is learning disabled. Sometimes, James is aggressive towards other people that live and work with him. He kicks and punches them. You encounter James whilst he is engaged in this behaviour.

1. STRESS

This section asks about how stressful you would find this situation.

a) How stressful would it be for you to work with James in the above situation ?



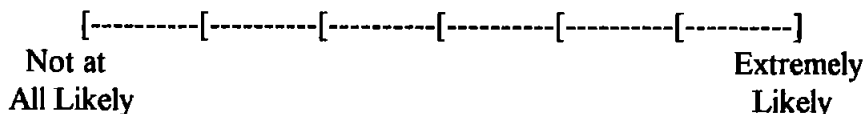
b) Please list below the emotions that you think you would feel if you were working with James.

2. REASONS FOR THE BEHAVIOUR

This section asks you what factors you feel might have led to James behaving in this way. In each case you will be asked to indicate how likely you feel the reasons given are:

a) **INDIVIDUAL FACTORS**

That is, reasons just concerned with James' own physical and mental world eg. his personality, pain, mental illness.



Please give any further examples of individual factors that in your experience might be relevant:

b) ENVIRONMENTAL FACTORS

That is, reasons to do with James' environment, including other residents but excluding unit staff eg. boredom, noise, bullying.

[-----[-----[-----[-----[-----[-----]
Not at
All Likely
Extremely
Likely

Please give any further examples of environmental factors that in your experience might be relevant:

c) AS A MEANS OF COMMUNICATION

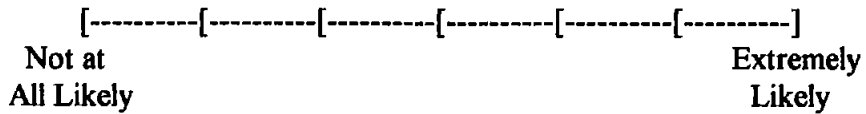
That is, as a way of James communicating with others, including unit staff eg. a desire for more attention or to communicate a need:

[-----[-----[-----[-----[-----[-----]
Not at
All Likely
Extremely
Likely

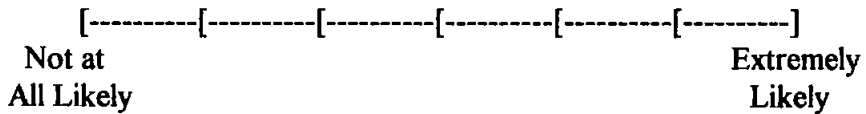
Please give any further examples of what James might be communicating through his behaviour:

c) DISTRACTION

ie. attempt to interest James in something that will distract him from performing the behaviour:

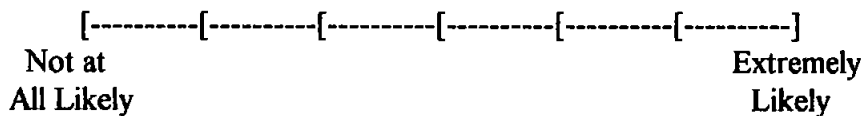


d) REPRIMAND



e) COMMUNICATION

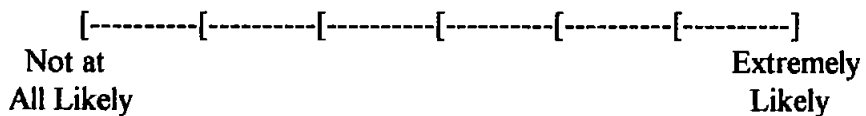
ie. talk to James to find out what has led to the behaviour and then seek to meet any need that may result from this:



f) OTHER

ie. any other course of action that you might follow. Please specify.....

.....



MEASURE B

STAFF ATTITUDES QUESTIONNAIRE

Thank-you for agreeing to fill in this questionnaire. It is important that you fill it in on your own, without reference to other staff. Your responses to the questions set out below will be treated in the strictest confidence and will only be seen by the researchers carrying out this study. Your name will not appear on the questionnaire and throughout the study you will be identified by a code number only.

In the questionnaire you will be presented with 8 statements, each one of which represents a quality or characteristic that might be possessed by a member of staff working with clients who have challenging behaviour needs. For each statement you will be asked to rate how much that characteristic is valued at the place where you work, how much you value it and to what extent you possess it.

For each statement you will be asked to indicate your view using a 7 point scale. For example, in relation to your place of work:

[-----[-----[-----[-----[-----[-----]

Not at all
Valued

Extremely
Valued

If you felt that the characteristic was not at all valued, you would put a cross on the marker at the far left of the scale. If you felt that it was extremely valued, you would put a cross on the far right marker. Where your preferred response was somewhere between the two you would put a cross over the marker which best represented your response on the scale provided.

1. IS ABLE TO TALK ABOUT PERSONAL FEELINGS AS THEY RELATE TO WORK.

a) How valued is this where you work ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

b) How much do you value it ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

c) To what extent do you possess this quality / characteristic ?

[-----[-----[-----[-----[-----[-----]
Not at all To a very great
Extent

2. FEELS CONFIDENT THAT THEY CAN DEAL WITH ANY SITUATION.

a) How valued is this where you work ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

b) How much do you value it ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

c) To what extent do you possess this quality / characteristic ?

[-----[-----[-----[-----[-----[-----]
Not at all To a very great
Extent

3. HAS A GOOD UNDERSTANDING OF THE PRINCIPLES OF NORMALISATION.

a) How valued is this where you work ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

b) How much do you value it ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

c) To what extent do you possess this quality / characteristic ?

[-----[-----[-----[-----[-----[-----]
Not at all To a very great
Extent

4. READILY AGREES WITH COLLEAGUES.

a) How valued is this where you work ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

b) How much do you value it ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

c) To what extent do you possess this quality / characteristic ?

[-----[-----[-----[-----[-----[-----]
Not at all To a very great
Extent

5. FOLLOWS DETAILED INSTRUCTIONS / WRITTEN GUIDELINES COMPLETELY.

a) How valued is this where you work ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

b) How much do you value it ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

c) To what extent do you possess this quality / characteristic ?

[-----[-----[-----[-----[-----[-----]
Not at all To a very great
Extent

6. FEELS STRONGLY THAT WHEN SOMEONE HAS DONE SOMETHING WRONG THEY SHOULD BE PUNISHED.

a) How valued is this where you work ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

b) How much do you value it ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

c) To what extent do you possess this quality / characteristic ?

[-----[-----[-----[-----[-----[-----]
Not at all To a very great
Extent

7. QUICK TO RECOGNISE SMALL CHANGES IN THE BEHAVIOUR OF OTHERS.

a) How valued is this where you work ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

b) How much do you value it ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

c) To what extent do you possess this quality / characteristic ?

[-----[-----[-----[-----[-----[-----]
Not at all To a very great
Extent

8. HAS STRONG PERSONAL BELIEFS AND SEEKS TO PERSUADE OTHERS OF THESE.

a) How valued is this where you work ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

b) How much do you value it ?

[-----[-----[-----[-----[-----[-----]
Not at all Extremely

c) To what extent do you possess this quality / characteristic ?

[-----[-----[-----[-----[-----[-----]
Not at all To a very great
Extent

MEASURE C

UNIT MEASURES

MONTHLY RECORD SHEET

Record filled in for the month of:.....

Date filled in:.....

Filled in by:.....

Total incidents in this month:.....

TOTAL INCIDENTS IN MONTH:.....

NUMBER OF CLIENTS FOR WHOM FORMAL GUIDELINES EXIST.....

Record of Compliance.

For each client for whom formal guidelines exist please indicate to what extent you feel that staff have complied with those guidelines. Please put a cross on the scales provided to indicate your view.

Client 1: [-----[-----[-----[-----[-----[-----]

Not at all
Compliant

Extremely
Compliant

Client 2: [-----[-----[-----[-----[-----[-----]

Not at all
Compliant

Extremely
Compliant

Client 3: [-----[-----[-----[-----[-----[-----]

Not at all
Compliant

Extremely
Compliant

APPENDIX C

TRAINING PACKAGES

WORKING WITH CHALLENGING BEHAVIOUR
ISSUES FOR STAFF

A DAY WORKSHOP FOR STAFF WORKING WITH
CHALLENGING CLIENTS

Neil Bathurst, Trainee Clinical Psychologist

September 1996

ABOUT THE WORKSHOP

Today's training has 4 main aims:

1. To introduce you to the role that past learning experiences may play in challenging behaviour.
2. To look at how the way in which we respond to challenging behaviours in the short term may make it worse in the long term.
3. To look at how the principles of learning can be used to help clients behave in more appropriate ways.
4. To discuss some key issues in relation to working with challenging clients.

The day is designed to be informal, relaxed and hopefully enjoyable. I aim to finish promptly at 4.30 pm and there will be breaks throughout the day. Whatever is said in the workshop will be treated in the strictest of confidence. Nobody is under any pressure to contribute to discussions but obviously I hope that you will feel comfortable in contributing your own views and experiences.

As you will be aware, this training forms part of a research project. In 2 weeks time you will receive by post 2 further questionnaires from me. It would be very helpful if you could fill these out and return them to me in the stamped addressed envelope provided. Your replies will be treated as strictly confidential and will be seen only by myself. Your cooperation is very much appreciated and I hope that you enjoy the day.

The plan for today is:

10.00 am: Introductions, Questions, Group Rules.

10.15 am: Exercise 1 and Discussion - Can clients learn challenging behaviours ?

11.00 am: BREAK

11.15 am: Can clients learn appropriate behaviours ?

12.00 am: Other causes of challenging behaviours.
12.30 pm: LUNCH
1.30 pm: Do written programs and guidelines matter ?
2.15 pm: Is the use of punishment OK ?
3.00 pm: BREAK
3.15 pm: Should you be able to cope with anything ?
4.00 pm: Do your own views and feelings matter at work ?
4.30 pm: Final discussion & Finish

SOME TERMS YOU WILL HEAR USED TODAY

Most of this morning will be taken up with discussing behaviour - both that of clients and staff. We will be discussing behavioural programs later on in the day.

When the behaviour of clients is discussed you will often hear certain terms used and these are also frequently used in written programs. These programs are normally written by **clinical psychologists** or **nurse behaviour therapists**. Behavioural programs begin with an in-depth and detailed analysis of the behaviour of the client. This is often done through **A,B,C** charts. When an incident occurs you are asked to record 3 things:

Antecedants: What was happening at the time of the incident ? Where was the client ? Who else was there ? What was the time ? etc

Behaviour: Exactly what did the client do ? Give a precise description of what happened.

Consequences: What happened as a result of the incident ?

A key question will be, '**why has the client behaved in this way**' ? The ABC chart can reveal patterns (eg. time of day, who else is present, certain consequences always occur as a result of the behaviour) that help us to understand the behaviour.

Behaviourists emphasises the role which **learning** plays in behaviour. When looking at an incident they will be asking, 'what has the client learned from this experience' ? We will today also be asking what you as a staff member may learn from an incident. Behaviourists argue that behaviour can often be explained in terms of the **consequences** that follow it. If we behave in a certain way and the consequences are pleasant then we are more likely to behave in that way in the future. For example, why do we come to work ? The consequences of coming to work are money (which we can

use to buy things we like), social contact, feeling of achievement etc. These consequences are called **reinforcers**.

A **reinforcer** is something which follows a behaviour - a consequence - which makes it more likely that the behaviour will happen again in the future. For example, in the above example your pay packet **reinforces** your behaviour in coming to work. If the reinforcer is removed you will stop coming to work. Reinforcers may also work by taking away something unpleasant ie. the behaviour enables you to avoid something .

An important point is that learning applies to us all. Learning experiences can lead us all to behave in challenging ways. Exactly what we learn will depend on our environment - particularly the way in which others respond to us. **The way in which others respond to our behaviour will be very important in our learning.** Things like praise, approval and attention can be very powerful in reinforcing our behaviour.

EXERCISE ONE

In one of the questionnaires you were given some examples of challenging behaviours. We are now going to consider one of these in more detail. A challenging behaviour quite commonly referred to clinical psychologists is self injury. The client we are concerned with has regular episodes of self-injury. ABC charts have revealed the following:

A: Usually the client is on his own. If staff or other residents are in the room they are normally not directly involved with him.

B: The client begins to scream and hits his fists against furniture. He then hits his fists against his head and continues screaming.

C: Staff intervene as quickly as possible. Most staff try and calm him and spend some time with him, trying to distract him with an activity. Others reprimand him and stay close to him for a while in case restraint is necessary. Normally, however, the behaviour quickly subsides.

Incidents are becoming more frequent. medical investigations have revealed nothing. The client seems to enjoy the company of others but has poor communication skills. In your groups please consider:

1. What do you think is happening in this situation ?
2. What are the reinforcers for this behaviour ?
3. What is the client learning in this situation ?
4. What about the staff involved ? What are the reinforcers for staff behaviour ?
5. What do staff learn in this situation ?

6. What is the problem here ?

THE VICIOUS CIRCLE

The example you have been discussing illustrates how difficult it can be in terms of responding to challenging behaviours.

The key to the behaviour of the client would appear to be attention, particularly attention from staff. At some point in the past the client has learned that screaming and hitting himself is a highly effective way of gaining your attention. This attention comes rapidly and leads staff to abandon whatever else they were doing. Possibly in the past the client copied the behaviour from someone else. Or perhaps on one occasion he was particularly frustrated at the lack of attention he was receiving and began to hit himself. Staff quickly intervened and the client learned that self-injury is an effective way of getting attention. It is, therefore, **staff attention** that is the reinforcer here. This means that although staff attention is designed to lessen the behaviour in fact it reinforces it.

For the staff involved the key factor is stopping the client's behaviour. To see someone injuring themselves or others is very unpleasant and obviously staff would want to prevent any injury. Staff will, therefore, want to stop the behaviour quickly. When they give the client attention the behaviour does indeed stop quickly. Staff, therefore, have learned that to intervene and give attention stops the incident. The client stopping the behaviour reinforces staff to give attention in the future.

This leaves client and staff locked in a vicious circle. The client's behaviour leads staff to respond in ways that, whilst quickly stopping an individual incident, reinforces the client's challenging behaviour in the future. Note also that punishing the client is unlikely to be effective. If the client wants attention, negative attention may be just as reinforcing. A member of staff reprimanding you is still better than no attention at all.

The vicious circle highlights how important your time with clients can be. The above example also applies if the client's motivation is to avoid attention. Some clients actively dislike contact with others and will behave in a challenging way to avoid it. Staff and other clients quickly learn to respond by leaving the client alone, thereby reducing the behaviour in the short term. However, the client has now learned that the most effective way of avoiding contact is to self-injure or be aggressive. Anyone who attempts to interact with that client in the future may be met with these behaviours.

This is a very difficult circle to break because where self-injury or aggression is occurring some intervention may be necessary for safety and ethical reasons. If injuries are likely to occur then some form of intervention is necessary.

This illustrates how learning can lead to challenging behaviours. The next section will look at how learning can be used to reduce challenging behaviours in the long term.

EXERCISE TWO

Look back at exercise 1. Clearly a learning process is at work here for both the client and staff. As a group I would like you to consider how learning might be used to break out of the vicious circle. You might like to think about the following:

Assuming that on occasions you do have to directly intervene in response to the behaviour, are there ways of intervening that minimise the reinforcement of the challenging behaviour ?

Can learning be used in a positive way when incidents are not happening ?

Is the client lacking in some skills ? Is communication an issue ?

What supports do staff need to help them in this situation ?

CAN APPROPRIATE BEHAVIOUR BE LEARNED ?

In the same way as negative behaviour can be learned, positive behaviour can be learned as well. In fact, when it is clear that a challenging behaviour has been learned this is, in some respects, encouraging in that it shows that the client learns from his / her environment. By changing the environment, especially the ways in which we respond to challenging behaviour, we may enable the client to learn more appropriate behaviour. Again, it is you as staff who are the key to the situation.

Considering the example we have been discussing there are strategies which could be used to help the client and staff involved. First, when intervention is necessary it can be made as non-reinforcing as possible. The behaviour can be dealt with in such a way as to give minimal attention. It can be dealt with in a calm, matter of fact way that does not result in prolonged staff contact **BUT** this will make matters worse and not better if no other learning takes place. The client will just become more frustrated and may increase self-injuring.

The key here is to reinforce positive behaviour. The client is actually indicating a genuine and reasonable need. He is bored and wants some staff time. The problem is the way this is being communicated. We can help the client learn that there are more appropriate ways of communicating. This may need a special program written by a psychologist. However, the main principle would be to encourage and reward the client for other, more appropriate, means of getting attention - such as approaching a staff member. When this occurs the client is given lots of praise and attention. If this is combined with minimal attention being given for self-injury, over time there is a good chance that the client will learn that appropriate behaviour is more successful in gaining attention than self-injury. The self-injury loses its purpose.

Many clients can be helped with their communication, even when they have no language at all. Signs can be used. The client can be taught how to use a

communication book. This will contain photos of typical activities. If the client wants a bath they can point to the picture of a bath. Often these quite simple interventions lead to quite significant changes in behaviour.

Some more minor behaviours can be ignored completely (again making sure that appropriate behaviour is reinforced). However, this sometimes leads to a temporary increase in the behaviour followed by a sharp decline. This is called an **extinction burst**. If the client has been gaining something by the behaviour and this gain is suddenly removed, the client may well try a strategy of increasing the behaviour before stopping it. Where the behaviour is difficult for others to cope with this can be a problem.

Finally, working with challenging behaviour is difficult and stressful. The more support you have the more likely you are to be able to cope with it and respond to it in a constructive way. Asking for help from others outside of the unit such as psychologists, OT's etc is not a sign of weakness or failure. Working with challenging behaviours requires a team approach.

OTHER CAUSES OF CHALLENGING BEHAVIOURS

So far we have concentrated most upon how challenging behaviour can be learned. However, there are many other important causes of challenging behaviour which need to be considered. It is important to ensure that these are taken account of in any assessment.

One of the most important factors is **communication**. many learning disabled people have severe problems with communication. It is often very difficult for them to make their needs known and this can lead to frustration and unhappiness. For example, imagine that you are bored and want to go into town. You know that you can only go out with a member of staff. You therefore want to tell a member of staff that you want to go out. However, you cannot make them understand what you want. When this happens repeatedly you might well become angry and irritable. behaviour is a very powerful way of communicating - we all use our behaviour to let others know how we are feeling. Others quickly learn what our behaviour is communicating and react accordingly. For those with major communication problems behaviour may be a very effective means of getting your needs recognised and met.

The **environment** will also be important. How happy we are with where we live and those we live with will obviously influence our behaviour. How many of our clients have had a choice in where they live or who they live with? Noisy environments may be upsetting. Those who have lived in large institutions may find living in a small house difficult to cope with. A client may strongly dislike other residents or staff. Lack of space may be a problem.

There are many **individual factors** that may lead clients to behave in challenging ways. Illness, both physical and mental, can produce challenging behaviours. A client who is in pain and cannot communicate this is likely to feel irritable and depressed.

Depression and anxiety may lead to challenging behaviours. Some forms of epilepsy can lead people to behave in aggressive or unusual ways. We all have moods and this can lead us to be challenging to others. Whilst this is regarded as quite normal for the rest of us, for clients with a learning disability it may be seen quite differently and result, for example, in extra medication. Medication may produce side-effects which lead to challenging behaviours.

Past factors may also be involved. On the questionnaires many of you mentioned past abuse as a factor in challenging behaviours. It is certainly the case that many clients, especially those who have spent time in large institutions, have been emotionally, physically and sexually abused. As with anyone else, this will have had a big effect upon them and how they view others. As mentioned before, some clients have spent long periods of time in institutions and will have learned to cope with institutional life. Life in a community-based home is likely to be very difficult to adjust to. Many of the behaviours that clients show may well have been learned many years ago.

DO WRITTEN PROGRAMS MATTER ?

When challenging behaviour has become a major problem or has led to concern a referral may be made to a psychologist or specialist nurse. They will assess the situation and may leave you with a program to follow. This normally involves you responding in a set way to the behaviour.

The biggest problem in working in this way is the fact that often programmes are not followed at all or are only partly followed. For example, this morning we discussed how to change a client's self-injurious behaviour by giving minimal reinforcement to the challenging behaviour but lots of attention to appropriate behaviour. This might well have been written up as a program. Hopefully, if the program was implemented, it would have been successful. But what if only half the staff followed it with the other half carrying on as before ? This is a major problem with these programs. If only a few staff fail to follow the program this may be enough to stop the client from learning that appropriate behaviour leads to better attention.

If a program is going to work it needs everyone involved to be consistent in using it.

What factors do you think might lead staff not to follow a program ?

How can we help staff to follow a program ?

PUNISHMENT

This is a very difficult and complex issue - it could be a day's training on it's own. In society at large it is generally recognised that certain behaviours, especially those that harm others, should be punished. Our laws are built around this principle. As children we are taught this from a very early age. Punishment is thought to stop people behaving in an anti-social way and makes us feel that justice has been done.

This can cause problems when working with challenging clients - both ethical and practical. Much challenging behaviour is very anti-social in nature, involving aggression and harm. It is quite natural, therefore, for staff to think of punishment as a response to this behaviour. Bearing in mind that punishment involves doing something to the client that they will find unpleasant and upsetting we need to consider:

1. To do something upsetting to anyone is a major step to take involving moral and ethical questions. That is why in society as a whole we have laws, courts and methods of appeal. For us as staff to punish someone in our care effectively over-rides all these things. Our clients are highly vulnerable and have no means of appeal or protection in these circumstances. Yet they are adults whose rights should be respected. In punishing a client we are effectively acting as judge and jury with no right of appeal.

2. Punishment is often associated with anger. An angry parent punishes a child, for example. The punishment often happens as a result of this anger and makes the 'punisher' feel better and that 'justice has been done'. The 'punisher' may well regret their actions once this anger has calmed down. We need to be aware that it can be this anger that is our main motivation in seeking to punish clients rather than teaching the client not to behave in that way in the future.

3. Challenging behaviour does not happen for 'no reason at all'. It generally indicates that there is a problem of some sort. Punishment is a poor strategy in response to it. All the client may learn is that staff are powerful. No constructive skills are learned. Punishment is very much about blame. It can be a convenient way of blaming the client for the situation and not looking at what other factors may be involved - are we as staff giving the client enough attention, for example? Does the client actually like where they are living? Do they feel unwell? Punishment closes down our thinking? A much more productive strategy is to try and think about what led to the behaviour. Remember, that the client has a learning disability and their experience of the world may be very different from yours.

4. Punishment may make matters worse. Try to think back to your own experiences of being punished. Punishment leads to feelings of upset and resentment. It may seriously damage your relationship with the client and your ability to help them in the future.

In exceptional circumstances a program may be written that does involve consequences which the client is likely to find unpleasant (eg. restraint). These are only written after much consultation and discussion. They have to be presented to a

good practice committee before being implemented. These programs are carefully monitored. These are the only circumstances in which strategies involving things the client may dislike may be used.

In your group, please discuss these points.

SHOULD YOU BE ABLE TO COPE WITH ANYTHING ?

Staff working with challenging clients are often under a great deal of pressure, coping with difficult behaviour as well as other day to day tasks. You may feel as an individual that there is a strong pressure for you to cope with whatever happens, regardless of your own well-being. You may be worried that you will be criticised if you ask for help or admit that you are frightened or upset by an incident. You may be afraid to talk about your feelings in general. This can be very dangerous:

1. It may lead you to try and deal with situations where you have had no appropriate training. This may lead to injuries to yourself or the client.
2. It may greatly increase your levels of stress and lead to ill health.

It is completely normal to feel upset, stressed and anxious about challenging behaviours. Talking to others about these feelings, especially when being debriefed after an incident, can help. Ignoring your own feelings is likely to seriously damage your ability to work effectively.

Nobody can be expected to 'cope with anything'. Indeed, to try and do so can only lead to harm. A vitally important point here is being aware of your own limitations and acting professionally by not seeking to go beyond these. Obviously, training is a key issue here. Training should enhance your skills and capabilities, thereby enabling you to manage more demanding situations.

The feeling that you must 'cope with anything' and not ask for help or support is dangerous for all involved. As mentioned earlier, challenging behaviour requires a team approach where skills and experience are pooled.

Please discuss these points in your group.

DO YOUR OWN VIEWS AND FEELINGS MATTER AT WORK ?

This leads on from the last discussion. Many differing opinions will have been voiced today and on many issues there are no clear cut answers. Your views as an individual and as a member of a staff team do matter:

1. You spend a great deal of time with particular clients. You will have vital information on their day to day behaviour which may not be immediately obvious to an outside person observing what is going on.
2. You will have detailed knowledge of how your unit works and how easy or difficult it will be to adopt particular strategies.
3. As a keyworker you may have an important role to play in advocating for a client.
4. Your own training and experience is important.

Please discuss these points in your group.

COPING WITH STRESS
A DAY WORKSHOP FOR STAFF WORKING WITH
CHALLENGING CLIENTS

Neil Bathurst, Trainee Clinical Psychologist

September 1996

ABOUT THE WORKSHOP

Today's workshop has 3 main aims:

1. To give you some information on stress and how it may affect you at work.
2. To look at ways in which stress can be reduced.
3. To draw up a stress management plan for where you work.

The day is designed to be informal, relaxed and hopefully stress free ! We will take regular breaks and be finished by 4.30 pm.

The day will concentrate very much upon your own experiences at work. Whatever is said in the workshop will be treated in the strictest of confidence. Nobody is under any pressure to talk in the group but obviously I hope that you will feel comfortable in contributing your own views and experiences.

As you will be aware, this training also forms part of my research project. In 2 weeks time you will receive by post 2 questionnaires. It would be very helpful if you could fill these in and return them in the envelopes provided. Your replies will be treated in the strictest of confidence and will be seen only by myself. The code number on the top of the questionnaires is for my use only. Your cooperation is very much appreciated and I hope that the final report will prove interesting for all involved.

The plan for today is:

10.00 am: Introductions, Group Rules.

10.15 am: How stress affects us all - Exercise 1 & group discussion.

10.45 am: What is stress ? What are the signs ? What are the risks ?

11.15 am: BREAK

11.35 am: Why can working with challenging clients be stressful ? Group discussion.

12.00 pm: Who's responsibility is it to tackle stress ?

12.30 pm; LUNCH

1.30 pm: What can we do about stress ? Countdown, Relaxation, Talking to Others, Debriefing.

2.20 pm: BREAK

3.00 pm: Stress management where you work. Discussion.

4.15 pm: Final discussion.

STRESS - DISCUSSION ONE

This exercise is designed to help you focus on how stress can affect us all and how it has affected you personally.

First, I would like you to think of an occasion where you felt stressed **away from work**. Please choose something that you would feel OK about talking about - it could be a time that you were stuck in a traffic jam or had to queue for a long time.

Write a brief description of the circumstances on your first bit of paper.

Now think about how you felt physically - what were the sensations in your body ? Write these down on the second bit of paper.

What were your thoughts as you became stressed ? What was going through your mind ? Write these down on the third piece of paper.

Did you experience any emotions in the situation ? Write these down.

Write down what you did in the situation - eg. in the traffic jam did you sound your horn ? Did you do anything which you feel was a result of stress ? Write this down on the last bit of paper.

SOME SIGNS OF STRESS

Stress is a very individual experience. Just to illustrate this some of the possible symptoms are listed below. Hopefully nobody gets all of these at the same time !

Tension headaches, migraines, feeling tense, fatigue, pounding heart, aching muscles, pains, grinding your teeth, tapping your foot, feeling nervous, finger-drumming, high

blood pressure, constipation, rashes, indigestion, repeated infections, weight change, waking up unusually early in the morning, being unusually accident prone, increased alcohol consumption and increased smoking.....

Feeling anxious, frustration, mood swings, bad temper, irritability, feeling that no one cares, depression, nightmares, worrying, feeling discouraged, unable to enjoy things that you would normally enjoy, episodes of crying.....

Apathy, loss of motivation, cynicism, feeling as if you have to prove yourself, feeling that you have lost direction, doubting yourself, feeling that life has lost it's meaning.....

Forgetfulness, dulled senses, poor concentration, feeling confused, feeling that your thoughts are racing and that you cannot focus upon them, boredom, feeling negative about yourself, poor work quality.....

Feeling isolated, being unusually intolerant/judgemental, loneliness, lashing out at others, avoiding contact with others, not seeing your friends, resentment, distrust.....

This may seem a very alarming list. All of us experience some of these things quite naturally without being severely stressed. However, if you do experience some of these symptoms over a period of time then it may well be that stress is an issue for you.

THE DANGERS OF STRESS

Stress can be a very positive thing in our lives. It keeps us alert and ready to respond. Some degree of stress and challenge in life is important and healthy for both physical and mental well-being. However, when demands become too much for us and become uncomfortable, danger signs begin to emerge. We all react to stress in different ways but common signs of stress becoming a problem are:

Physical: Headaches, stomach upsets, skin complaints, allergies, problems sleeping, problems with breathing eg. asthma. In addition, prolonged chronic stress can make you more vulnerable to cardio-vascular disease and ulcers.

Psychological: In relation to work: dreading coming into work, feeling anxious and panicky about work, feeling resentful about work, becoming isolated from friends and work colleagues. In more general terms you may become vulnerable to depression (low mood, sleeping problems, poor appetite, feeling guilty & worthless) and anxiety (feeling 'wound up', tense & unable to relax). You may lose interest in sex. Things that would normally not worry you become major worries - things get out of proportion.

Behaviour: The behaviour of those experiencing chronic stress often changes. They may cease seeing friends and become isolated, their alcohol intake may increase, they may smoke more and/or take more drugs (prescribed & non-prescribed) and either

overeat or undereat. The person may become aggressive and over-react to small events. Their work may deteriorate as a result. Their relationships may suffer.

The end result of this process may be **BURNOUT**. Burnout has 3 main parts:

1. Physical exhaustion: the body's physical reserves get used up and the person feels tired and lacking in energy. Lack of sleep makes this worse.
2. Emotional exhaustion: the person feels helpless, depressed & hopeless. They may lose any motivation to do a good job. They may feel angry and cynical about their job
3. Thoughts: very negative attitudes to work may develop. Both clients and other staff may be seen in very negative terms. Clients may be dehumanised and not seen as people.

Inevitably relationships suffer the process becomes a vicious circle. Job performance gets worse and the person may then go off sick or leave altogether. As this process happens there are increased risks to the individual and those around them.

THE RISKS OF STRESS

When you are experiencing uncomfortable levels of stress risks to yourself and others increase. Some examples of these risks are set out below:

For **yourself** you are at greater risk of physical & mental ill health. This may range from minor short-lived problems to serious long term illnesses. Your enjoyment of life is likely to be reduced and your relationships may suffer.

You will also be less responsive to your clients and this may both make challenging behaviour more likely and increase your vulnerability to it. You may find it difficult to motivate yourself to carry out programs written for clients. This may bring you into conflict with managers and may again lead to increased levels of challenging behaviours. You may also find that you make more mistakes with paperwork and administration. You may forget to write things up, forget to record when a client has had their medication etc. Again, this may have serious consequences.

For **clients** there are serious risks. Highly stressed staff may be unable to provide a therapeutic service. As a result challenging behaviours may increase leading to clients or others being injured.

Many clients find it difficult to communicate and build relationships. Where staff are irritable and impatient due to stress the client may find this even more difficult. A relationship between a staff member and a client that has taken months to establish may be seriously damaged if the staff member is stressed and can no longer respond effectively. Where staff are stressed clients are at much greater risk of verbal or even physical aggression. Where staff are not working effectively due to stress safety precautions may not be fully followed and clients may be endangered as a result.

For **other staff** working with someone who is highly stressed can be difficult. Conflicts may arise and small issues may become major sources of disagreement. It may be difficult for others staff to cope in a situation where one member of staff is not performing well due to stress. If the person becomes isolated this is likely to make the problem worse.

For the **service** stress means a poorer service, greater risks to both staff and clients, more sick leave, dissatisfied staff, greater costs and low morale.

WHY IS WORKING WITH CHALLENGING CLIENTS STRESSFUL ?

Below is a list of factors that might make working with challenging clients stressful. Stress is a very individual thing and what one person finds stressful another may not. However, these are things that most people would find demanding:

1. **Aggressive behaviour** - experiencing or witnessing aggression is likely to heighten your feelings of stress. It is quite normal to feel tearful, sad, hurt or resentful afterwards. This is why 'debrief' is so important.
2. **Self-Injury** - when a client has deliberately injured themselves this can have a significant impact upon those around that person. You may feel upset, sad, tearful, helpless and vulnerable after witnessing this sort of behaviour.
3. **Unpredictability** - challenging behaviours often occur quite suddenly, This can make it difficult for staff to feel totally relaxed and secure at work.
4. **paperwork** - challenging behaviours/incidents have to be recorded, assessment charts filled out, reports written, meetings attended etc. This is often time consuming and carried out in the immediate aftermath of an incident can significantly add to the stress involved.
5. **Day to day needs** - working with people who have a high level of need can in itself be stressful. Physical needs such as bathing and personal care may be physically tiring. day to day tasks such as washing clothes may be both tiring and unstimulating. Emotional demands made upon staff may be great - comforting distressed clients, being involved in restraints etc. The work may also be mentally tiring - communicating with clients who have limited communication abilities will take time, skill and effort.
6. **The demands of others** - residential homes which cater for those with challenging needs usually have contact with outside professionals. Nurses, psychologists, psychiatrists, OT's and social workers may all ask staff to carry out additional tasks, ask for written reports or question staff about particular issues.
7. **The rest of your life !** - just like anybody else staff working with challenging clients may be experiencing stress in other aspects of their lives - financial, relationships etc. It

can be extremely difficult for a member of staff who has just been involved in a restraint to come home to 'normal family life'.

COPING WITH STRESS

The most immediate problem is what to do when you are involved in a difficult situation eg. dealing with a difficult behaviour which is making you feel very stressed. **This is a danger time.** It is a time when you might over-react or react without thinking. In this situation it is likely that your heart rate will be raised, adrenalin will be pumping into your system and your body will be geared for action. The first step here is **awareness.** Be aware of your stress in order that you can combat it. Two simple techniques may help here - **countdown and controlling your breathing.**

In many situations you will be assessing a situation and deciding upon what action to take. Immediate action may not be needed. Here you can take a few seconds to calm yourself. Where you feel yourself about to act without thought say to yourself '**stop!**'. If possible try and remove yourself from the immediate situation for a few seconds (if this is not possible the following can be done where you are). Try and slow your breathing into a steady rhythm. Breathe in slowly through your nose and as you exhale through your mouth mentally say to yourself 'ten'. Repeat this, each time counting down by one. Continue until you reach one. Alternatively, instead of counting down numbers you could mentally say to yourself 'calm' when you breathe out.

This technique can help in that it will steady your breathing, clear your mind and prevent immediate unconsidered action. It is very important to be aware of your breathing when you are feeling highly stressed. When we are stressed we tend to breathe much faster and this can produce unpleasant feelings - dizziness, panic, nausea. If you feel like this then controlling your breathing may help.

You could also try the following procedure:

1. Try and remove yourself to a quieter area.
2. Slowly breathe in for a count of 6 (or whatever feels comfortable).
3. As you breathe out say to yourself, '**calm**'. Think about being calm and in control. Where your muscles are tense try and relax them.
4. Repeat this until you feel calmer.

Any form of relaxation is a skill. You will need to try this for yourself on a number of occasions until it feels comfortable.

An important element in coping with stress is **how you look after yourself.** If you are 'run down' or tired you will be more vulnerable to stress. Areas to think about would be:

1. Do you eat at least 1 good hot meal a day ?
2. Do you leave yourself enough time to sleep properly ? Most people need about 8 hours a night on a pretty regular basis (for some people this is more and some less).
3. If you are upset do you talk to somebody ? 'Bottling things up' can make you feel lonely and resentful. It may make stress worse.
4. Do you take regular exercise ? Taking exercise can help reduce stress and if it involves a sport, for example, can increase your social life.
5. Is your social life OK ? Do you have interests away from work ? Do you have something to look forward to during the week ?
6. Are you smoking or drinking more than usual ? Caffeine, contained in coffee, can also be a problem. If you are drinking a lot of strong coffee during the day this may increase your stress - it may make you feel anxious, increase your heart rate and lead to disturbed sleep.
7. Do you find yourself 'rushing about' a lot during the day ? Is there any way of slowing this down ?
8. Do you get time to yourself during the day ? Is there time to relax, listen to music, watch TV etc ?

All of the above points are worth thinking about. talking to someone else about your worries and concerns can be very helpful and many people who work with challenging clients say that one of the things that helps them cope is being able to talk to others about their experiences. Usually this involves other staff. It can be informal, over a cup of tea, or be more organised like a staff support group. There are also others outside of where you work who can be contacted - the Exeter Trust has a list of approved counsellors who can be contacted in confidence.

Does your partner/family understand that your job can be stressful ? If you have just been involved in an incident it can be very hard to come home as if nothing has happened. If you are feeling stressed and upset tell your family how you feel - their support may be important in helping you cope with the stress of your job.

Putting on a 'brave face' or 'laughing it off' may in fact be the worst possible response to stress and actually make things worse

perhaps the most important form of talking about your feelings in relation to challenging behaviour is **debriefing**. If you have been involved in a challenging incident this will have some emotional impact upon you. You may feel:

Shaky, nervous, tearful, angry, resentful, afraid.....

For a time after the incident it will be difficult for you to function normally in your job. If you are not given support after an incident you may be left feeling stressed &

vulnerable. After an incident it is helpful if you are debriefed as soon as possible. This means talking to someone about what has happened and how you feel about it.

Nobody should leave their shift without receiving some support if they have been involved in an incident. Often the person who debriefs you will be your team leader or other qualified staff. The emphasis should be on how you are and how you feel.

Debriefing may be a very important way of helping you cope with challenging behaviour.

TIME MANAGEMENT

Some pressures are unavoidable. Incidents of challenging behaviours can occur at any time and can cause great stress. However, stress can also arise because we organise our time in a stressful way. Often, routines are followed just because 'it's always been done that way' without anyone really looking at how much stress this causes. Both in your personal and work lives there may be many things you do and routines that you follow that could be organised in such a way as to reduce stress.

For example, a not very important task is always done by a member of staff at 8.30 am in the morning. The task has always been done at this time. The task stresses the member of staff because it is boring and is done just when there are lots of other things to be done as well. All the clients have, for example, to be ready for 9.00 am to go to their day services. The rush of getting everything done leaves the staff member stressed for the rest of the morning. In fact the task could be done at anytime during the morning. Stress could be reduced just by doing the task at 10.00am when the unit is quiet.

A lot of stress may be removed where you work by looking at the tasks you have to do and the routines you follow. What things have to be done at certain times ? What other things could be done at different times ? Are things in a rut ? Do the same staff always do the boring or difficult jobs ? Are staff kept informed about changes in normal routine ? Is communication good ?

In your own personal life do you put yourself under unnecessary pressure ? Could you change your routines so that your life out of work is less stressful ?

SUMMARY

1. Working with challenging clients can be stressful.
2. This stress can damage your health and make it difficult for you to do your job.
3. This stress can be dangerous for you, your clients and those you work with.

4. We all have a responsibility to try and reduce our stress.
5. The first step is to be aware of your stress. Be aware of how you normally react to stress. What are the danger signs for you ?
6. If you are involved in an incident try countdown and breathing to reduce the immediate stress.
7. Debriefing is very important after an incident and should happen before you go home.
8. Talk to others if you feel stressed. Make sure that your family and friends know about your stress.
9. Look after yourself. Eat well. get enough sleep.
10. Time management. Can you make your day less stressful ?
11. Where stress is becoming a major problem ask to see an approved counsellor. **This will be in strict confidence.**

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