

**The experiences of female care staff supporting men with intellectual disabilities
with sexualised challenging behaviour: An Interpretative Phenomenological Analysis**

Thesis submitted in part fulfilment of the degree of

Doctorate in Clinical Psychology

(DClinPsy)

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By

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Declaration

I confirm that this thesis, comprising of literature review, research report, and critical appraisal, is an original piece of work. It was written and submitted in part-fulfilment of the degree of Doctorate in Clinical Psychology. It has not been submitted for any other academic award, and was checked prior to submission.

Kerry Jayne Cope

The experiences of female care staff supporting men with intellectual disabilities with sexualised challenging behaviour: An Interpretative Phenomenological Analysis

Kerry Jayne Cope

Thesis Abstract

Literature Review

A systematic review of the existing literature was conducted. Fifteen studies met the inclusion criteria of factors influencing attributions and emotional responses of care staff towards adults with intellectual disabilities who display challenging behaviours. Narrative synthesis identified many factors relating to the individual with challenging behaviour have an impact on the attributional style and emotional response of staff. Attributional theory may have limited utility in making sense of staff reactions to challenging behaviour due to the complexity and quality of staff-service user relationships. As such, further research is called for to explore the role of relationships in the understanding of behaviour.

Research Report

Interpretative Phenomenological Analysis (IPA) was utilised to explore female care staff experiences of supporting men with intellectual disabilities with sexualised challenging behaviour. Three superordinate themes were generated: *'you wonder if you're doing the right thing'*, concerned with the tension the women felt between a desire to provide support whilst simultaneously grappling with an uncertainty as to whether the men deserved care; *'always looking for danger'*, concerned with an enduring sense of danger felt in working with patients with sexualised challenging behaviour; and *'no one really cares about the staff'*, concerned with how the women felt devalued at work, where emotional reactions were disregarded or disallowed. Findings highlighted the importance of services acknowledging staff emotions, and allowing safe spaces for the discussion of this. Further qualitative research is called for exploring services factors which allow or inhibit staff emotional expression.

Critical Appraisal

The critical appraisal offers the researchers personal and professional reflections on the research process.

Acknowledgements

Firstly, I would like to thank the four women who agreed to take part in this study, without whom this research would not be possible. I greatly appreciated your candour in sharing your experiences with me. I hope that those who read this thesis are now able to have a greater appreciation of the resilience of individuals such as yourselves in supporting people whose behaviour is deemed to be challenging.

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¹ Names have been omitted to protect the anonymity of the services involved

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Table of Contents

| | |
|------------------------------------------------|-----------|
| Declaration | i |
| Thesis Abstract | ii |
| Acknowledgements | iii |
| Word Count | iv |
| Table of Contents | v |
| Addenda | vii |
| List of Tables | viii |
| List of Figures | ix |
| Part One: Literature Review | 1 |
| Abstract | 2 |
| 1. Introduction | 3 |
| 2. Method | 6 |
| 3. Results | 7 |
| 4. Discussion | 19 |
| 5. References | 26 |
| Part Two: Research Report | 32 |
| Abstract | 33 |
| 1. Introduction | 34 |
| 2. Method | 37 |
| 3. Results | 42 |
| 4. Discussion | 60 |
| 5. References | 71 |
| Part Three: Critical Appraisal | 77 |
| 1. Introduction | 78 |
| 2. Choosing a Research Topic | 78 |
| 3. Choosing a Methodology | 79 |
| 4. Research Ethics | 79 |
| 5. Recruitment and Data Collection | 80 |
| 6. Data Analysis | 83 |
| 7. Dissemination | 85 |
| 8. Personal and Professional Development | 85 |
| 9. References | 87 |

| | |
|---------------------------------------------------------------------|-----------|
| Appendices | 88 |
| Appendix A: Guidelines for Authors..... | 88 |
| Appendix B: Search Strategy | 98 |
| Appendix C: Data Extraction Form | 99 |
| Appendix D: Quality Appraisal | 100 |
| Appendix E: Characteristics of Publications..... | 101 |
| Appendix F: Statement of Epistemological Position | 107 |
| Appendix G: Correspondence from the Research Ethics Committee | 109 |
| Appendix H: Correspondence from the Local Research Committee | 109 |
| Appendix I: Informed Consent Form..... | 113 |
| Appendix J: Participant Information Sheet | 114 |
| Appendix K: Invitation Letters to Hospitals..... | 118 |
| Appendix L: Advertisement Poster | 119 |
| Appendix M: Interview Schedule | 120 |
| Appendix N: Coded transcript: Anna and Callie..... | 121 |
| Appendix O: Emerging Theme Development: Becca and Danielle | 123 |
| Appendix P: Superordinate Theme Development | 125 |
| Appendix Q: Contributions to Themes..... | 126 |
| Appendix R: Chronology of Research Process..... | 127 |

Addenda

Transcripts² have been submitted separately as an Addendum

Transcript 1: 'Anna'

Transcript 2: 'Becca'

Transcript 3: 'Callie'

Transcript 4: 'Danielle'

² To preserve confidentiality, pseudonyms have been assigned and these are used throughout the thesis, including the submitted transcripts

List of Tables

Part 1: Literature Review

Table 1: Description of Attitudes 4

Table 2: Study Characteristics 8

Part 2: Research Report

Table 3. Participant Characteristics 40

List of Figures

Part 1: Literature Review

| | |
|-------------------------------------------|---|
| Figure 1: Systematic Search Strategy..... | 6 |
|-------------------------------------------|---|

Part 2: Research Report

| | |
|----------------------------------------------|----|
| Figure 2: Superordinate and sub-themes | 43 |
| Figure 3: Triangle of Reality | 62 |
| Figure 4: Triangle of Communication | 64 |

Part One: Literature Review

Factors influencing attributions and emotional responses of care staff towards adults with intellectual disabilities who display challenging behaviours: A systematic review

**(Guidelines to authors for the target journal for the literature review can be found in
Appendix A)**

Factors influencing attributions and emotional responses of care staff towards adults with intellectual disabilities who display challenging behaviours: A systematic review

By Kerry Jayne Cope

Abstract

Aim: This paper reviewed literature regarding factors influencing the attributions and responses of care staff towards people with intellectual disabilities (ID) who engage in challenging behaviour (CB).

Background: Large volumes of research relating to ID and CB has focussed on the role of attitudes and understanding of CB, typically framed by attribution theory. This theorises attributions regarding causes of behaviour influences emotional response and behaviour. Literature indicates that there is inconsistent support for the theory in the field of ID, suggesting other variables likely moderate the relationships between attributions and responses.

Method: A systematic literature search of four electronic databases (CINAHL Plus, PsycINFO, Scopus, and Web of Science) was conducted. A search strategy was developed and eligibility criteria were applied. A total of 15 papers were included.

Results: Findings were subjected to a narrative synthesis. Though findings were not consistent, they suggested variables relating to the individual with ID such as diagnosis, ability and type of behaviour impacted upon attributions and emotions. Limited evidence was found for the role of variables relating to staff and organisations. Additional interactions between attributions and emotional responses not accounted for by attribution theory were evidenced.

Conclusions: Findings suggest many factors relating to the individual with CB have an impact on the attributional style and emotional response of staff. Attributional theory may have limited utility in making sense of staff reactions to challenging behaviour due to the complexity and quality of staff-service user relationships. Further research is warranted to explore the role of relationships in the understanding of CB.

1. Introduction

Challenging behaviour (CB), within the intellectual disabilities (ID) field, has been defined as behaviour which *'is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion'* (Royal College of Psychiatrists *et al.*, 2007). Although CB is sometimes referred to as a diagnosis, it should not be seen as so. It is a behaviour that serves a purpose, resulting from interactions between the person and their environment. The term 'challenging behaviour' is a socially constructed phenomenon, and has been seen as contentious because the term is often written about in ways that suggest individuals 'have' or 'display' CB, masking the importance of context and relationships. The term is also often used in ways that neglect that it is staff teams and services that often deem behaviour as 'challenging' (*ibid.*).

Hutchinson *et al.* (2014) proposed a number of factors they believed influenced how staff respond to individuals with ID who challenge, including: The culture of the working environment; emotional responses to CB; and knowledge, beliefs and attitudes to CB. The relevance of attachment theory has also received recent attention (BPS, 2017), including consideration of how the attachment styles and experiences of staff members are likely to influence their responses to CB (e.g. Schuengel *et al.*, 2010). However, a large volume of research in this area has focussed on the role of attitudes and understanding of CB, typically being framed by attribution theory.

Attribution theory (Weiner, 1986)

Weiner's attribution theory posits that attributions regarding causes of behaviour will influence individual's emotional response to that behaviour, in turn influencing behavioural response. Different dimensions of attributions have been proposed: controllable-uncontrollable; global-specific; internal-external; and stable-unstable (See Table 1). The model proposes three pathways which were thought to lead to increased helping behaviour: Pathway 1 – Low attributions of stability, leading to high levels of optimism; Pathway 2 – Low attributions of control leading to high levels of sympathy;

Pathway 3 – Low attributions of control leading to low levels of anger (Weiner, 1986). Support for the three pathways has been found in the general population in non-clinical settings (Weiner 1985, Schmidt & Weiner, 1988).

TABLE 1 - DESCRIPTION OF ATTRIBUTIONS

| Attributional dimension | Description |
|--------------------------------|----------------------------------------------------------------------------------------------------------------------|
| Controllable-uncontrollable | Individual deemed to have control over the behaviour vs behaviour due to factors outside of the individual's control |
| Global-specific | Behaviour leads to many vs few potential different outcomes |
| Internal-external | Behaviour originates from the individual vs triggered by the environment |
| Stable-unstable | Behaviour is seen to be permanent vs temporary |

Previous reviews

Willner and Smith (2008) completed a systematic review to explore the extent to which literature supported attribution theory in relation to care staff working with people with ID who challenge. They concluded the literature was largely inconsistent, and only partial support for the theory was evidenced. Pathway 1 was supported by findings from Sharrock *et al.* (1990), but no role for affect (Hill & Dagnan, 2002; Stanley & Standen, 2000), or stability (Dagnan *et al.*, 1998) was evidenced. The effect of stability was also found to be in the wrong direction (Dagnan & Cairns, 2005; Stanley & Standen 2000). For Pathway 2, support for low control, positive affect and helping was found (Dagnan *et al.*, 1998; Stanley & Standen, 2000; McGuiness & Dagnan, 2011), though the relationship was found to be in the wrong direction by Wanless and Jahoda (2002). For Pathway 3, low control was related to high negative affect, and the relationship with helping was not reported (Bailey *et al.*, 2006), and negative affect was not found to be related to helping (McGuiness & Dagnan, 2001; Stanley & Standen 2000). They proposed that as Weiner's (1986) model of attribution theory and helping behaviour was intended to apply to behaviours of low frequencies, it may not be as applicable to habitual behaviours like CB.

Wishart *et al.* (2013) argued that other variables are likely to moderate the relationships between attributions and responses to CB. They found that knowledge, and attributions of low stability and controllability were significantly correlated with helping behaviour. However, a regression analysis found that only knowledge was a significant predictor for helping behaviour, concluding that increasing staff knowledge through training may influence staff practice to some extent, but trying to change staff attributions via training may be less successful. However, this interpretation is in conflict with the finding that training resulted in changes in staff attributions in eight of 11 reviewed papers by Williams *et al.* (2012). They found that immediate changes to attributions occurred when training explored 'causes' of CB, and suggested that further impact may be brought about by training that requires staff to think about how their thoughts may impact upon emotions and behaviours in response to CB. It is important to note that although there are different ways of formulating CB, it remains unclear as to which approach may be more therapeutic for the individuals being supported, as well as the staff for whom the behaviour presents a challenge.

Aims & Rationale

Although attribution theory posits pathways to account for some of the differential responses to CB, the literature summarised above indicates that there has been inconsistent support for the theory in the field of ID. As has previously been argued (e.g. Wishart *et al.*, 2013), inconsistencies in the extant literature relating to responses to CB, could be explained in terms of other variables moderating attributional and emotional responses to CB.

The aim of the current review was to gain an understanding of factors influencing the attributions and responses care staff within the UK have towards people with ID who challenge. Consideration of such variables may result in a more refined understanding of sense-making and responses to CB, which in turn would have clinical utility for guiding interventions to support staff teams, and to further enable provision of quality care. In order to achieve this aim, a systematic review of the published literature was undertaken.

2. Method

2.1. Search Strategy

Searches were performed in September 2017 on four electronic databases (CINAHL Plus; PsycINFO; Scopus; Web of Science). Search strings were developed in relation to the terms '*intellectual disability*', '*challenging behaviour*' and '*attributions and responses*' (see Appendix B). As attitudes tend to be influenced by culture and time, studies were limited to those conducted in the UK, published within the past 15 years.

A title and abstract screen was undertaken to extract papers of potential relevance to the review. After duplicates had been removed 50 abstracts were screened against further inclusion criteria (see 2.2). Full-text versions of 17 papers were retrieved and rescreened against eligibility criteria, resulting in two articles being excluded. A further eleven papers of potential relevance were identified through checking the reference lists of returned papers, however none of these studies met inclusion criteria.

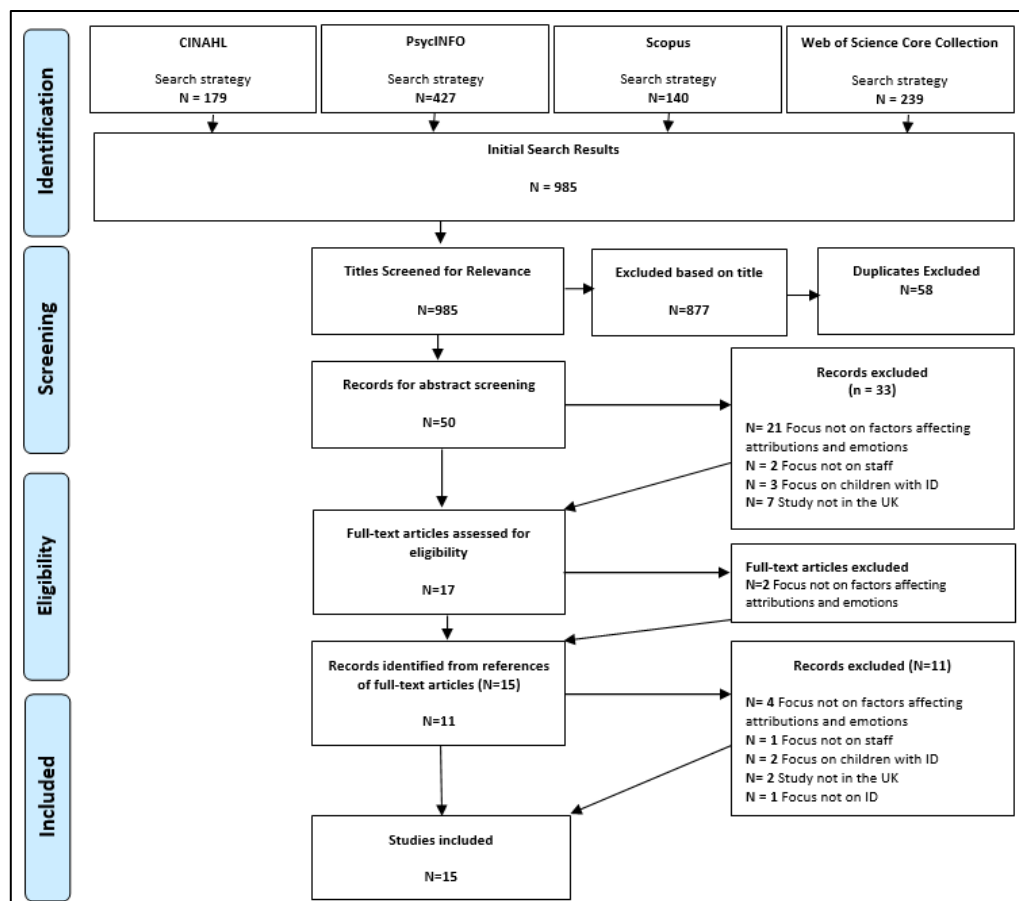


FIGURE 1 - SYSTEMATIC SEARCH STRATEGY

2.2. Eligibility

Studies were included in the review if their main focus was on factors influencing staff attributions and emotional responses to adults with ID who engaged in CB. Studies exploring the impact of training on attributions or emotional reactions were excluded due to these factors having been explored in a previous review (Williams *et al.*, 2012). A total of 15 studies were identified for review.

2.3. Data Extraction and Quality Appraisal

A data extraction form (Appendix C) was used to summarise the main findings of each study and to aid with quality appraisal, for which the QualSyst (Kmet, Lee & Cook, 2004) was used. This checklist was selected due to it being designed to appraise diverse study designs. The scores on the QualSyst varied from .60 to .96, with scores closer to 1.0 indicating higher quality. The majority of the studies (n=13) were deemed to be of a high quality, obtaining scores above .70 (see Appendix D for further details). A narrative synthesis was selected over a meta-analysis due to there being few studies examining the effects of different variables, and there being significant heterogeneity between papers with regards constructs and measures.

3. Results

3.1. Characteristics of Publications

Study characteristics will be summarised before presentation of the synthesis. Summary information regarding vignettes and topography of CB is presented in Table 2 (see Appendix E).

Setting and Participants

Studies recruited from a mix of residential care homes, supported living accommodation, day services, and short break facilities. Sample sizes ranged from 15

to 160. The experience staff members had of working with people with ID who engaged in CB was inconsistently reported.

Vignettes

Nine studies explored attributions and responses via the means of a fictional vignette presented to the staff, whilst four examined attributions and responses towards the individuals the staff supported on a daily basis. One study used both vignettes and a known individual, and one study did not report on this. It is noted that studies utilising vignettes may be regarded as having less ecological validity than studies exploring known individuals.

Topography

Topography of behaviour included aggression (n=10), self-injurious behaviour (n=5), and stereotypy (n=2). Two studies did not disclose topography.

Table 2 - Study Characteristics

| Author | Vignettes | Topography |
|-------------------------------|-------------------------------|-----------------------------------------|
| Bailey <i>et al.</i> (2006) | Known individual | Self-injurious behaviour "other" CB |
| Dagnan & Cairns (2005) | Vignettes | Aggression |
| Dagnan <i>et al.</i> (2015) | Vignettes | Aggression Self-injury Stereotypy |
| Dilworth <i>et al.</i> (2011) | Known individual | Aggression Self-injury |
| Gifford & Knott (2016) | Vignettes | Aggression Stereotypy |
| Hill & Dagnan (2002) | Vignettes Known individual | Aggression |
| Jones & Hastings (2003) | Vignettes | Self-injury |
| Kleinberg & Scior (2014) | Vignettes | Aggression |
| Noone <i>et al.</i> (2006) | Known individual | Aggression |
| Rose & Rose (2005) | Undisclosed | Undisclosed |

| | | |
|-------------------------------|------------------|--------------------------|
| Snow <i>et al.</i> (2007) | Vignettes | Self-injury |
| Tynan & Allen (2002) | Vignettes | Aggression |
| Weigel <i>et al.</i> (2006) | Known individual | Aggression Stereotypy |
| Williams <i>et al.</i> (2015) | Vignettes | Aggression |
| Wishart <i>et al.</i> (2013) | Undisclosed | Undisclosed |

Findings from the studies were subjected to a narrative synthesis and are grouped relating to: variables impacting on attributions; variables impacting on emotional responses; and interaction between attributions and emotional responses.

3.2. Synthesis

3.2.1. Variables impacting on attributions

The Attributional Style Questionnaire (ASQ; Peterson *et al.*, 1982) and Challenging Behaviour Attributions Scale (CHABA; Hastings, 1997) were used in six and four studies respectively (See Appendix E). The ASQ was initially developed to measure attributions people experiencing 'depression' made about good and bad events in their lives. A preliminary version of the scale was piloted with 145 psychology graduates, and after revisions, was completed by another 130 graduates. The ASQ codes attributions on a binary scale along four dimensions: Controllable-uncontrollable; global-specific; internal-external; and stable-unstable. The ASQ is reported to have good internal consistency (0.72-0.75; Peterson *et al.*, 1982), however no further validity data were reported.

The CHABA was specifically developed to measure attributions of challenging behaviour. Ninety care staff working with people with ID participated in the research to develop the CHABA. The CHABA aims to measure attributions concerning the aetiology of CB along five subscales: biomedical; emotional; learned behaviour; physical environment; and stimulation. Moderate to good internal consistency for the subscales have been reported (0.65-0.87; Hastings, 1997), however no further validity data were reported.

It is noted that the reliability of these scales varies, and some of the subscales for the CHABA (biomedical, learned negative behaviour, stimulation) fall below the recommended 0.7 cut off point for research use. This may lead to inconsistent findings, which needs to be considered when drawing conclusions from results. Despite this, the ASQ and CHABA have been cited in 706 and 43 records, respectively within one electronic database (PsychInfo).

Individual Variables

Nine studies explored variables relating to the person displaying CB (Bailey *et al.*, 2006; Dagnan *et al.* 2015; Dilworth *et al.* 2011; Gifford & Knott, 2016; Jones & Hastings, 2003; Kleinberg & Scior, 2014; Noone *et al.* 2006; Tynan & Allen, 2002; Williams *et al.*, 2005). Variables included gender, ability, diagnosis, and differences in CB.

Kleinberg and Scior (2014) was the only study to explore the impact of gender, reporting that this variable resulted in non-significant differences in staff attributions relating to CB.

Three studies reported on the effect of an individual's abilities on staff attributions. Tynan and Allen (2002) examined the effects of the level of ID on staff attributions of aggressive behaviour. Staff were given identical vignettes, but the individual's ID was described as 'mild' in one and 'severe' in the other. It was found that staff rated the behaviour as significantly more challenging in the 'severe condition' rating this person as having significantly less 'control' over the behaviour than the person in the 'mild condition'. No significant difference in ratings of 'stability' were found. Biomedical causal factors were rated more frequently in the 'severe' ID condition, with no significant differences found for other causal factors. Similarly, Williams *et al.* (2015) employed vignettes to examine the effect of moderating descriptions of a person's communicative abilities on attributions of 'control'. The individual portrayed was deemed to have the same level of 'control', but significantly less responsibility in vignettes where he was portrayed to have communication difficulties. A large effect size was found for this relationship. Both studies imply that

staff experience people with ID as having less responsibility for their behaviour if they are perceived to have more significant impairments. However, Dilworth *et al.* (2011) found there were no significant correlations between attributions of 'control' and overall ability of the individual. Dilworth *et al.* (2011) asked staff to rate attributions in relation to individuals they supported on a daily basis. This may mean that Dilworth *et al.*'s study was of higher ecological validity compared to the studies utilising vignettes. Their method meant that other factors, such as individual relationships, would have confounded exploration of the effect of ability, but evidenced that in real life practice other factors might be more significant in impacting upon staff understandings of CB beyond a person's ability.

Gifford and Knott (2016) was the only study to explore the impact of diagnostic label on attributions. Staff were asked to watch one of three videos of a staff member talking about a fictional individual with CB, differing only in the diagnostic label ascribed (*Autism*; *Down's syndrome*; and *Unspecified ID*). Staff made fewer biomedical attributions (medium effect size) and more learned behaviour attributions (small effect size) in the *Unspecified* condition compared with the *Autism* and *Down's syndrome* conditions. The authors speculated that staff were more likely to favour biomedical attributions for the *Autism* and *Down's syndrome* group due to the supposed organic and genetic nature of the conditions.

Three studies reported on the effect of topography of CB. Dagnan *et al.* (2015) found staff tended to view vignettes of stereotypic CB as more 'internal' than aggression and self-injury, but found no significant differences between 'stable' or 'controllable' attributions, though effect size could not be calculated. Additionally, staff rated self-injury to be most likely caused by emotional factors; aggression by positive reinforcement or the need for stimulation; and stereotypy by emotional causes and negative reinforcement. However no statistical tests were completed for these variables, providing weak support that certain types of causal attribution were more likely than others. The study also used vignettes, reducing ecological validity. In contrast, Bailey *et al.* (2006) compared staff attributions for self-injurious behaviour with other forms of CB, for individuals known to staff. They found staff were

significantly more likely to rate self-injurious behaviour as 'uncontrollable' and 'unstable' compared to other forms of CB, but did not report data in a way that allowed for effect size to be calculated. Dilworth *et al.* (2011) found staff attributed aggressive behaviour as being more 'controllable' than self-injurious behaviour, again suggesting topography affects staff perception of 'control'. Though some contradictions are apparent, the studies above offer some evidence that topography affects staff attributions. Evidence for this appeared stronger in cases where staff gave attributions for individuals known to them, as opposed to vignettes.

Two studies reported upon the impact of the perceived function of behaviour and attributions. Noone *et al.* (2006) found staff made different attributions about the behaviour of two similar individuals known to the staff, who engaged in similar types of CB, but for whom the behaviour had been assessed as serving different functions: escape and avoidance (Individual A) gaining tangible items (Individual B). Staff made more 'personal' and 'controllable' attributions for Individual A, and more 'internal' attributions for Individual B, though it was not possible to calculate effect size. Furthermore, an assumption is made that individuals differed only in regard to the function of behaviour, whereas it is likely that they differed in multiple ways. Jones and Hastings (2003) found that staff who were presented with a vignette depicting 'escape-maintained' behaviour, as opposed to 'attention-maintained', were more likely to report 'controllable' attributions. Both studies suggest staff make different attributions for behaviour, depending upon their perception of the behaviour's function. In these instances, staff appeared to view behaviour as 'controllable' if the behaviour was deemed to be serving a purpose of escape.

The studies offer evidence that staff attributions are affected by a number of variables associated with the individual with ID such as diagnosis, ability and the topography and function of CB. However, it is important to note that case vignettes are presented in an Operant Theory (OT) context. In doing so, there is an underlying assumption that the function of CB is in direct response to environmental factors. In doing so, this ignores the role of relationships and attachment in CB.

Staff Variables

Six studies reported on staff variables impacting upon attributions (Dilworth *et al.*, 2011; Kleinberg & Scior, 2014; Noone *et al.*, 2006; Rose & Rose, 2005; Snow *et al.*, 2007; Wishart *et al.*, 2013). This included gender, experience, age, stress, and emotional regulation style.

Three studies provided results comparing attributions made as a function of staff gender, with all three papers reporting non-significant differences (Dilworth *et al.*, 2011; Kleinberg & Scior, 2014; Noone *et al.*, 2006).

Snow *et al.* (2007) found a moderate significant positive relationship with 'internal' and 'unstable' attributions, and experience of working with self-injurious behaviour. Although they explored age and experience working with people with ID more generally, no significant relationships were found. Noone *et al.* (2006) and Dilworth *et al.* (2011) also found no significant relationships between attributions and age or experience.

Rose and Rose (2005) hypothesised that staff experiencing stress, as measured by the General Health Questionnaire (Goldberg, 1972), would be more likely to make negative and blaming attributions, but did not find any significant relationships between stress and attributions. Finally, Wishart *et al.* (2013) hypothesised that there would be a significant relationship between attributions and staff emotion regulation styles (as measured by the Emotion Regulation Questionnaire (Gross & John, 2003). However, found no significant relationships.

Despite Snow *et al.* (2007) finding evidence that experience of working with self-injurious behaviour had some association with 'internal' and 'unstable' attributions, the above studies offer little evidence that staff individual characteristics affect attributions. However, only limited factors were reviewed, for example there was no consideration of staff's own attachment variables in understanding CB (e.g. Schuengel *et al.*, 2013).

Organisational Variables

Dilworth *et al.* (2011) found that staff ratings of individuals' 'control' over CB were significantly lower if care managers rated positive service indicators to be present, as opposed to absent. Attributions of 'control' were lower if it was indicated by managers that staff displayed positive attitudes towards the individual, the environment was appropriate to meet needs, and if the overall approach to giving care seemed well structured. This suggests positive service indicators are associated with fewer blaming behaviours, and that inadequate environments and approaches to giving care could lead to more attributions of 'control' (Dilworth *et al.*, 2011). However it is possible that staff in services where management were keen to impress researchers might have experienced greater pressure to rate attributions according to social desirability bias.

The studies offer evidence that staff attributions are affected by a number of variables associated with the individual, though little evidence to suggest that staff variables impact upon attributions. The differences found in attributions of behaviour may explain some of the inconsistencies found in Willner and Smith's (2008) review, and may provide further evidence that Weiner's (1986) model of attribution theory and helping behaviour is not as simple as originally proposed for ID, due to the varied nature of CB.

3.2.2. Variables impacting on emotional responses

Emotional responses were commonly measured using the Emotional Response to Challenging Behaviour Scale (ERCB; Mitchell & Hastings, 1998) or Likert scales (Appendix E). The ERCB is reported to have good internal consistency and test-retest reliability (Mitchell & Hastings, 1998). One subscale measures 'depression/anger'; the other 'fear/anxiety', which were derived based on factor analysis. Jones and Hastings (2003) adapted the ERCB to include two further 'positive affect' subscales following factor analysis: 'cheerfulness/excitement' and 'confidence/relaxed', which were rated to have good internal consistency. Rose and Rose (2005) used Likert scales to measure various emotional responses to CB, then completed a factor analysis that

resulted in: 'negative emotion' ('anger', 'disgust', 'fright'); 'empathy' ('sadness', 'sympathy'); and 'positive emotion' ('relaxed', 'happiness').

Individual Variables

Three studies explored variables relating to the person with ID (Dagnan *et al.*, 2015; Gifford & Knott, 2016; Kleinberg & Scior, 2014), including topography, diagnostic label, and gender.

Dagnan *et al.* (2015) found staff reported higher levels of happiness in response to vignettes of physical aggression compared with self-injury and stereotypy; happier in response to stereotypy compared with self-injury; and less frightened of stereotypy than aggression and self-injury. Though effect size could not be calculated, results suggest that staff feel angrier at behaviours directed towards themselves, and more frightened of behaviours likely to cause harm to themselves or individuals in their care. This may be due to staff viewing behaviour as personal if it is directed to themselves. Staff may have felt more frightened of self-injurious behaviours if they felt they were unable to do anything to protect the individual.

Gifford and Knott (2016) explored the impact of diagnostic label on emotional response to CB using the videos previously described. The videos in which the person was described as 'having' *Autism* or *Down's syndrome* resulted in the reporting of more 'positive' emotions and fewer 'negative' emotions than the 'Unspecified ID' condition (small to medium effect sizes). 'Positive emotions' were also reported more in the *Autism* group than the other two conditions. Gifford and Knott (2016) reflected that higher ratings of positive emotions in the *Autism* group may have been a consequence of individuals with autism being more readily represented in media campaigns at the time of the study.

Kleinberg and Scior (2014) looked at the impact of an individual's gender on staff emotional responses to aggression, though no relationship was found. No other studies reported on the impact of the gender of the person with ID.

The above studies offer evidence that topography and diagnosis can impact upon staff emotional reactions to CB. As such, it highlights the importance of staff having an understanding of the potential functions of behaviours, and an understanding of the individual being supported, in order to provide a more holistic view of the individual, and to help staff feel more confident in understanding and managing CB. This is line with findings that attitudinal change and increased knowledge can lead to better outcomes for individuals with CB (e.g. Ager & O'May, 2001; McClean *et al.*, 2005).

Staff Variables

Two studies looked at the impact of staff variables on emotional response (Kleinberg & Scior, 2014; Rose & Rose, 2005). Kleinberg and Scior (2014) found female participants reported significantly higher scores on the 'fear/anxiety' and 'depression/anger' subscales on the ERCB than males (medium effect sizes). They also reported significantly lower scores (medium effect) on the 'confident/relaxed' subscale. Kleinberg and Scior (2014) concluded the relationship between gender and emotional response required further investigation, and put forward an alternative explanation that female staff may be more willing to express negative emotions than men, though this was not evidenced.

Rose and Rose (2005) hypothesised that staff experiencing stress would more likely to experience negative emotions. They found stress, as measured by the GHQ had a moderate positive correlation with 'negative emotion'. However, the GHQ would have been sensitive to sources of stress outside of the workplace, limiting the conclusions which could be drawn into workplace stress and negative emotion. Further, causality cannot be ascertained.

The studies have provided some evidence that staff emotional responses to CB can be affected by the perception they have of the individual presenting with CB. This holds implications for the importance of staff training to enable a holistic view of the individual, to explore possible functions of behaviour, and to allow staff to feel confident in their abilities to understand and manage behaviours effectively. There is

limited evidence to suggest that staff variables impact upon emotional response, though high experiences of stress may be related to higher experience of 'negative emotions'.

3.2.3. Interactions between attributions and emotional response

Seven studies reported on interactions between attributions and emotional response to CB, which were not accounted for by Weiner (1986), (Bailey *et al.*, 2006; Dagnan & Cairns, 2005; Hill & Dagnan, 2002; Jones & Hastings, 2003; Rose & Rose, 2005; Snow *et al.*, 2007; Weigel *et al.*, 2006).

Controllable-uncontrollable.

Weigel *et al.* (2006) found that staff who displayed low expressed emotion (measured by a speech sample, as described by Magana *et al.*, 1986), were more likely to make 'uncontrollable' attributions, whilst those who expressed high expressed emotion (e.g. critical, hostile) were more likely to make 'controllable' attributions. These findings may have some parallels with attribution theory in that Weiner (1986) proposed 'controllable' attributions would lead to feelings of anger.

Stable-unstable

Four studies reported upon interactions between emotions and 'stable' attributions, as not accounted for by Weiner (1986). Bailey *et al.* (2006) reported significant moderate positive associations between scores on the 'depression/anger' subscale of the ERCB and 'stable' attributions. However, in contrast, Rose and Rose (2005) reported a significant weak negative association between scores on 'negative emotions' and 'stable' attributions. Both studies were of a high quality, however Bailey *et al.* explored views in response to a known individual, whereas Rose and Rose (2005) did not specify whether vignettes were used, or the type of CB. As such it is possible the participants in this study were commenting on their views of CB in general, as opposed to basing these on a particular individual or a scenario. Dagnan and Cairns (2005) and Hill and Dagnan (2002) found a significant positive correlation between

ratings of 'sympathy' and stable attributions (small and strong effect sizes respectively).

Snow *et al.* (2007) found a weak significant negative correlation between 'emotional exhaustion' (as measured by the Maslach Burnout Inventory, Maslach & Jackson, 1986) and 'stable' attributions. Rose and Rose (2005) found that although 'emotional exhaustion' had a moderate positive correlation with 'negative emotion', there were no significant relationships between emotional exhaustion and attributional style.

The above studies have provided conflicting evidence for the relationship between emotions and 'stable' attributions, finding associations between this variable and both positive and negative affect.

Internal-external

Weiner's (1986) attributional model does not account for 'internal-external' attributions, though interactions were found with emotional responses for this domain. Bailey *et al.* (2006) reported significant positive associations between the 'depression/anger' subscale of the ERCB and 'internal attributions' (moderate-to-large effect size). However, Jones and Hastings (2003) reported a significant weak relationship in the opposite direction. Differences found may be due to the use of vignettes in Jones and Hastings' (2003) study as opposed to known individuals, where stronger negative affect may be due to other variables.

Both Dagnan and Cairns (2005) and Hill and Dagnan (2002) found significant negative correlations between 'sympathy' and 'internal' attributions (medium and strong effect sizes respectively). Additionally, Rose and Rose (2005) also found a weak significant negative correlation between 'empathy' and internal attributions.

Weigel *et al.* (2006) found that staff who displayed low expressed emotion were more likely to attribute causes for CB as being external to the individual whilst those who expressed high expressed emotion were more likely to attribute behaviour as being internal, however it was not possible to calculate effect size.

Studies reporting on the internal-external attribution appeared consistent in their findings; generally relationships were found with internal attributions and negative affect. However, due to the correlational nature of the studies, causation cannot be implied. It is possible that negative affect in staff teams was pre-existing, due to other factors outside of CB, which may have impacted upon their attributions.

Summary

The studies demonstrated some interaction between emotional response and attributional style, however interactions were not always consistent, and limited results are available for each variable. Furthermore, associations found were often weak, suggesting other factors may influence staff behavioural responses to CB.

4. Discussion

4.1. Summary

A systematic review was undertaken to explore factors affecting staff attributions and emotional responses to CB. Results were subjected to a narrative synthesis and were grouped in relation to variables impacting on attributions; variables impacting on emotional responses; and the interaction between attributions and emotional responses. Results will be summarised, before a broader critique of the reviewed studies and attribution theory is offered. The limitations of the present review will be considered and clinical implications discussed.

There was little evidence to suggest that staff demographical variables impacted upon attributions or emotional response. However, a number of variables associated with the individual with ID such as diagnosis, ability and the topography and function of behaviours were related to attributions and emotions. Specifically attributions of control were more likely for individuals who were deemed to be lower functioning, and aetiology of behaviour was more likely to be attributed to biomedical causes if the individual was seen to have an organic or genetic condition. Research in other areas has demonstrated that labelling of an individual can affect attributions (Kali *et al.*, 2012; Scior *et al.*, 2013).

In terms of additional interactions between attributions and emotional responses that were not proposed by Weiner's (1986) model, stable attributions were found to be associated with both positive and negative affect, and internal attributions were related to negative affect. This has some contrast in the findings that staff reported more positive affect in individuals whom CB was deemed more likely to be caused by biomedical (internal, stable) factors (Gifford & Knott, 2016). These individuals were also likely to be viewed as having less control over their behaviour (Tynan & Allen, 2002; Williams *et al.*, 2015) which according to Weiner (1986) would lead to more positive and less negative affect. An alternative explanation could be that staff experience negative affect if they attribute CB to internal and stable causes in individuals who do not have obvious organic or genetic conditions. This may reflect a 'fundamental attribution error' (Ross, 1977, cited in Tynan & Allen, 2002) whereby individuals place disproportionate emphasis on internal factors. These findings, along with the findings in Willner and Smith's (2008) review, demonstrate a more complex relationship than proposed by Weiner's (1986) model.

4.2. Limitations of Reviewed Studies

Reviewed studies utilised quantitative methodologies to focus on a phenomenon that may not be easily reduced to numerical data. Tools such as the ASQ impose and limit the attributions that staff can rate in a 'top down' manner, and assume a dichotomous orientation towards attributional dimensions. Qualitative research has illustrated that staff can hold multiple beliefs regarding CB. Whittington and Burns (2005) found staff identified both internal and external attributions for behaviour for the same individuals. Staff believed the behaviour to be a consequence of a variety of factors including the individual's disability or 'illness'; reaction to events; staff responses; communication; hostile motivations; or an attempt to seek attention. This may be due to the method allowing staff to draw upon their understandings of CB, rather than being restricted to responses given to them. Measures such as the ASQ would not have allowed staff to demonstrate such flexibility in their understandings of behaviour. Furthermore, the use of these dimensions gives an indication that the researchers have identified a range of ways of making sense of CB, which is

problematic if this leads to assumptions that they have encapsulated all ways of making sense of behaviours. Although the constructs assessed by the measures are theoretically informed, the present reviewed literature does not provide good support for the hypotheses that might be predicted by attribution theory, and a previous related review similarly did not find good support for the applicability of this framework in the field of ID and CB (Willner & Smith, 2008).

The studies did not attempt to explore the 'accuracy' of the attributions of behaviour. For example, it is entirely plausible that in some situations CB by an individual might have been intentionally undertaken to harm a staff member, however in other situations an individual might not have any awareness of the impact of their behaviour on others, which would lead to different attributions of such behaviour. Within the literature there was sometimes a tendency to assume that certain attributions staff made about their clients were more morally correct than other ways of construing the behaviour, without consideration of the actual function of a person's behaviour. (e.g. 'blaming' vs 'helpful' attributions Rose & Rose, 2005; Wishart *et al.*, 2013).

The use of vignettes in some of the studies raises issues of validity. The actual relationship with an individual can have more of an impact on attributions and experience than the information presented about a fictional client. The latter method allows for emotionally detached logical reasoning, which might not be possible in the context of an actual relationship, as highlighted by findings from Wanless and Jahoda (2002). Staff reactions to vignettes and incidences of real CB were compared, with staff rating more anger and disgust, and less sympathy in response to the latter condition. The individual being supported was also perceived more negatively than those in the vignettes.

4.3. Limitations of Current Review

Following a systematic search of the literature, it became apparent that a dearth of information existed regarding factors impacting upon staff attributions for CB. Only 15 studies were identified as relevant, with only five of these being published

in the past five years. Additionally, the variables considered within these studies varied widely, as did the methodology, settings, and types of CB, presenting challenges to make direct comparisons between studies. Consequently, a narrative synthesis was chosen as opposed to a meta-analysis. Although this allowed findings to be summarised, it did not allow for a more sophisticated analysis of the data.

This review limited the inclusion of studies to those from the UK. Although there was clear rationale for this, in that attitudes tend to be influenced by culture, the transferability of this review to other countries would not be possible. Additionally, potentially relevant findings from other countries were not included in the review.

Finally, the topography of behaviours within the studies varied widely. Most papers focussed on aggression (n=10) and self-injury (n=5). Stereotypic behaviour was only explored in two studies, and other forms of behaviour, such as sexualised behaviour, disruptive behaviour, and withdrawal, were missing from the sample. This may reflect the nature of referrals to CB services, in that staff refer for behaviours which cause more anxiety within teams, due to risk issues. Other behaviours may cause less of a challenge to staff teams (e.g. withdrawal) but can have detrimental effects for the individual concerned.

4.4. Clinical Implications

Although findings were mixed, they revealed a wide variety of factors which potentially influence both attributions for, and emotional reactions to CB. Of particular importance, were the differences found in attributions and emotions in response to factors relating to the individual whom was being supported. Results indicated that diagnosis, ability, and topography and function of behaviours could all impact upon attributions and emotions. Potential implications arise if staff were to treat individuals differently based upon their attributions and emotions, particularly if assumptions were made only upon a particular diagnosis or condition. This highlights the importance of staff having a full understanding of the individuals they are supporting, to gain a comprehensive view of the behaviours they present with.

Additionally, evidence suggested there was a relationship between staff attributions of behaviour and emotional responses to behaviour. Although this relationship was not always akin to the pathways predicted by Weiner's (1986) model, it highlighted staff members' emotional state may influence their attributions for behaviour, and vice versa. Potential implications may arise if negative emotional reactions are related to blaming attributions and punitive responses to individuals, thus risking engendering further abuse towards individuals with ID and CB. However it is important to note that negative emotional response does not necessarily equate to punitive actions (Jahoda & Wanless, 2005).

4.5. Future Research

Further qualitative research would be beneficial in exploring staff understandings of CB, without predisposing pre-existing ideas via standardised measures. Further research of a qualitative nature is called for to allow for more nuanced descriptions of staff experience of managing CB, and the potential impact this has upon the staff themselves.

There is a distinct lack of literature regarding the role of the relationship between the staff member and the individual they are supporting in the staff member's understanding of behaviour. Furthermore, within the literature on attachment, good quality care with high levels of attunement between staff and individuals is thought to be important for an individual's emotional security and well-being (Schuengel *et al.*, 2009, 2010). Research has indicated that interventions can be effective at improving attunement between staff and the people they support (e.g. Damen *et al.*, 2011). Given the relatively poor support for attribution theory, interventions targeted at improving staff-service user attunement might have greater benefit for both staff and people with ID (Schuengel *et al.*, 2010), compared with 'top-down' training packages designed to teach staff the 'correct' ways to understand CB.

In light of the differences in attributions highlighted as a result of individual variables, it is unknown to what extent staff would have been basing their attributions on the behaviour described, or their relationship with the individual. This may also

explain some of the differences found when comparing attributions for vignettes and known individuals (e.g. Wanless & Jahoda, 2002). As such, it may be worthwhile exploring the nature of the relationships between staff and individuals with CB, as well as the experiences of staff in providing care for such individuals. A better understanding of this relationship would enable services to tailor staff based interventions to promote positive relationships, with a view to delivering better quality care. This would also be in line with the findings from Dilworth *et al.* (2011) which suggests that positive service indicators are associated with fewer blaming behaviours. Additionally, guidelines for clinical psychologists working with people with ID cite the importance of understanding attachment when working with individuals (British Psychological Society, 2017). At times, CB could be understood as attachment behaviours, and this should be considered when formulating an understanding of an individual's difficulties. As such, services should endeavour to equip staff with the skills to consider the importance of the function of emotional and behavioural responses from individuals, as well as the role of attachment with care givers in their understandings of behaviour (British Psychological Society, 2017).

Finally, due to the complex nature of CB and findings of different attributional styles as a function of topography, it may be worthwhile exploring how staff relationships and experiences vary depending upon the type of behaviour displayed.

4.6 Conclusion

This review explored variables likely to moderate attributional style and emotional responses to CB in light of the inconsistent support for Weiner's (1986) attributional model in the field of ID. The review highlighted that many factors relating to the individual displaying CB could impact upon attributional style and emotional response. Furthermore, attributional style and emotional response were found to interact, but not as simply as the model predicted. As such, further research is called for to explore the role of the relationship between the staff member and the individual they are supporting, in the staff member's understanding of behaviour, of which qualitative methods may be better suited. Attributional theory may have limited utility

in making sense of staff reactions to CB due to it not being able to take into consideration the complexity and quality of individual staff-service user relationships.

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Note: ** denotes studies forming the basis of the current review

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Part Two: Research Report

**The experiences of female care staff supporting men with intellectual disabilities
with sexualised challenging behaviour: An Interpretative Phenomenological Analysis**

The experiences of female care staff supporting men with intellectual disabilities with sexualised challenging behaviour: An Interpretative Phenomenological Analysis

By Kerry Jayne Cope

Abstract

Aim: The present study was designed to explore care staff experiences of supporting people with ID who were perceived to have been engaging in sexualised challenging behaviour.

Background: Much of the research that has been completed in the intellectual disability field in recent years can be grouped into studies considering attitudes towards people with intellectual disabilities and challenging behaviour and improving staff attitudes towards challenging behaviour. However, there has been much less research into care staff experiences of challenging behaviour. One topography of challenging behaviour that has been viewed as particularly difficult to work with is that of sexualised challenging behaviour which can be significantly distressing to carers, and may be construed as sexual abuse if they were to occur in a different context. There has been no research to date which aims to explore care staff experiences of supporting people with an intellectual disability who specifically are seen to display sexualised challenging behaviour.

Method: Semi-structured interviews were conducted with four female staff who had recently experienced sexualised challenging behaviours from men with intellectual disabilities in their care. The interviews were transcribed and then analysed using Interpretative Phenomenological Analysis.

Results: The analysis generated three superordinate themes: tensions the women felt between a desire to provide support whilst simultaneously grappling with an uncertainty as to whether the men deserved care, and how this care should be given (*you wonder if you're doing the right thing*); an enduring sense of inevitable danger in working with patients with sexualised challenging behaviour, and the sense of hypervigilance and need to protect that came with this (*always looking for danger*); and how the women felt devalued at work, where emotional reactions were disregarded or disallowed (*no one really cares about the staff*).

Conclusions: The findings demonstrated the complex nature of staff meaning making of sexualised challenging behaviour. Themes were discussed in relation to social constructionism and object relations theory. Clinical implications of the importance of services acknowledging staff emotions, and allowing safe spaces for the discussion of this are explored, along with the need for further qualitative research related to this.

1. Introduction

1.1. Intellectual Disabilities and Challenging Behaviour

It was estimated that in England in 2015, 1.08 million people had intellectual disabilities (ID), including 930,400 adults over the age of 18 (Public Health England, 2015). Behaviour that is deemed to be challenging is relatively common among people who have ID, with estimated prevalence rates of 5–15%. However, significantly higher rates (30-40%) are found in people with ID who live in hospital settings rather than in the community (NICE, 2015).

Various definitions of challenging behaviour (CB) have been put forward. A well-regarded definition was put forward by a multidisciplinary working group, who argued that behaviour should be regarded as challenging if it is of *'such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion'* (Royal College of Psychiatrists *et al.*, 2007, p.10). The term 'challenging' refers not only to the impact and effect of the individual's behaviour, but also to the challenge faced by those people supporting them.

1.2. Existing Research

Much of the research that has been completed in the ID field in recent years can be grouped into studies considering attitudes towards people with ID and CB (e.g. Bailey *et al.*, 2006) improving staff attitudes towards CB (e.g. Hutchinson *et al.*, 2014); and the utility of Positive Behavioural Support in managing CB (e.g. LaVinga & Willis, 2012). To the degree that understanding of CB has been explored, this has often been in a deductive 'top-down' decontextualized way, in which staff have been asked to give ratings of their understandings on pre-determined response scales such as the Challenging Behaviour Attributions Scale (CHABA; Hastings, 1997) or the Attributional Style Questionnaire (ASQ; Peterson *et al.*, 1982). However, these scales limit understandings of behaviours to pre-disposed, often dichotomous choices.

Research has also placed emphasis on how best to support people with ID, whilst also advising on how staff 'should' behave, and what attitudes may or may not be constructive (e.g. 'blaming' attributions, Rose & Rose, 2005). Furthermore, staff having negative feelings towards CB, or locating problems within the individual, has often been framed as undesirable within existing research; as reactions that needed rectifying through training (e.g. Hutchinson *et al.*, 2012; McGrath, 2013). In this context, no consideration was given into the experiences of the care staff in question. Whilst such research has clear value in improving the lives of people with ID, who are a disempowered population vulnerable to abusive practices, outputs rarely acknowledge the emotional impact or experiences of staff who provide support for hours at a time to individuals whose behaviour is regarded as challenging. Storey *et al.* (2011) employed a psychoanalytically informed methodology to explore the experiences of staff supporting people with ID and 'complex mental health needs'. Their findings indicated staff found the work difficult due to the different complex needs of the service users, and feeling understaffed. Staff also did not appear to be given the opportunity to reflect on the emotional impact of the work, which led to various unconscious defences such as denial, forgetting, and the displacement of emotions.

1.3. Sexualised Challenging Behaviour

One specific topography of CB that has been viewed as particularly difficult to work with is that of sexualised challenging behaviour (SCB), which can be significantly distressing to carers (Stubbs, 2011). As with 'challenging behaviour' more generally, definitions for SCB have been contested. Lockhart *et al.* (2009) reflected that although many people had attempted to define SCB, definitions had not been based on evidence. As such, they utilised a qualitative design to empirically define SCB with an emphasis on the challenges posed to services, rather than as a diagnostic label. They defined SCB as: *'Sexualised challenging behaviours are those that are deemed inappropriate as a result of the nature of the behaviour (including touch or contact, exposure or display, masturbation, language, communication or images, invasion of personal space or boundaries, fetishism, or aggressiveness linked to sexual arousal) or*

the setting in which they occur (i.e., a public or observed place). These behaviours may be self-directed or directed at others, including targeting or fixating on individuals. Where others are involved the contact may be unwanted or nonconsensual. These behaviours occur on a continuum from minor behaviours up to and including sexual assault. In addition, the behaviour may interfere with normal activity or be harmful or distressing to self or others' (Lockhart et al., 2009, pp 299).

Although there has been a wide range of research on ID and sexuality (e.g. Wilkinson *et al.*, 2015) or ID and sexual offending (e.g. Lindsay, 2012), there has been much less research into SCB, which often blurs sexual offending with SCB. Recent research into SCB in ID has examined staff attributions of challenging behaviour compared to sexual offending (e.g. MacKinlay & Langdon, 2009) and carers' propensity to help men with ID who display SCB (e.g. Willner & Smith 2008). MacKinlay and Langdon (2009) used a quantitative checklist to compare the attributions staff made when comparing sexual offending to non-sexual challenging behaviour. They found staff were more likely to view sexual offending as more 'stable' (permanent, less likely to change) and 'uncontrollable' by people with ID than general CB. Willner and Smith (2008) tested Weiner's (1986) attribution theory of helping for men with ID and SCB. They found partial support for the model in that staff increased efforts of help were related to a perception of the SCB being unstable, and therefore amenable to change.

Although there has been research into the experiences of care staff and sexualised behaviours within older adults (e.g. Haywood *et al.*, 2012), to the author's knowledge there has been no research to date which aims to explore care staff experiences of supporting people with an ID who specifically are seen to display sexualised challenging behaviour.

1.4. Rationale and Aims

In light of this, the present study was designed to explore care staff experiences of supporting people with ID who were perceived to have been engaging in sexualised challenging behaviour. The focus of the present study was on sexualised behaviours directed towards staff, with a focus on the particular staff member's

perception of a behaviour as being sexually inappropriate. It was anticipated that this type of interaction could potentially be highly distressing, as the particular behaviours may be construed as sexual abuse if they were to occur in a different context. Outside of ID contexts, Warner (2009) proposes that women who have experienced sexual abuse make sense of their reality through the relationship between their understanding, experience and identity. As such, it is possible that women who experience similar sexual behaviours within their work with men with ID could potentially make sense of their experiences in this way.

This study was undertaken because it was believed that it is essential to gain insight and understanding into the experiences and meaning-making to staff providing support to people with ID: a belief that, in order to ensure good quality care for this client group, it is important to be able to provide support for those delivering the care.

2. Method

2.1. Design

The study aimed to explore female care staff experiences of working with SCB. As such, a qualitative approach was used to gain a rich data set regarding participants' experiences. An Interpretative Phenomenological Analysis (IPA) approach was used due to the primary focus of the study being on lived experience and meaning making. IPA is an approach concerned with how people make sense of their lived experiences, and is concerned with exploring the experience in its own terms (Smith *et al.*, 2009).

Furthermore, IPA examines in detail what a particular experience is like for a particular individual, and what sense the individual is making of that experience. Within an IPA approach, the researcher acknowledges that a participant's experience is only available to the researcher by means of what the participant tells them. Therefore the researcher is themselves making sense of how the individual is making sense of their experience, via the researcher's own interpretation of the account (Smith *et al.*, 2009). It is important to note that the research was based on how the participants made sense of SCB. Therefore, no claims are made by the researcher regarding the patient's experience of, or motivations for, the behaviour in question

2.2. Epistemological Position of the Researcher

The study was conducted from a contextual constructionist position (see Appendix F for details).

2.3. Ethical Considerations

The research proposal for this study was initially peer-reviewed by a service user reference group alongside staff from the University of Leicester. Following recommendations from this, the proposal was submitted to the University of Leicester Ethics Board (Appendix G), and was also submitted to the local NHS research committee for approval (Appendix H).

Prior to engaging in the research, informed consent was gained from all participants (Appendix I), and all participants were offered the opportunity to attend a debrief with the researcher following the interviews, where any arising concerns could be discussed. The participant information sheet (Appendix J) and informed consent form highlighted the sensitive nature of the topic being discussed, as well as limits regarding confidentiality.

2.4. Recruitment

2.4.1. Setting and Recruitment Process

Participants were recruited from care staff employed in hospitals within the Midlands that provided inpatient care for males with intellectual disabilities. The researcher initially sent letters to three hospitals (Appendix K), which included the participant information sheet, to see if they would be willing to take part in the study. These hospitals had been identified by the researcher and academic and field supervisors. Once permission from service managers was gained, the researcher attended team meetings to talk to the staff group about the rationale behind the research and nature of the study. The researcher then displayed a poster (Appendix L) in staff-only areas, along with the participant information sheet. Potential participants were asked to complete an opt-in form if they were interested in taking part in the research.

Due to an initial low response rate, the researcher then made themselves available for drop in clinics at the various hospitals, where participants could discuss the research project in more detail, and could arrange to attend interviews. In order to aid recruitment at this stage, an amendment was also approved for participants to be interviewed at their place of work, and for the participants to receive a monetary voucher for taking part. Due to lower than expected uptake, an amendment was sought to open up the research to a fourth hospital within the area.

It is possible that the low uptake of participants could have been due to an avoidance of discussing sexualised behaviour. This may have been either a strategy for avoiding difficult emotions this raised (e.g. negative reinforcement) or in more unconscious processes such as denial or repression. In relation to the latter, Sinason (1992) proposed that sexuality in people with ID is an intolerable concept to consider because it violates phantasies that they are asexual or “eternal children”, and as such thoughts of sexualised behaviours cannot be tolerated.

2.4.2. Inclusion and Exclusion Criteria

The idiographic focus of IPA privileges a relatively homogenous sample because a person’s experience of a given ‘phenomenon’ might be expected to vary in relation to demographic or other contextual factors. As such purposive sampling was used to recruit participants. In order to be eligible for the study, participants needed to be a woman, over the age of 18 working in a hospital supporting people with intellectual disabilities. In order to ensure the participants had enough experience to reflect upon, they also needed to have worked with someone in the previous year who had been perceived to have been displaying behaviour towards them that they (the staff member) had experienced as sexual. Again, centring the staff’s meaning-making, potential participants were encouraged to decide if what they had experienced was SCB.

2.4.3. Sample Size and Participant Characteristics

A sample size of between three and six research participants has been suggested as suitable for IPA-based methodologies for doctoral studies (Smith *et al.*, 2009) because the approach emphasises depth of analysis and idiography.

The current study recruited four participants from between the various sites. A summary of their characteristics can be found in Table 3 below.

TABLE 3 - PARTICIPANT CHARACTERISTICS

| Name | Age | Experience of behaviour participants deemed to be sexually inappropriate |
|-------------------|-------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Anna ³ | 40-50 | Being cornered in a bathroom and feeling she would be raped, witnessing masturbation, having sexualised comments made about her body, and being touched inappropriately during restraints |
| Becca | 50-60 | Patient ⁴ ejaculating whilst holding her hand, and having a patient constantly following her, and making inappropriate sexual comments. |
| Callie | 40-50 | Being followed constantly by a particular patient, patient trying to get her on her own, being touched on the arm by patients, and having her personal space invaded |
| Danielle | 21-30 | Being touched on the groin area, whilst being asked questions about her body, and feeling as though patients are deliberately looking at various parts of her body. |

2.5. Procedure

2.5.1. Materials

The researcher made participant information sheets available at all sites following attending staff meetings. Potential participants were asked to complete an opt in form, which included confirmation that they met the inclusion criteria. Participants were also asked to identify their job role⁵ and age bracket. Participants eligible to take part completed an informed consent form prior to being interviewed. The interviews were guided by a schedule (Appendix M) which focused on the experiences of care staff working with people with intellectual disabilities and SCB.

³ In order to preserve the participants' anonymity, pseudonyms are used throughout.

⁴ The term 'patient', although controversial, will be used to refer to the men with intellectual disabilities staff are referring to. This is because three out of four women typically referred to the men using this term, and also because 'patient' was taken to be more fitting than 'client' or 'service user' given that the men did not have any choice as to their being within the hospitals

⁵ In order to preserve anonymity, job role has not been reported upon

2.5.2. Interviews

The researcher met participants individually in order to conduct the interviews. Interviews were conducted in the workplace for all participants, despite the option of being interviewed at an alternative base having been offered. In accordance with the principles of IPA, the questions within the interview schedule were open to reduce potential for the researcher imposing meaning. Additionally, the interview schedule was used as a guide only, as participants were encouraged to talk about what experiences and sense making that they felt was relevant to working with people displaying SCB.

2.5.3. Analysis

Interviews were transcribed by the researcher, and data was analysed using the IPA analytic process as outlined by Smith *et al.* (2009). This entailed a number of stages, starting with reading and re-reading each text, in order to ensure active engagement with the data. This was aided by the researcher transcribing the interviews, and checking transcribed data for accuracy. The next step included initial noting of anything of interest within the data, and to identify specific ways the participant understood the issue being explored. Following on from this, emergent themes were developed from the initial noting stage. Connections across emergent themes were then explored via the means of a case summary before repeating the process with the next transcript. Once this process was completed for all individual cases, patterns across cases were identified to form various superordinate and sub-themes. See Appendices N-P for a sample of the stages of analysis.

2.6. Quality Issues

The quality of research utilising a qualitative method significantly impacts upon the credibility of the findings. A number of guidelines for assessing quality within this field of research have been published, and Smith *et al.* (2009) recommend the criteria outlined by Yardley (2000) for IPA studies. Yardley identified four principles: sensitivity

to context, commitment and rigour, transparency and coherence, and impact and importance.

The researcher attended an applied workshop on IPA analysis (facilitated by Michael Larkin). All stages related to the development of emergent themes and subordinate themes were discussed in research supervision, with a supervisor who had previous experience of utilising IPA. This enabled the researcher to ensure themes were centred on experiential claims, and that interpretations did not stray too far from the original data. Supervision also enabled the researcher to engage in reflexive conversations to consider how their own experiences may have been influencing their interpretations of the data. To support transparency and generate a research trail, all discussions and decisions made in research supervision were documented throughout the research process.

Finally, due to the dearth of research in this area, the researcher felt it would be of upmost importance to disseminate the findings of the research appropriately. The researcher plans to contact each of the services involved in the research to verbally feedback the findings and implications, and will also offer a written summary to each participant who has taken part.

See Appendix R for a full chronology of the research process.

3. Results

Figure 2 illustrates the three superordinate themes and seven subthemes which were generated from the accounts of the women, illustrating their experiences of caring for patients with ID and SCB. To support transparency (Yardley, 2000), the women's contribution to themes can be found in Appendix Q.

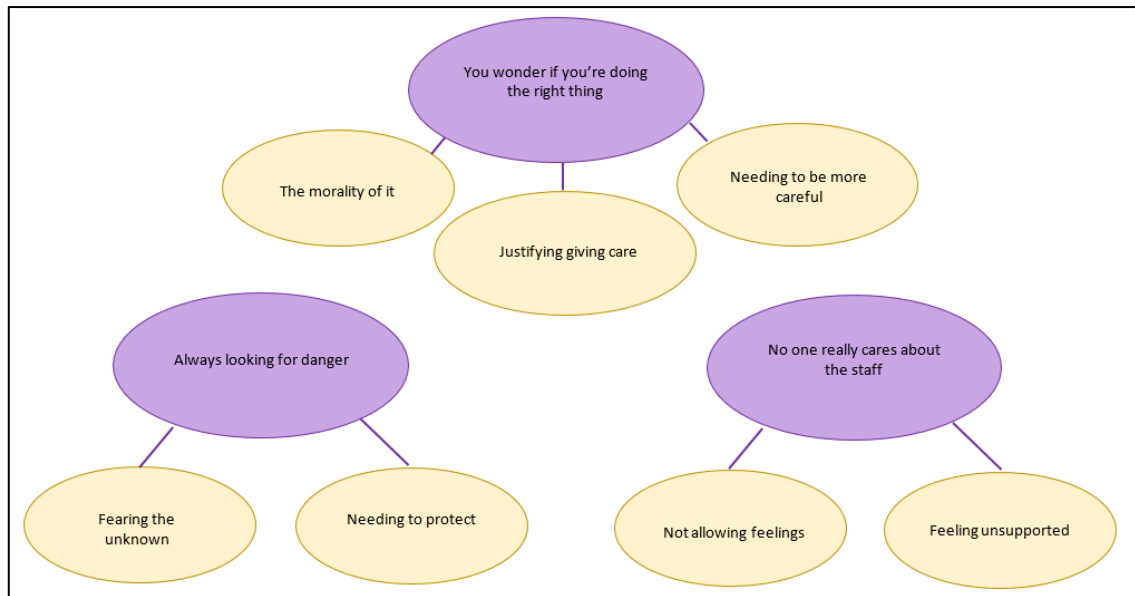


FIGURE 2 - SUPERORDINATE AND SUBTHEMES

3.1. You wonder if you're doing the right thing

This theme, derived from a quote by Becca, is concerned with the tensions the women seemed to battle with when thinking about providing care to men who engaged in SCB, and how they responded to these dilemmas. These tensions related to a desire to provide support whilst simultaneously grappling with an uncertainty as to whether the men deserved care (3.1.1). The women spoke of the strategies they used to manage this tension and justify providing support to men who were experienced as deviant (3.1.2), whilst the third theme is concerned with the dilemmas about specific care-giving actions: Wanting to provide care but being concerned their actions might be misconstrued as sexual (3.1.3).

3.1.1. *The morality of it*

The women all viewed caring as integral to their professional and personal identities, with it being important to them that they did their job well. All the women

made explicit links to caring being integral to the role, and two women made links with their identities as mothers:

you've got to want to help these guys (...) ⁶ if you genuinely want to help these guys get back into that community, or give them a better quality of life, this is a job for you (Anna)

a mother, an older woman (...) I've had 2 boys (...) and did a damn good job with them, maybe (...) there's still that motherly instinct in there somewhere (Callie)

However, it was more challenging for the women to experience compassion towards certain men who displayed SCB, who were often differentiated from other patients through terms such as 'paedophiles' (two women) or 'them' (four women). The women came to understand these men through an awareness of these men's previous sexual offending behaviours. This appeared to lead to a tension as to whether they deserved care, either due to moral reasons, how others may perceive the women for providing care to the patients, or the women's own experiential reactions to the patients:

the most thing I'm finding difficult now (...) it blows my mind coz I've got four granddaughters, erm, I think, how can I work with these kind of people and then go home and be normal with them (Anna)

you think about, erm, the morality of it, because of the fact that they're harming children, or they have harmed children in the past, or they're having thoughts about harming children, and you

⁶ Denotes words which have been removed for ease of reading, purposes of confidentiality, not added meaning to the theme, or used when the researcher offered a response to the participant

wonder if you're doing the right thing by working with them
(**Becca**)

The women thus experienced a tension between wanting to care and do their job well, but a difficult to voice anxiety that doing so might mean they are supporting individuals not worthy of affection.

3.1.2. *Justifying giving care*

This theme is concerned with how the women appeared to be searching for a reason for SCB, in order to justify giving care. It seemed easier for the women to justify giving care if it was believed the patient was not altogether responsible for their behaviour, or if it was believed the patient was capable of changing their behaviour.

In the search for whether or not a patient was responsible for their SCB, the women appeared to consider various reasons which lay behind the behaviours that differed from the tendency, described in the preceding theme, to sometimes understand the men in terms of deviant identities. These understandings ranged from beliefs that patients did not realise they were doing anything wrong (*'they feel it's normal'*, **Anna**; *'they might not understand what they are doing is wrong'*, **Callie**; *'if they've got a learning disability they might just think that it's normal'*, **Danielle**); medical model explanations (*'it's their illness at the end of the day'*, **Anna**; *'the brain's wired up differently'*, **Becca**; *'how bound he was by his autism'*, **Danielle**) and lived-experience explanations (*'these guys have had some serious upbringings'*, **Anna**; *'how they're brought up, and the environment plays a big part in it'*, **Becca**; *'were they in- in gangs, were they easily led'*, **Callie**; *'they're kind of doing the behaviours because it's what's been done to them'*, **Danielle**). Throughout these accounts, there was a sense

from the women that they found it more acceptable to give care to the patients if they found a reason that mitigated the patient from the behaviour, relieving the tension described in 3.1.1.

Anna and Danielle appeared to experience the behaviour as more problematic when they perceived it as being motivated by a desire for sexual gratification, rather than seeing the behaviour as a response to medical or social factors. Danielle conveyed a belief sexual gratification was the predominant motivator for ‘higher functioning’ patients, whom she viewed as more responsible for their actions:

*I think there's two very clear, group- like groups, you've got your people who are kind of more moderate, and severe learning disabilities, and they're kind of doing the behaviours because it's what's been done to them, whereas then you've got the people that are kind of a bit more mild, or borderline learning disabilities, and, they kind of, doing it for personal reasons, rather than, past experiences. (...) I think people are kind of a bit more accepting, of it, of the lower functioning (**Danielle**).*

It appeared Danielle was more accepting of the behaviour from lower functioning patients, and as such found it more difficult working with higher functioning patients, who to Danielle, always appeared ‘one step ahead’.

Anna spoke about experiencing SCB as frustrating but ‘easier to cope with’ when she understood SCB as a result of what she termed ‘gate fear’ (relating to a patient’s presumed anxiety of the prospect of being moved on from the hospital). In contrast, she expressed feelings of outrage when it was perceived that a patient was engaging in a behaviour for personal gratification:

you're feeling invaded, and you know, er, I wouldn't say, you're disgusted in them, but it's more "How dare you grab me, how dare you do that to me", you know (Anna).

The women also appeared to find it easier to justify giving care to patients if they felt patients were capable of changing their behaviour. For Callie, such attributions reflected positions she felt morally obliged to adopt; that for her it was essential to give patients '*the benefit of the doubt*' in order to provide good care:

You've got to think that to get where they are now, they've gone through a lot, they've gone through a lot of changes. (...) so you've got to give them the benefit of the doubt that, hopefully, they've learnt or they are changing (Callie).

This sense of a patient being able to change was also shared by Anna:

I've had a couple of success stories, you know I've seen them, I've seen them get out and do it (Anna).

It also appeared for Anna that the core essence of her job was to provide rehabilitation, and as such she viewed enabling patients to change their SCB to be another facet to this ('*it's another form of rehab int it?*').

The women thus wrestled with various competing ways of making sense of men's SCB. The degree to which they were able to feel compassionate to the men varied with their sense-making, but the women sometimes seemed to also actively privilege certain ways of understanding the men in order to rationalise providing care.

3.1.3. *Needing to be more careful*

Another tension the women seemed to battle with concerned how they should be when providing care. They described feeling as though the care or concern they gave could be misconstrued as sexual; leading to questions around how they should be with, and give care to, patients. At times this was linked to a feeling of personal responsibility for causing the behaviour:

*I just thought “I better be more careful” and not sort of, maybe not hold hands with a patient (**Becca**, who experienced a man ejaculating after she had held his hand to provide comfort)*

*Could I have done anything different? Have I done something to make him feel he should be able to talk to me, and behave like that (**Callie**)*

Anna perceived the behaviour and appearance of younger, more ‘naïve’ staff as inviting SCB:

*they’re not realising what they’re doing is having an impact on the guys, you know (...) if you’ve got a young girl that’s coming to work, plastered in make-up, shirt unbuttoned (...) it can’t happen (**Anna**)*

In these accounts, there was an implicit assumption that the behaviour of women, be it physical aspects of giving care, or their appearance, ‘made’ the patients engage in SCB, alleviating the patient of blame. Therefore it was implied it was the duty of the staff member to change their behaviour to manage this, and that the more nurturing side of care needed to be avoided.

This seemed to be particularly important to Callie:

should I have been more assertive, is it my fault that, my temperament, my personality, isn't that kind of person? (...) So you do wonder whether it's your own personality, should I have spoken up sooner? (...) I wish I could be that sort of person sometimes, I guess! But I'm not (...) maybe I should look into the way I am
(Callie)

Throughout her interview she spoke extensively about how she was a caring individual, who was naturally a calm and quiet personality. However her experiences of SCB appeared to make her question whether her personality was suited to the role, and whether she needed to change her core way of being with patients, in order to effectively manage behaviours. Callie, like the other women, experienced an additional tension between wanting to be caring but concerned that attempts to demonstrate care could trigger SCB or blur carer-patient relationship boundaries. Additionally, Callie also spoke about feeling part of the reason she had experienced SCB was due to her own naivety when she commenced her role:

originally I was naïve I suppose, hadn't done the job before, so, and didn't think owt of it **(Callie)**

3.2. Always looking for danger

This theme, derived from a quote by Anna, is concerned with the enduring sense of danger the women felt in working day by day with patients with SCB, and the sense of hypervigilance and need to protect that came with this. The women spoke about the unpredictability of the patients in their care, and an inevitable sense of assault they experienced. In line with this, the women viewed themselves as being vulnerable (3.2.1). The second theme is concerned with the sense of responsibility the women felt in ensuring the safety of themselves and others (3.2.2).

3.2.1. *Fearing the unknown*

The women portrayed a sense of an ever present danger from the patients:

Just the fear of the unknown (...) you never know what's going to happen (Anna)

I am a lot more wary, (...) I don't, don't trust him, erm, I think, you know, given the opportunity, I think any, anybody, could be at risk (Danielle).

Anna and Danielle both spoke about worries they had in terms of themselves or others being at risk of sexual behaviours from the patients. This fear may have been exacerbated by the way in which they both viewed the patients' propensity for harm; both speaking in ways which left images of predatory, calculated behaviours:

they'll wait until a fe – a young female, or any female is on the general obs or whatever and know that you've got to open the door to check on them, and they'll be doing, masturbating in front of you (Anna)

they're all, kind of, up to no good, that they're all kind of, plotting something, or getting a kick, or that, you know, that's why they're sat there because everyone's walking past, it's kind of like, prime, place to sit, to see everybody (Danielle)

This ever present sense of danger was coupled with three of the women describing a sense that a serious staff assault was an inevitable tragedy waiting to happen:

I do believe that a young girl's gonna get attacked before long, and I don't mean physically, I, I mean rape (Anna)

before coming to work in the mornings (...) my stomach's churning (...) you think "Oh my god, what's going to happen when I get out there" (Callie)

The women conveyed a sense of vulnerability in light of the danger the patients posed, which was exacerbated by the prospect of being alone with the patients:

I either don't walk down that corridor if I- if I think there's going to be someone dangerous there, or I either walk down feeling very wary (Becca)

I won't go on the upstairs corridor on my own (Danielle)

For two women, their sense of vulnerability and hypervigilance to threat extended beyond the hospital to include potential threat from members of the public (*'they tar you with the same brush because you're looking after them', Anna*) or males in general (*'I'm quite wary about being with men on my own, I don't feel as safe as I used to (...) I don't feel as trusting of men as I used to' Becca*).

Finally, for Anna and Callie, age and gender were seen to be protective in the sense that men and older women were seen to be less vulnerable. They both viewed their age as 'older women' as protective factors, viewing their age and 'motherly' status in relation to the men as less likely to 'invite' SCB:

to me they don't (...) a lot of these young guys actually see me as a mother figure (Anna)

they might see me as mother figure because I'm more older woman anyway (Callie)

Both women viewed younger, female colleagues as more vulnerable, and likely to experience SCB:

if you have got a young timid little girl, you'll find that they will be the prime target (Anna)

If I saw it happen to like one of the younger colleagues, that would bother me (Callie)

Of particular pertinence to Anna, was a sense that younger females were more at risk of SCB due to a naivety that came with a lack of experience (*'they've got no idea of the intensity of these guys'*). She felt that in order to be able to effectively manage the behaviour of patients, staff needed to have a certain level of competency about them, which she felt went hand in hand with gaining experience through age:

the people that ... I'd say can support these people better are people who've had life experiences, who've had, you know, the more mature support worker (Anna)

Finally, for both women there was also a sense that women were vulnerable in a way men were not, making sense of their vulnerability in terms of them being women working with men who were sexually predatory to women:

I always come in to handover in the morning, I'll look round table ... and I, I always look for how many males I've got on, always (Anna)

Anna appeared to feel that the presence of male staff on shift inhibited the patients' sexual behaviours, thus reducing the sense of vulnerability. She explained feeling that the patients were aware of the ratio of female and male staff on the unit

at any one time, which led to less incidents of SCB. For Callie, the male gender appeared to be linked to a '*pecking order*', with a sense that patients had more respect for male staff than female staff:

if they see a handful of men walk on, you don't tend to get as many behaviours (Anna).

if it had came from a male, a male staff member, it was more, it sort of had more weight behind it (...) I don't know if it's the erm, authoritative figure, they, could be they had bit more respect if it, it was a male that, that erm, had respect anyway, that's worked here a long time, and, had respect, erm, whether it's a pecking order (Callie)

All the women implied that the patients' sexualised urges would be directed to female staff again highlighting a sense that they as women were inherently more vulnerable compared to male counterparts. This vulnerability was enhanced given that the women presumed young females to be the object of male sexual desire.

3.2.2. Needing to protect

In the context of hypervigilance to impending danger and a sense of vulnerability (for self or others), all the women spoke of a strong sense of personal responsibility for ensuring their own safety or that of others.

For Anna, this sense of responsibility appeared to be centred on keeping her colleagues safe from harm, which was tied into her self-identified 'mother' role in relation to the younger female staff:

*I feel like a mother figure to all the younger support workers (...)
I'm, I'm doing my job, but I'm trying to protect them as well
(Anna)*

Indeed, it felt that for Anna, a serious assault on a staff member due to her not being around to protect them would have been unbearable for her, and the sense of personal responsibility was felt so keenly, that it was negatively impacting upon her ability to manage distress outside of work:

*what if I'm not up on that corridor (..) if somebody was to get
attacked, or, I don't think I'd be able to live with myself (Anna)*

*I need my time off, but (...) if I know the following day they're
gonna be short, (...) I really have to fight with myself not to give in
(...) my kids are saying (...) "I think you think more of work than
you do us" (Anna)*

Tied into this sense of responsibility to keep others safe, Anna also spoke about being hypervigilant to potential dangers:

*the way I deal with it, is, I'm, I'm watching for stuff you know what
I mean? If, if I see something might, might, somebody might going
to expose himself or, might do it, I'll jump in first (Anna)*

This sense of responsibility to protect others from the patients was also echoed by Becca. In caring for patients with SCB, it seemed Becca felt it was her responsibility to work with patients to make them change their behaviour (*'If we can contain their behaviours and change their behaviours'*), rather than the patients taking responsibility for this.

if we can protect children or vulnerable females from these type of patients that's positive (Becca)

For Callie and Danielle, this sense of responsibility appeared focused on a responsibility they felt to keep themselves safe. Particularly for Callie there was a strong sense of her feeling a responsibility to avoid putting herself in position of risk. This led to Callie feeling as though she needed to avoid certain patients in order to remain safe:

got to the stage where I thought I , I'm going to have to either back, you know, keep my distance from him, and I don't want to do that, I want to do my job, I don't wanna be able to avoid a specific person (Callie)

This then appeared to have an added tension for Callie, that in order for her to keep herself safe, she wouldn't necessarily be able to do her job to the best of her ability. To manage this tension, Callie and Danielle both spoke about the importance of maintaining professional boundaries in their relationships with patients:

Don't get me wrong I'm not emotionally (...) I don't think anything about them, I don't feel anything for them, but I am here to a job, and I will do that to the best of my ability (Callie)

I think I'm quite ... clear in my communication, so people know, there and then ... what my expectations are (...) if something is inappropriate (Danielle)

For Callie, this led to her perceiving her role to be more related to providing practical, rather than emotional, support; allowing Callie to maintain her sense of

personal safety, whilst still being able to give care. For Danielle, this professionalism and responsibility for personal safety extended to seeking safety measures:

that's the job for the psychologists, not mine. I'm here to support them, the day to day tasks (Callie)

do I need somebody else in there with me, you know, what room was I gonna use, is there a window, erm, you know, also my alarm checked, those sorts of things, I would always make sure those things were, covered (Danielle)

3.3. No one really cares about the staff

This theme, derived from a quote by Becca, is concerned with how it seemed the women felt they were devalued at work. Interview data suggested they viewed their emotional reactions as being disregarded or unspeakable (3.3.1). There was also a sense that they felt unsupported in managing difficult feelings that did arise (3.3.2).

3.3.1. Not allowing feelings

Two of the women spoke about their feelings in response to SCB being ridiculed and minimised:

They thought it was funny (...) I felt it had been trivialised (...) I still felt, erm, my feelings weren't taken on board (Becca)

the staff kept saying "Oh he's harmless, he wouldn't have done owt to you", "Excuse me, he had me pinned" you know (Anna)

Becca recalled this left her feeling unable to trust that her senior colleagues would support or even believe her if she was to experience a similar situation in the

future, and she and Anna expressed resignation that staff were not valued by management:

we're here for the patients and everything's for the patients, but no one really cares about the staff (Becca)

the worst thing for staff that work in this environment is to come into handover in the morning, and your manager comes in and (...) makes you feel that low, and then you've gotta go out on that floor for twelve hours and try and make (...) them guys' lives better (Anna)

All the women portrayed a sense of not allowing themselves to be affected by the patients' SCB, and needing to appear 'strong' when faced with difficult feelings:

My family, they said I've, I've "toughened". Erm ... (sigh), what's the word? Emotionally I've toughened up (Anna)

I can't let it affect me, (...) it could just probably eat you up (...) So I don't let it affect me (Callie)

In order to do this, the women claimed to use 'separating' as a strategy; either by separating the patient from the behaviour (Callie & Danielle); or separating work and home-life (Anna & Becca):

being able to separate off the two, so obviously, being a health care professional, being able to separate pe-people's pasts out, realise that they're here for treatment (Danielle)

I feel like I have to (...) compartmentalise my life, erm, my work is separate, and I don't talk about it, and my home life is separate

from that, you know, it's almost like I'm two different people
(Becca)

Although all the women spoke about not being affected by SCB, there were contradictions in their accounts and emotional responses to such experiences:

they always say leave your personal life at the door (...) but you can't do that all the time (...) a lot of the things that these guys say you do find more personal, you take more personal (Anna)

Erm, (long pause, sigh) I find sometimes I don't sleep very well (...) ruminate about (...) what the patients have said and done (Becca)

It appeared that the women felt a need to say they were not affected by behaviours in order to maintain a sense of professional competence, which may have been exacerbated by a sense that the system they were working in discouraged expression of affect. This in turn might have reinforced the sense that the women reported they ought to be able to cope and not feel distressed in relation to their work; that any such affect was an indication of their failings as a staff member:

the manager said (...) that if anyone here has a problem with working with paedophiles, you need to go and find a job somewhere else. (...) I was hurt that he had that attitude. (Becca)

As such, the women may have felt that to experience negative emotions would be seen as a weakness, or grounds for disciplinary action. They may have felt they needed to maintain they were unaffected by SCB as protective mechanism against this, to uphold their perceptions of themselves as competent, professional carers, and to defend against others viewing them as incompetent.

3.3.2. *Feeling unsupported*

This theme is concerned with the women's desire for extra support, in light of feeling unsupported by senior staff. From Anna, there was a sense that she felt as though she and her colleagues were left to work out their feelings between them, paired with a feeling of resentment that they had to do this:

we'd talk about it between ourselves (...) whereas what ought to be happening really is an after event debrief with MDT, support staff, nurses, managers so on and so forth, so then we could, we could sit round together and say "look, why did this happen?"

(Anna)

This sense of being alone in managing feelings appeared even more significant for Becca:

erm, you just feel alone with it really, that you've got no one to talk to about it I feel a bit isolated in that way (Becca)

Perhaps in light of this feeling of isolation, Becca spoke about the need for 'professional' help in managing difficult feelings evoked by supporting patients with SCB:

I think we should have someone that we sit and talk to, professional, on a regular basis (...) I hear a lot of erm, staff saying negative things about paedophiles and things like that, and I think they should have the opportunity to talk about, because it's obvious that they're having problems with it, and they should get some support (Becca).

In contrast to Anna and Becca, Danielle did appear to feel she had adequate support in managing her feelings, though again acknowledged that the support came mainly from her immediate colleagues:

you've got your supervisions, and support systems, and those kinds of things, erm, but it does really come from your day to day colleagues that you are working with (Danielle).

Finally, the women spoke about a need for further training:

we should have had training, we should have had, I don't know, some, something to give us the right mind set of what these guys are in for (...) but when you've had nothing like that and then they're just brought, right deal with them, it makes it a lot harder (Anna).

I think (sigh) I think people need to realise that to work with these individuals you do need additional training (Danielle)

This again added to the sense that the women felt undervalued as staff members, viewing themselves as being under skilled with better ways of working with the patients being available, but being inaccessible to them.

4. Discussion

4.1. Summary

The current research explored female care staff experiences of supporting males with ID who were perceived to have been engaging in SCB. An IPA approach was utilised to analyse interview data from four participants. Three superordinate themes were generated from the accounts of the women. These related to: tensions the women felt between a desire to provide support whilst simultaneously grappling with an uncertainty as to whether the men deserved care, and how this care should be

given (*you wonder if you're doing the right thing*); an enduring sense of inevitable danger in working with patients with SCB, and the sense of hypervigilance and need to protect that came with this (*always looking for danger*); and how the women felt devalued at work, where emotional reactions were disregarded or disallowed (*no one really cares about the staff*).

The results will be discussed in line with extant research and theory, drawing particularly on social constructionism and object relations, to enable the work to be placed in a wider context (Smith *et al.*, 2009). Clinical implications of the research will be discussed, along with acknowledgement of study limitations and ideas for future research.

4.2. Relationship with Extant Theory and Literature

Previous research in staff understanding of challenging behaviour in the ID field has often focussed on the role of attitudes and understanding of CB, typically being framed by attribution theory. Weiner's (1986) attribution theory suggests that attributions regarding causes of behaviour will influence an individual's emotional response to that behaviour, which in turn influences behavioural response. Different dimensions of attributions have been proposed: controllable-uncontrollable – whether an individual is deemed to have control over their behaviour; global-specific – whether the behaviour leads to many or few outcomes for the individual; internal-external – whether the behaviour originates from the individual or the environment; and stable-unstable – whether the behaviour is amenable to change.

However, a recent literature review conducted by the author revealed inconsistent support for attributional theory in the understanding of challenging behaviour, and wide variance of support was found for the differing poles of the attribution dimensions. Furthermore, there was a lack of any consistent findings regarding how staff and organisational characteristics may affect staff understandings of behaviour within the attribution dimensions. Furthermore, in contrast to much of the previous research that has been concerned with quantifying staff understandings of challenging behaviour utilising attributional theory (e.g. Bailey *et al.*, 2006) the

current research has demonstrated that staff meaning making of challenging behaviour is very complex, and does not necessarily fit into binary understandings of behaviour, as proposed by attributional theory. Furthermore, the super-ordinate themes within this research – tensions the women felt between a desire to provide support whilst simultaneously grappling with an uncertainty as to whether the men deserved care (*you wonder if you're doing the right thing*); an enduring sense of inevitable danger (*always looking for danger*); and feeling devalued and disregarded at work (*no one really cares about the staff*) do not fit into the attributional dimensions proposed by attributional theory.

An alternative theory as to how staff understand SCB is that of Warner's (2009) 'triangle of reality' and 'triangle of communication' which draws upon social constructionist and object relations theory. Warner's (2009) model may offer a more comprehensive understanding of the traumatic effects of SCB and how this feels for female victims; thus drawing attention to the need to care for and support the emotional resilience of staff.

Warner (2009) proposed a 'triangle of reality' (Figure 3) as a useful framework for making sense of the experiences of women victims of sexual assault. The theory privileges a social constructionist conceptualisation of 'identity', regarding this as a fluid construct. Warner (2009) proposed that a sense of self will be shaped by abusive experiences, but also that this sense of self will mediate understanding and meaning making of such experiences. Furthermore, meaning making will be influenced by messages received from important others and social structures within the context of the environment.

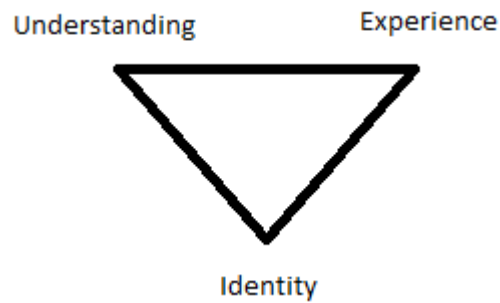


FIGURE 3 - TRIANGLE OF REALITY, WARNER, 2009

The women all discussed tensions felt in viewing themselves as professional carers, whilst feeling undecided as to whether the men in their care were deserving, in light of their SCB. All women in the present study spoke of 'caring' as being central to their self and professional identities, but they had all endured abusive experiences as a consequence of fulfilling their work roles. They experienced the men they worked with in uneasy ways, and sometimes struggled to rationalise these feelings in the context of their identity as carers. The resultant ambivalence they encountered with regards to their obligation to support the men seemed to be reinforced by dominant societal messages concerning 'paedophiles' and discourses perhaps shared within and outside hospital settings about the essentialised deviant predatory nature of such offenders (Imhoff, 2015). Additionally, they got the message from the services they worked in that they weren't supposed to feel distressed by what had happened to them. Most of the women spoke of not feeling able to speak about what had happened and of a service context that seemed to give the message that the women should be able to cope with the work, separate out home and work life, and not feel distressed by actions of the people they are supporting. Such messages have parallels with the messages Warner (2009) describes victims of abuse receiving from abusers: Messages from more powerful others that seek to silence victims by dismissing the reality of the survivors' experiences of abuse. This all impacted upon their identity as a caring professional causing conflict that needed to be resolved in some way, and to defend against a further identity of being 'incompetent' or 'vulnerable'.

The women appeared to employ various defences in order to manage this conflict. Warner (2009) proposed a 'triangle of communication' (Figure 4), whereby an

individual employs certain 'behaviours' to due to thoughts and feelings which can't be expressed. In the case of Anna and Becca, their seeming need to protect their carer identities may have been achieved via displacement of care from men experienced as deviant onto others perceived as vulnerable, namely younger female staff, or the public, whom perhaps it felt more acceptable to give care. Another mechanism utilised by Callie and Danielle was that of splitting the patient from the behaviour, a defence employed to keep apart two opposing thoughts or feelings such as empathy and disgust. This has parallels with accounts from Sandhu et al. (2012) in their exploration of staff experiences of working on a sex-offender treatment programme, where such splitting allowed the participants to empathise with those in their care.

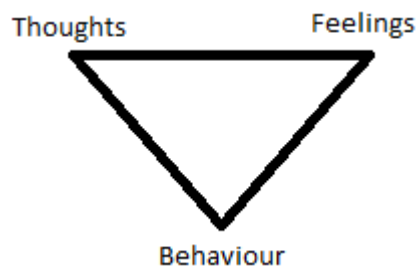


FIGURE 4 - TRIANGLE OF COMMUNICATION, (WARNER, 2009)

Linked to this tension was a feeling held by some of the women that they may have been personally responsible in causing sexualised challenging behaviour, which has parallels with societal discourses of victim blame in sexual assault. One theory regarding victim blaming was put forward by criminologist von Hentig (1940). This theory, victim precipitation, proposed that victims of rape were blamed as their 'personalities', behaviour, or inactions were perceived to have invited sexual abuse. Although this theory has been heavily criticized due to unfounded assumptions, ignorance of social change, and the rise of feminism (Cortina et al., 2017) recent research into perceptions of sexual violence demonstrates instances of victim blaming still occurs (Felson & Palmore, 2018; Hackman *et al.*, 2017). Within this research, the women gave examples of how they had seemed to have internalised messages that staff were responsible for inviting the abuse. There was evidence that women blamed themselves due to their 'personalities' (*is it my fault that (...) my personality, isn't that kind of person; Callie*), 'inaction' (*should I have spoken up sooner; Callie*) or behaviours

(*plastered in make-up, shirt unbuttoned; Anna*). The latter quotes are also reflective of societal discourses about sexual abuse that presume women invite abuse through fitting socially constructed ideals concerning a sexualized female appearance (Loughnan *et al.*, 2013; Shaw *et al.*, 2017). Thus through these discourses the women might feel further responsible for the abuse they have endured, feel less able to speak out or gain support from the system, and justify providing support to the men who can be perceived as less responsible for their actions.

In their accounts of the men's SCB, the women appeared to view them as either sexually deviant or asexual. This has parallels with existing literature on ID and sexuality (McRuer & Mollow, 2012; Winges-Yanez, 2014). Particularly for Danielle, this appeared to be linked with the patients' level of cognitive functioning, whereby she viewed the individuals who were lower functioning as being asexual. It appeared that the women found it more difficult to work with the patients if they felt behaviours were a means to gain sexual gratification, and it appeared difficult for staff to recognise the sexuality of the patients. There are also links with attribution theory, in that staff view patients as being less in control of their behaviour, if they are deemed to be lower functioning (Tynan & Allen, 2002). However, on the opposite side of this, viewing the patient as asexual may also link back to the victim blaming discourses, in that if the patient was not sexually motivated, then the SCB may have been caused somehow by the staff member.

The women spoke about an enduring sense of danger felt in working day by day with patients with SCB, and a sense of hypervigilance and need to protect that came with this. Previous research into challenging behaviour has demonstrated that fear and anxiety is greater among staff where the behaviour is perceived to be of a higher severity and frequency (Lambrechts *et al.*, 2009). Furthermore, Raczka (2005) found that staff reported a range of physical and emotional negative responses in relation to challenging behaviour, along with anticipation of the behaviour, which resonated with experiences of the women in the present study (*my stomach's churning, Callie; I don't sleep very well, Becca; you're carrying it around, Danielle; I do worry about it all day, Anna*). Furthermore, Mills and Rose (2011) found that staff who

reported greater fear of assault, also reported higher levels of burnout, and this replicated findings from previous studies into negative emotional response and burnout amongst care staff (e.g. Mitchell & Hastings 2001). Research into the impact of sexual assault has highlighted high rates of post-traumatic stress reactions, including hypervigilance to danger, with support networks identified as protective factors (Kramer & Green, 1991). These studies demonstrate the need for staff to be supported not only in managing the challenging behaviour of patients, but to be supported in managing their emotional responses.

However, the women in the present study felt they were not supported in their experiences of negative emotions to the challenging nature of their work. The women spoke about feeling their emotional reactions were both disregarded and discouraged. This led to some of the women 'shutting off' from emotional experiences ("I'm numb to it"; **Anna**). This may have served the purpose of defending against thoughts and feelings which could not be safely expressed. This shutting off from emotional experiences was also found by Lee and Kiemle (2015) in their exploration of care staff experiences in working with patients with ID and personality disorder. In line with this, both Lee and Kiemle (2014) and Mills and Rose (2011) highlighted the need for staff to receive adequate supervision and debriefings in order to manage the emotional impact of the work.

In light of the above, the author feels Warner's (2009) theory offers a better theoretical understanding of staff understanding and meaning making of SCB, than that of Weiner's (1986) attributional theory. Warner's (2009) theory allows for more complex understandings of challenging behaviour, and allows for the role of relationships within this. However, the theory has not been researched. As such, further research into the theory is called for, to further explore how the theory supports staff experiences of caring for men with SCB,

Finally, the results could also be understood in terms of attachment theory. Within the field of ID, recent developments have highlighted the importance of understanding and working with attachment when supporting individuals with ID (BPS, 2017). The super-ordinate themes within the results highlight three elements of

attachment that are required for enriching relationships: *emotional safety* – which is threatened by the lack of certainty about what the right thing to do is; *actual physical safety* – which is threatened by the vigilance to threat; and *a benign presence of authority* to provide this safety, care and validation – which is threatened by the absence of a support from management at work. In light of this, it might be possible to view the results under one super-ordinate category of “Threats to Attachment Security in the Role of Staff at Risk from Sexualised Challenging Behaviour” which would link all three super-ordinate themes theoretically.

4.3. Clinical Implications

The results have illustrated the complexities in understanding how care staff make sense of SCB. The way staff make sense of SCB cannot be simplified into various positions on dichotomous dimensions of attributions as per attribution theory: In reality, the relationship staff have with challenging behaviour is much more complex, with staff holding multiple views at any one time.

The findings have illustrated the difficulties staff have in separating out the patient from the behaviour when trying to investigate staff views of CB. Clinical implications exist for the relationship staff have with patients, if they are unable to see past the behaviour which challenges. Within the literature on attachment, good quality care with high levels of attunement and empathy between staff and individuals, is thought to be important for an individual’s emotional security and well-being (Schuengel *et al.*, 2010). If staff are ‘shutting off’ from individuals, for their own emotional protection, this then may lead to individuals within the system receiving less than adequate care. Furthermore, individuals may perceive staff to be dismissing of them, which could potentially be further detrimental to well-being, and may also exacerbate challenging behaviours, causing staff to further withdraw. In addition, Skelly (2016) speaks of the importance of staff remaining compassionate and empathic towards the individual’s they are supporting. Reduced empathy could also result in splitting among teams, especially where there is a disconnect regarding the amount of negative emotion experienced, and differing beliefs that one should be able to tolerate such emotional responses (Skelly, 2016).

In light of this, staff need to be able to feel supported in being able to honestly discuss how patients make them feel, without the fear of being perceived negatively. This research has highlighted the importance of direct care staff feeling able to talk about the inevitable difficult thoughts and feelings arising from working with SCB, and the need for services to address this. The Schwartz Rounds® programme (The Kenneth B. Schwartz Center, 2008) recognises experiencing negative emotion is an inevitable part of patient care, whilst acknowledging that care staff often have no outlet for expressing such feelings. As such, the programme promotes a multidisciplinary forum where staff can discuss emotional issues in an open and honest manner, in a supportive space. The rationale behind the programme is that staff will be better enabled to care for patients if they have a greater insight into their own emotional responses to the work. Studies into the effectiveness of Schwartz Rounds have demonstrated that attendance to such forums have enabled staff to feel more connected to patients, feel less alone in their experiences at work, and be more aware of the emotional impact of their work (Farr & Barker, 2017; Moore & Phillips, 2009). Furthermore, Haydon-Laurel *et al.* (2009) argue that offering systemic consultation with staff teams will enable further sense making of difficult experiences. This highlights an opportunity for clinical psychologists within teams to promote a culture of open expression of feelings, and to help staff voice and name prejudices that they might find difficult to speak about, in order that these understandings can collaboratively be discussed in ways that remain respectful of staff and service users.

4.4. Limitations and Recommendations for Future Research

The current research focused on women's experiences of supporting men with SCB. In line with an IPA approach, purposive sampling was utilised to gain a relatively homogenous sample in order to explore the meaning making of a specific group (Smith *et al.*, 2009). As IPA is purposefully idiographic, the findings are unlikely generalisable to the wider population. However, it is possible that other women working with men with ID displaying SCB may have had similar experiences under similar circumstances that could be compared with the findings from the present study. However, the sample may have been more homogenous than initially anticipated. Although the

research was opened up to four inpatient sites, participants were not represented from each site. Furthermore, three of the four participants fell into the 40 to mid-50 age bracket, and all participants were white British. As such, further research into the experiences of male staff, as well as staff working in different settings, and from different backgrounds, would be beneficial in order to gain a more rounded understanding of care staff's meaning making of SCB.

With regards to potential bias, the researcher's role as a trainee clinical psychologist may have impacted upon what information the participants shared in their accounts of their experiences. Furthermore, the researcher was lead analyst in the interpretation and write up of the results. However, in order to ensure reflexivity, the researcher discussed findings in supervision to ensure the interpretations remained grounded in the data. A reflective journal also enabled personal reflections on the recruitment, data collection, and analysis processes.

It remains unclear as to why staff feel they are unable to speak about how supporting individuals with SCB makes them feel, or why services appear to position staff into not talking about emotions. As such, further research into perceptions of experiencing negative emotions among care staff would be warranted. Furthermore, it would be of benefit to explore what kinds of support would be beneficial to staff, as well as the perceived barriers to this. In line with this, further research into the impact of being 'unheard' on staff members would enrich this understanding.

Previous research into attitudes has often taken a form of a top down approach. The current research highlights how constrained staff feel with regards to what they think they should say or feel; as such more qualitative research advocating a bottom up approach should be encouraged. Although the present study utilised a qualitative design, the author was responsible for interpretation. Action research methods (Reason, 2003) or participant validation methods might support a more collaborative approach to generating understandings of staff experiences. Furthermore, it would be important to explore the roles of managers in services and policy making, in order to allow for working environments where staff do feel supported in expressing emotions.

Finally, there is the potential for quantitative research in this area. It would be beneficial for research into the effects of Schwartz rounds in staff who experience SCB. Furthermore, in light of the results being able to be viewed in line with attachment theory, research into attachment-informed workshops on staff and patient outcomes would be of benefit.

4.5. Conclusions

This research has shown that care staff meaning making of SCB is complex. Staff appear conflicted between wanting to give care, yet endured abusive experiences as a consequence of this. This led to tensions as to whether the staff believed the men they worked with were deserving of such care. This was further complicated by staff fearing for the safety of themselves and others at work, and a sense of being undervalued, unheard, and uncared for as a staff member. Further qualitative research is called for in exploring the effects of feeling unheard, as well as exploring services factors which may exacerbate or alleviate this.

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Part Three: Critical Appraisal

Reflections of undertaking the research

1. Introduction

The purpose of the critical appraisal is to share my reflections of the research process. In doing so, I will consider the development of the research question, through to collecting data, analysis, and write up. I will also consider how the research has impacted upon my personal and professional development.

2. Choosing a Research Topic

I came to training from having had three years' experience working as an Assistant Psychologist in an inpatient unit for men with intellectual disabilities (ID) and challenging behaviour. This experience had increased my interest in the ID field, specifically how staff teams viewed the notions of 'challenging behaviour'. I also had an interest in the needs of staff teams; in a previous role I had undertaken a training needs analysis for support workers in an inpatient unit for men with enduring mental health needs, and was surprised at how many staff felt they required more training in understanding the behaviour of their patients. Furthermore, in both of these roles, I had experienced the tendency for higher management within these organisations to place blame with the immediate staff team for contributing to patients' behaviours, as well as the lack of a structured space for staff to explore their feelings.

I came to training having had very little experience of conducting research projects. Therefore, I was extremely interested to hear various proposals from the staff team. I was immediately drawn to an idea that was presented by, who would become, my research supervisor. This was for a qualitative piece of work examining how staff teams constructed challenging behaviour in incident forms. This led to an initial literature review in my first year, examining the literature to gain an understanding of the attitudes and responses care staff had towards individuals with learning disabilities who engaged in challenging behaviour. However, through conducting this review it became apparent to me that most of the literature used pre-determined response scales in order to elicit attitudes. Within supervision, we reflected that these papers had not explored what it was actually like for care staff to be working with challenging behaviour. In terms of the original research proposal, we

also discussed that staff teams were trained in how to write incident forms, and therefore are very objective. Again, this would not have allowed for any exploration of what it was like for staff to experience challenging behaviour. As such, it was decided that the research would allow for a qualitative exploration of the experiences of staff members working of challenging behaviour. Due to the breadth of the nature of challenging behaviour, it was decided to focus on one particular topography. I chose to focus on sexualised challenging behaviour for two reasons. Firstly, as an Assistant Psychologist, although I had never experienced sexualised challenging behaviour directed towards myself, I was acutely aware of the impact this had on some of the support workers who had experienced the behaviour on a regular basis. Secondly, through my review of the literature, it became apparent that sexualised challenging behaviour in intellectual disabilities was a relatively under-researched area.

3. Choosing a Methodology

Qualitative methodology has always been of an interest to me, and fits with my own views of how individuals make sense of experiences. As a Trainee Clinical Psychologist, I am very drawn to systemic approaches, which advocate multiple perspectives in understanding such experience, therefore dismissing that one 'true' reality exists (Hedges, 2005). In light of the conversations I'd had in supervision, and gaps in the existing published research, I wanted to choose a research question that allowed myself as the researcher to get close to the staff lived experiences. Interpretative Phenomenological Analysis (Smith *et al.*, 2009) therefore was felt to fit best with this aim, due to IPA being an approach concerned with how people make sense of their lived experiences, and exploring the experience in its own terms (Smith *et al.*, 2009).

4. Research Ethics

I commenced this study without any experience of previous clinical research or navigating ethical boards, and as such felt very apprehensive as to what this may entail. Prior to submitting to ethics, my research proposal underwent a peer review at the University, which received positive feedback. As my research was not going to use

service users' as participants, it was decided that the research would go through the University of Leicester's Ethics Board, as opposed to IRAS. Although submitting to the University ethics board went smoothly, at the time changes were being made to the IRAS system, whereby HRA was being introduced. This caused confusion with the local NHS R&D board, and led to some conflict between what both they and the University ethics board required, thereby delaying local R&D approval.

5. Recruitment and Data Collection

5.1. Recruitment

Due to the delays in gaining ethical approval, I was eager to commence the recruitment process. Initially I was very optimistic about potential uptake for the study, due to field supervisors identifying that a large proportion of the staffing teams would meet the inclusion criteria. Conversations were had in supervision as to what would happen if more participants wanted to take part than the nature of the study would allow. It was decided that if that was to happen, participants would be chosen in a way as to ensure homogeneity of the sample.

I made contact with all the sites and attended staff meetings to explain the research in detail. In all cases I was met with enthusiasm, with staff verbally expressing an interest. However, after two weeks, no one had registered interest by returning the opt-in form. I again re-contacted the services, and arranged to attend staff meetings. After a further month, the lack of interest was discussed in supervision, and it was agreed that I would request two amendments; one to be able to interview the participants at work if services were amenable to this; and two, to offer a small monetary reimbursement for the participants' time. A £25 voucher was agreed upon, after consultation with both my research supervisor and field supervisors. It was felt that this would offer incentive, but not be too high as to entice people into volunteering.

After these amendments were made, there was still no registered interest. As such, after consultation and agreement with the sites involved, I decided to offer "drop-in" clinics whereby staff could come and meet with me to ask questions about

the study, and arrange to be interviewed during the clinic time. At this point, four participants were recruited into the study, and consented to be interviewed.

Recruitment was then postponed for a year due to myself going on maternity leave. Upon my return I notified all the sites, and asked for advertisement posters to be re-displayed in staff areas. However, I was informed that the incidences of sexualised challenging behaviour had significantly reduced at all sites due to the patient turnover within the last year. As such, staff were no longer meeting the eligibility criteria. A further amendment was requested for a fourth site within the Midlands, which was approved. I met with the lead Clinical Psychologist at the service who was very hopeful that staff would participate. She informed me that she was very interested in staff resilience, given that the majority of female staff had regularly experienced sexualised challenging behaviour from the patients. However, after another six weeks, no one else registered interest. Again, this was discussed in supervision and I made the decision to cease recruitment and continue with analysis due to the upcoming deadline. I was reassured that I had recruited four participants, and Smith *et al.* (2009) had recommended three to six participants as being suitable for thesis level studies.

I was disappointed at the difficulties I'd faced with recruitment. I reflected on various reasons as to why staff may have not volunteered for the study. I knew from my experience of working in inpatient units that care staff are extremely busy. As such they may have felt unwilling to come in on their days off, or unable to give up their time to be interviewed whilst at work, due to the strain this may have placed on their colleagues. However, service managers had assured me that there would be adequate staff cover to allow for staff to attend the interviews. Staff may have also felt unwilling to discuss such a sensitive topic, or felt it would raise too much anxiety. This is something I further reflected on during the analysis process and the development of the theme "no one cares about the staff", that staff felt their views were invalidated, or dismissed. Furthermore, the #MeToo campaign (Schugerman, 2017) was highlighted by the media during the second round of recruitment, and I also wondered whether this would have impacted on individuals volunteering. I wondered whether

staff may have felt they were “jumping on the bandwagon”, or whether they may have drawn parallels with their experiences with sexualised challenging behaviour, and the reports of sexual abuse in the media, which felt uncomfortable.

5.2. The Interview Process

Having no prior IPA experience, I did a lot of reading around ‘how’ to conduct an IPA interview whilst waiting for participants. I also felt reassured by the interview guide which I had developed in collaboration with my research supervisor. Having discussed this in supervision, we reflected on the importance of the guide being a ‘loose guide’ to allow the participants to speak about topics of importance to them, and to keep a focus on the ‘experience’.

I attended the first interview with slight apprehension, but also excitement that data collection was underway. During the initial interview, I was acutely aware of trying to remain a ‘researcher’ and not a ‘clinician’. At times this was testing, especially when discussing emotive topics. Nonetheless, I came away from the first interview with a sense of achievement. When I listened back to the interview, I noticed for the most part, I had managed to remain a ‘researcher’. However I also noticed at times some of my comments could have been perhaps ‘leading’, or that I may not have followed up on particular lines of enquiry. I took this as a learning point, and held these in mind for the following interviews.

I also reflected upon how the participants may have experienced myself during the interviews. As a Trainee Clinical Psychologist, I wondered whether they had perceived me as an “other”, akin to the management and MDT they felt unsupported by. I also wondered whether the fact I was pregnant had impacted upon what they felt they could disclose; particularly when one participant had spoken about how she felt some patients experienced pregnant women. However, all the women also thanked me for my time. At the time, I found this slightly puzzling, as I felt it should have been me thanking them, however following the development of the themes, I now wonder whether they appreciated the opportunity to be heard.

I also considered my own position in relation to the women. Having been part of an MDT, I often heard staff refer to the MDT as “those on the other side of the door”. Although this often appeared to be said in jest, as the MDT offices were situated in a corridor away from the main unit, I now wondered whether there was an underlying meaning to these comments, in that MDT and support staff felt separate from one another. I also reflected on my own frustrations within the MDT that psychology often felt “unheard” by the support staff.

Following the collection of all the data, I had some worries about whether the data was “good enough”. This worry was further compounded by the fact that I hadn’t managed to recruit my original target of 6 participants. However, the data was discussed in supervision, and I was reassured by comments from my supervisor about the interesting and rich nature of the data.

5.3. Transcription of Interviews

I initially made notes immediately after the interviews, and listened to them back in order to record my initial reflections. However due to my maternity leave, transcription was commenced a few months after the initial data collection. I chose to transcribe the data myself to help get close to the data, as suggested as the first stage of IPA analysis. Although I am glad I chose to transcribe the data myself, due to the understanding I was able to develop of the data, I grossly underestimated how time consuming this task would be. I was taken by surprise when transcribing the interviews, that I was least able to recall the third interview. I wondered whether this reflected the nature of being unheard and undervalued that women had discussed.

6. Data Analysis

6.1. Coding and Developing Themes

Although extremely time consuming, again an area I had under estimated, and over-whelming at times, I found the analysis process very enjoyable and enlightening. Following IPA guidelines, I processed each transcript individually. However, I did often

notice similarities and contrasts between participants. When this happened, I made efforts to come to the individual, and to focus on their experiences.

During the analysis process, I attended an IPA workshop facilitated by Dr Michael Larkin where I was able to bring along examples of my data and coding. This enabled me to increase my confidence in my coding, and that I was actually “doing IPA”. Nevertheless, when developing the emergent themes, I was worried about being both over and under inclusive. This was discussed extensively in supervision, and I was often prompted to think about the experience for the individual, and whether the interpretations I was making were being based in the data, and were experiential claims.

Another area discussed extensively in supervision was the naming of themes. I initially found it challenging to make sure I was using experiential labels, and that the label captured the entirety of the theme. This also enabled me to reflect on the themes I had created, to ensure they were inclusive of participants, and to check they were all distinct themes in their own right.

6.2. Writing up the Results

As I started to write up the research report, I noted how many quotes I had selected for inclusion within each theme. I realised that I would not be able to incorporate all these into the write up, so revisited each transcript to make sure I had incorporated those that I had highlighted to be of significant relevance to each participant. This had been aided by notes I’d made regarding what I had termed the ‘core essence’ of each interview.

When writing up the results I was also acutely aware of trying to keep a balance between being descriptive and interpretative. Although I was initially worried I would be too descriptive, I was pleased with the interpretative stance I’d taken.

7. Dissemination

Given the dearth of research regarding sexualised challenging behaviour and intellectual disabilities, it feels very important that the results from the research are disseminated appropriately. Particularly, with regards to staff experiencing negative emotions as a result of their experiences, and not having the opportunity to discuss this. The findings have particular importance to staff wellbeing, which appears to be a neglected area in the extant literature.

Firstly, all the participants expressed a wish to receive a copy of the research report. As such, I will contact the participants to arrange for them to receive this. Second, the research will be presented at a research conference in September 2018. Finally, I have spoken to my research supervisor regarding the possibility for submitting the research for publication.

8. Personal and Professional Development

Overall, I have found the research process to be extremely challenging, yet rewarding. I feel my confidence has grown in navigating the ethics and research process in the future, a competency required of a clinical psychologist. I have however, a greater insight into the challenges of research, and have a greater understanding of why clinicians may feel unable to embark on research whilst in full time clinical roles. Although this process at times has felt never-ending, I am grateful I have had the opportunity to have dedicated time to see a research project through, from generating an initial research question, to the final write up.

The past six months have been particularly challenging, requiring me to juggle clinical placements, research, and home life. This was particularly difficult due to having a young toddler at home, and due to the recent ill-health of an immediate family member. At times it felt as though research had become all consuming, and I felt torn as to where I should be placing my time and energy. However, this has further increased the importance of keeping perspective, and highlighted the need for planning, and not underestimating research tasks.

Something I found of particular interest to me, was what it had felt like to hear from staff rather than patients. I became aware of the differences in my experiences as a clinician, to those described by the participants. I felt privileged in terms of being able to access reflective supervision, and reflective practice groups, which actively encouraged me to think about my own emotional reactions, to the work. I came to the realisation that I had taken these opportunities for granted, and had assumed that care staff would have had a similar space in their own supervisions.

Overall, I feel more confident regarding completing research in the future. The process has enabled me to gain an appreciation of the difficulties clinicians face in completing research, but also the necessity for the well-being of staff to be highlighted by research. I feel extremely grateful to the four women who shared their experiences with me. I hope that as I embark on my career as a clinical psychologist, I continue to hold their experiences in mind, to enable me to further help give care staff a voice within teams, where perhaps this has been lost.

9. References

Hedges, F. (2005). *An Introduction to Systemic Therapy with Individuals: A Social Constructionist Approach*. Palgrave USA, Gordonsville

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Appendices

Appendix A: Guidelines for Authors

Author Guidelines: Journal of Applied Research in Intellectual Disabilities

1. GENERAL

The *Journal of Applied Research in Intellectual Disabilities* is an international, peer-reviewed journal which draws together findings derived from original applied research in intellectual disabilities. The journal is an important forum for the dissemination of ideas to promote valued lifestyles for people with intellectual disabilities. It reports on research from the UK and overseas by authors from all relevant professional disciplines. It is aimed at an international, multi-disciplinary readership.

The topics it covers include community living, quality of life, challenging behaviour, communication, sexuality, medication, ageing, supported employment, family issues, mental health, physical health, autism, economic issues, social networks, staff stress, staff training, epidemiology and service provision. Theoretical papers are also considered provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. All original and review articles continue to undergo a rigorous, peer-refereeing process.

Please read the instructions below carefully for details on submission of manuscripts, the journal's requirements and standards as well as information concerning the procedure after a manuscript has been accepted for publication. Authors are encouraged to visit <http://authorservices.wiley.com/bauthor/> for further information on the preparation and submission of articles.

All manuscripts must be submitted solely to this journal and not published, in press, or submitted elsewhere.

2. ETHICAL GUIDELINES

Acceptance of papers is based on the understanding that authors have treated research participants with respect and dignity throughout. Please see Section 2.2 below.

2.1 Authorship and Acknowledgements

Authorship: Authors submitting a paper do so on the understanding that the manuscript has been read and approved by all authors and that all authors agree to the submission of the manuscript to the journal. ALL named authors must have made an active contribution to the conception and design and/or analysis and interpretation of the data and/or the drafting of the paper and ALL authors must have critically reviewed its content and have approved the final version submitted for publication.

Participation solely in the acquisition of funding or the collection of data does not justify authorship.

It is a requirement that all authors have been accredited as appropriate under submission of the manuscript. Contributors who do not qualify as authors should be mentioned under Acknowledgements.

Acknowledgements: Under Acknowledgements please specify contributors to the article other than the authors accredited. Please also include specifications of the source of funding for the study and any potential conflict of interest if appropriate. Suppliers of materials should be named and their location (town, state/county, country) included.

2.2 Ethical Approvals

Research involving human participants will only be published if such research has been conducted in full accordance with ethical principles, including the World Medical Association Declaration of Helsinki (version, 2002 www.wma.net) and the additional requirements, if any, of the country where the research has been carried out. Manuscripts must be accompanied by a statement that the research was undertaken with the understanding and written consent of each participant (or the participant's representative, if they lack capacity), and according to the above mentioned principles. A statement regarding the fact that the study has been independently reviewed and approved by an ethical board should also be included.

All studies using human participants should include an explicit statement in the Material and Methods section identifying the review and ethics committee approval for each study, if applicable. Editors reserve the right to reject papers if there is doubt as to whether appropriate procedures have been used.

Ethics of investigation: Papers not in agreement with the guidelines of the Helsinki Declaration as revised in 1975 will not be accepted for publication.

2.3 Clinical Trials

Clinical trials should be reported using the CONSORT guidelines available at www.consort-statement.org. A CONSORT checklist should also be included in the submission material (www.consort-statement.org).

The *Journal of Applied Research in Intellectual Disabilities* encourages authors submitting manuscripts reporting from a clinical trial to register the trials in any of the following free, public trials registries: www.clinicaltrials.org, www.isrctn.org. The clinical trial registration number and name of the trial register will then be published with the paper.

2.4 Conflict of Interest and Source of Funding

Conflict of Interest: Authors are required to disclose any possible conflict of interest. These include financial (for example patent ownership, stock ownership, consultancies, speaker's fee). Author's conflict of interest (or information specifying the absence of conflict of interest) will be published under a separate heading.

The *Journal of Applied Research in Intellectual Disabilities* requires that sources of institutional, private and corporate financial support for the work within the manuscript must be fully acknowledged, and any potential conflict of interest noted. As of 1st March 2007, this information is a requirement for all manuscripts submitted to the journal and will be published in a highlighted box on the title page of the article. Please include this information under the separate headings of 'Source of Funding' and 'Conflict of Interest' at the end of the manuscript.

If the author does not include a conflict of interest statement in the manuscript, then the following statement will be included by default: 'No conflict of interest has been declared'.

Source of Funding: Authors are required to specify the source of funding for their research when submitting a paper. Suppliers of materials should be named and their location (town, state/county, country) included. The information will be disclosed in the published article.

2.5 Permissions

If all or parts of previously published illustrations are used, permission must be obtained from the copyright holder concerned. It is the author's responsibility to obtain these in writing and provide copies to the Publishers.

2.6 Copyright Assignment

If your paper is accepted, the author identified as the formal corresponding author for the paper will receive an email prompting them to login into Author Services; where via the Wiley Author Licensing Service (WALS) they will be able to complete the license agreement on behalf of all authors on the paper.

For authors signing the copyright transfer agreement

If the OnlineOpen option is not selected the corresponding author will be presented with the copyright transfer agreement (CTA) to sign. The terms and conditions of the CTA can be previewed in the samples associated with the Copyright FAQs below:

CTA Terms and

Conditions http://authorservices.wiley.com/bauthor/faqs_copyright.asp

3. ONLINEOPEN

For authors choosing OnlineOpen

If the OnlineOpen option is selected the corresponding author will have a choice of the following Creative Commons License Open Access Agreements (OAA):

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To preview the terms and conditions of these open access agreements please visit the Copyright FAQs hosted on Wiley Author

Services http://authorservices.wiley.com/bauthor/faqs_copyright.asp and visit <http://www.wileyopenaccess.com/details/content/12f25db4c87/Copyright--License.html>.

If you select the OnlineOpen option and your research is funded by The Wellcome Trust and members of the Research Councils UK (RCUK) you will be given the opportunity to publish your article under a CC-BY license supporting you in complying with Wellcome Trust and Research Councils UK requirements. For more information on this policy and the Journal's compliant self-archiving policy please visit: <http://www.wiley.com/go/funderstatement>.

4. SUBMISSION OF MANUSCRIPTS

Submissions are now made online using ScholarOne Manuscripts (formerly Manuscript Central). To submit to the journal go to <http://mc.manuscriptcentral.com/jarid>. If this is the first time you have used the system you will be asked to register by clicking on 'create an account'. Full instructions on making your submission are provided. You should receive an acknowledgement within a few minutes. Thereafter, the system will keep you informed of the process of your submission through refereeing, any revisions that are required and a final decision.

4.1 Manuscript Files Accepted

Manuscripts should be uploaded as Word (.doc) or Rich Text Format (.rft) files (not write-protected) plus separate figure files. GIF, JPEG, PICT or Bitmap files are acceptable for submission, but only high-resolution TIF or EPS files are suitable for printing.

To allow double-blinded review, please upload your manuscript and title page as **separate** files.

Please upload:

1. Your manuscript without title page under the file designation 'main document'.

2. Figure files under the file designation 'figures'.
3. Title page which should include title, authors (including corresponding author contact details), acknowledgements and conflict of interest statement where applicable, should be uploaded under the file designation 'title page'.

All documents uploaded under the file designation 'title page' will not be viewable in the HTML and PDF format you are asked to review at the end of the submission process. The files viewable in the HTML and PDF format are the files available to the reviewer in the review process.

Please note that any manuscripts uploaded as Word 2007 (.docx) will be automatically rejected. Please save any .docx files as .doc before uploading.

4.2 Blinded Review

All articles submitted to the journal are assessed by at least two anonymous reviewers with expertise in that field. The Editors reserve the right to edit any contribution to ensure that it conforms with the requirements of the journal.

5. MANUSCRIPT TYPES ACCEPTED

Original Articles, Review Articles, Brief Reports, Book Reviews and **Letters to the Editor** are accepted. **Theoretical Papers** are also considered provided the implications for therapeutic action or enhancing quality of life are clear. Both quantitative and qualitative methodologies are welcomed. Articles are accepted for publication only at the discretion of the Editor. Articles should not exceed 7000 words. Brief Reports should not normally exceed 2000 words. Submissions for the Letters to the Editor section should be no more than 750 words in length.

6. MANUSCRIPT FORMAT AND STRUCTURE

6.1 Format

Language: The language of publication is English. Authors for whom English is a second language must have their manuscript professionally edited by an English speaking person before submission to make sure the English is of high quality. It is preferred that manuscripts are professionally edited. A list of independent suppliers of editing services can be found

at http://authorservices.wiley.com/bauthor/english_language.asp. All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

6.2 Structure

All manuscripts submitted to the *Journal of Applied Research in Intellectual Disabilities* should include:

Cover Page: A cover page should contain only the title, thereby facilitating anonymous reviewing. The authors' details should be supplied on a separate page and the author for correspondence should be identified clearly, along with full contact details, including e-mail address.

Running Title: A short title of not more than fifty characters, including spaces, should be provided.

Keywords: Up to six key words to aid indexing should also be provided.

Main Text: All papers should have a structured abstract (maximum 150 words) as follows: Background, Method, Results, and Conclusions. The abstract should provide an outline of the research questions, the design, essential findings and main conclusions of the study. Authors should make use of headings within the main paper as follows: Introduction, Method, Results and Discussion. Subheadings can be used as appropriate. All authors must clearly state their research questions, aims or hypotheses clearly at the end of the Introduction. Figures and Tables should be submitted as a separate file.

Style: Manuscripts should be formatted with a wide margin and double spaced. Include all parts of the text of the paper in a single file, but do not embed figures. Please note the following points which will help us to process your manuscript successfully:

- Include all figure legends, and tables with their legends if available.
- Do not use the carriage return (enter) at the end of lines within a paragraph.
- Turn the hyphenation option off.
- In the cover email, specify any special characters used to represent non-keyboard characters.
- Take care not to use l (ell) for 1 (one), O (capital o) for 0 (zero) or ß (German esszett) for (beta).
- Use a tab, not spaces, to separate data points in tables.
- If you use a table editor function, ensure that each data point is contained within a unique cell, i.e. do not use carriage returns within cells.

Spelling should conform to *The Concise Oxford Dictionary of Current English* and units of measurements, symbols and abbreviations with those in *Units, Symbols and Abbreviations* (1977) published and supplied by the Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE. This specifies the use of S.I. units.

6.3 References

APA - American Psychological Association

References should be prepared according to the Publication Manual of the American Psychological Association (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper.

A sample of the most common entries in reference lists appears below. Please note that a DOI should be provided for all references where available. For more information

about APA referencing style, please refer to the [APA FAQ](#). Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page one.

Journal article

Example of reference with 2 to 7 authors

Beers, S. R. , & De Bellis, M. D. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *The American Journal of Psychiatry*, 159, 483–486. doi:10.1176/appi.ajp.159.3.483

Ramus, F., Rosen, S., Dakin, S. C., Day, B. L., Castellote, J. M., White, S., & Frith, U. (2003). Theories of developmental dyslexia: Insights from a multiple case study of dyslexic adults. *Brain*, 126(4), 841-865. doi: 10.1093/brain/awg076

Example of reference with more than 7 authors

Rutter, M., Caspi, A., Fergusson, D., Horwood, L. J., Goodman, R., Maughan, B., ... Carroll, J. (2004). Sex differences in developmental reading disability: New findings from 4 epidemiological studies. *Journal of the American Medical Association*, 291(16), 2007-2012. doi 10.1001/jama.291.16.2007

Book Edition

Bradley-Johnson, S. (1994). Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school (2nd ed.). Austin, TX: Pro-ed.

6.4 Tables, Figures and Figure Legends

Tables should include only essential data. Each table must be typewritten on a separate sheet and should be numbered consecutively with Arabic numerals, e.g. Table 1, and given a short caption.

Figures should be referred to in the text as Figures using Arabic numbers, e.g. Fig.1, Fig.2 etc, in order of appearance. Figures should be clearly labelled with the name of the first author, and the appropriate number. Each figure should have a separate legend; these should be grouped on a separate page at the end of the manuscript. All symbols and abbreviations should be clearly explained. In the full-text online edition of the journal, figure legends may be truncated in abbreviated links to the full screen version. Therefore, the first 100 characters of any legend should inform the reader of key aspects of the figure.

Preparation of Electronic Figures for Publication

Although low quality images are adequate for review purposes, print publication requires high quality images to prevent the final product being blurred or fuzzy. Submit EPS (line art) or TIFF (halftone/photographs) files only. MS PowerPoint and Word Graphics are unsuitable for printed pictures. Do not use pixel-oriented programmes. Scans (TIFF only) should have a resolution of at least 300 dpi (halftone)

or 600 to 1200 dpi (line drawings) in relation to the reproduction size. Please submit the data for figures in black and white or submit a Colour Work Agreement Form. EPS files should be saved with fonts embedded (and with a TIFF preview if possible).

Further information can be obtained at Wiley-Blackwell's guidelines for figures: <http://authorservices.wiley.com/bauthor/illustration.asp>.

Check your electronic artwork before submitting it: <http://authorservices.wiley.com/bauthor/echecklist.asp>.

Permissions: If all or parts of previously published illustrations are used, permission must be obtained from the copyright holder concerned. It is the author's responsibility to obtain these in writing and provide copies to the Publisher.

Colour Charges: It is the policy of the *Journal of Applied Research in Intellectual Disabilities* for authors to pay the full cost for the reproduction of their colour artwork. Colour Work Agreement Form can be downloaded [here](#).

7. AFTER ACCEPTANCE

Upon acceptance of a paper for publication, the manuscript will be forwarded to the Production Editor who is responsible for the production of the journal.

7.1 Proof Corrections

The corresponding author will receive an e-mail alert containing a link to a website. A working e-mail address must therefore be provided for the corresponding author. The proof can be downloaded as a PDF file from this site.

Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from the following website:

www.adobe.com/products/acrobat/readstep2.html

This will enable the file to be opened, read on screen, and printed out in order for any corrections to be added. Further instructions will be sent with the proof. Proofs will be posted if no e-mail address is available; in your absence, please arrange for a colleague to access your e-mail to retrieve the proofs.

Proofs must be returned to the Production Editor within 3 days of receipt.

As changes to proofs are costly, we ask that you only correct typesetting errors. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately. Other than in exceptional circumstances, all illustrations are retained by the Publisher. Please note that the author is responsible for all statements made in their work, including changes made by the copy editor.

7.2 Early View (Publication Prior to Print)

The *Journal of Applied Research in Intellectual Disabilities* is covered by Wiley-Blackwell's Early View service. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have a volume, issue or page number, so Early View articles cannot be cited in the traditional way. They are therefore given a DOI (digital object identifier) which allows the article to be cited and tracked before it is allocated to an issue. After print publication, the DOI remains valid and can continue to be used to cite and access the article.

7.3 Author Services

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Appendix B: Search Strategy

| |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Search strings used for searching CINAHL Plus, PsycINFO, Scopus, and Web of Science Core Collection |
| |
| learning disab* OR intellectual disab* AND challenging behav* AND Attitude* OR attribution OR attributions OR beliefs OR experience* or emotion* OR respond OR responses OR perception* OR opinion* OR reaction* |

Appendix C: Data Extraction Form

| |
|-----------------------------------|
| Data Extraction Form |
| Article: |
| Title: |
| Year: |
| Author (1st only): |
| Aims: |
| Participants and sampling: |
| Study Design: |
| Measures: |
| Analysis: |
| Findings: |
| Conclusions: |
| Other comments: |

Appendix D: Quality Appraisal

| Criteria for Quantitative Studies 2 = fully met, 1 = partially met, 0 = not met | Bailey et al | Dagnan & Cairns | Dagnan et al | Dilworth et al | Gifford & Knott | Hill & Dagnan | Jones & Hastings | Kleinberg & Scior | Noone et al | Rose & Rose | Snow et al | Tynan & Allen | Weigel et al | Williams et al | Wishart et al |
|------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-----------------|--------------|----------------|-----------------|---------------|------------------|-------------------|-------------|-------------|-------------|---------------|--------------|----------------|---------------|
| 1 Question/objective sufficiently described? | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 2 |
| 2 Study design evident and appropriate? | 1 | 1 | 1 | 2 | 2 | 1 | 2 | 2 | 1 | 2 | 2 | 2 | 1 | 2 | 2 |
| 3 Method of subject/comparison group selection or source of information/input variables described and appropriate? | 1 | 1 | 0 | 2 | 1 | 1 | 2 | 1 | 1 | 2 | 1 | 2 | 1 | 2 | 1 |
| 4 Subject (and comparison group if applicable) characteristics sufficiently described? | 2 | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 1 | 1 | 2 | 1 | 2 | 2 |
| 5 If interventional and random allocation was possible, was it described? | N/A | N/A | N/A | N/A | 2 | N/A | 1 | 2 | N/A | N/A | N/A | 2 | N/A | N/A | N/A |
| 6 If interventional and blinding of investigators was possible, was it reported? | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 7 If interventional and blinding of subjects was possible, was it reported? | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 2 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 8 Outcome and (if applicable) exposure measures well defined and robust to measurement / misclassification bias? Means of assessment reported? | 2 | 1 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 1 | 1 |
| 9 Sample size appropriate? | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 2 | 1 | 1 | 2 |
| 10 Analytic methods described/justified and appropriate? | 2 | 2 | 2 | 2 | 2 | 1 | 2 | 2 | 1 | 2 | 1 | 2 | 2 | 2 | 1 |
| 11 Some estimate of variance is reported for the main results? | 0 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 0 | 2 | 2 | 2 | 2 | 2 | 2 |
| 12 Controlled for confounding? | N/A | N/A | N/A | N/A | 2 | N/A | 1 | 2 | N/A | N/A | N/A | 2 | 1 | 2 | 1 |
| 13 Results reported in sufficient detail? | 1 | 2 | 1 | 1 | 2 | 2 | 2 | 1 | 1 | 2 | 2 | 1 | 1 | 2 | 2 |
| 14 Conclusions supported by results? | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Score (total sum/possible sum) | 0.75 | 0.8 | 0.75 | 0.95 | 0.96 | 0.75 | 0.92 | 0.92 | 0.6 | 0.90 | 0.85 | 0.96 | 0.73 | 0.91 | 0.82 |

Appendix E: Characteristics of Publications

| STUDY DETAILS | AIMS | PARTICIPANTS & SETTING | METHOD AND MEASURES | ANALYSIS | RESULTS |
|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| BAILEY, HARE, HATTON & LIMB (2006) | To compare staff attributions for self-injurious behaviour compared to other types of challenging behaviour. | N = 43 Mean age =40.95 years (SD=10.33) Gender = undisclosed Mean experience = 10.48 years, (SD=6.20) Day centres | Method: Staff identified patients that engaged in: self-injurious behaviour; other CB; both SI and other CB, then completed a range of measures Measures: Challenging Behaviour Attributions Scale (CHABA, Hastings 1997) Emotional Responses to Challenging Behaviour Scale (ERCB, Mitchell & Hastings 1998). | Paired T-Test Pearsons Correlation | Depression/anger sig correlated with uncontrollable attributions for SIB ERCB sig correlated with uncontrollable attributions for both CB and SIB Internal and stable attributions were sig positively correlated with depression/anger scores. |
| DAGNAN & CAIRNS (2005) | To examine the importance of staff judgements of responsibility for challenging behaviour in predicting their emotional responses | N = 62 Mean age = 36.2 (SD=10.9) Gender = 32 female; 30 male Mean experience = 8.5 years (SD=8.0) Residential | Method: Participants read the vignette then completed a range of measures Measures: Attributional Style Questionnaire (ASQ) Modified by Peterson <i>at al.</i> (1982) Emotional response: (anger & sympathy) rated on 7-point bipolar scale Responsibility for Challenging behaviour: 2 separate questions on 7-point bipolar scale regarding responsibility for development of, and future change of the behaviour. | Bivariate correlations of all variables | Attributions of internal causes are negatively correlated with sympathy. Stability correlates positively with sympathy |
| DAGNAN, MCDOWELL & JAMES (2015) | To examine beliefs concerning causes of CB, as well as the attributions and | N = 23 Mean age = 39.8 (SD=12.5) Gender = 12 female; 11 male Mean experience = 7.2 years | Method: Participants completed individual interviews to complete measures for each vignette | Friedman non-parametric ANOVA | Staff viewed stereotypic behaviour as more internal than aggression and self-injury Feel more angry about physical aggression than SIB and |

| | | | | | |
|----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | emotions in response to CB. | (SD=6.5) Day services | <p>Measures: ASQ Peterson <i>et al.</i> (1982)</p> <p>Rate on an analogue line how they would feel on four emotions- anger, happiness, sympathy and fear, from 'not at all' to 'very'</p> <p>Causes of CB were coded using the categories identified in the CHABA (Hastings 1997)</p> | | <p>stereotypy</p> <p>Happier about physical aggression than SIB and stereotypy</p> <p>Happier about stereotypy than SIB</p> <p>More sympathetic about SIB and stereotypy than aggression</p> <p>Less frightened of stereotypy than aggression and SIB</p> <p>Causes of CB:</p> <p>SIB – primarily caused by emotional factors</p> <p>Aggression – learned positive reinforcement or stimulation</p> <p>Stereotypy – emotional causes with learned negative reinforcement</p> |
| DILWORTH, PHILLIPS, & ROSE (2011) | To explore the relationship between attributions of control over challenging behaviour , and personal and organisational factors | <p>N = 139</p> <p>Mean age= age between 18 and 66</p> <p>Gender= 108 females, 31 males</p> <p>Mean experience= 6 years (range 0-31)</p> <p>Residential</p> | <p>Method: Cross-sectional survey using a between-subjects natural groups design</p> <p>Residential key workers completed assessments in an interview format.</p> <p>Measures: The Systems Service Assessment (Allen 1999)</p> <p>Participants completed:</p> <p>Demographic information – gender, length of experience, shift pattern</p> <p>Disability Assessment Schedule(Behavioural items only; DAS-B; Holmes <i>et al.</i> 1982)</p> <p>Adaptive Behaviour Scale – Residential and Community 2nd Edition (part 1) (short from; SABS; Hatton <i>et al.</i> 2001)</p> | <p>Independent t-tests</p> <p>Between subjects ANOVA</p> <p>Spearman's Rho</p> | <p>There was no sig correlation relationship between attributions of control and overall ability of the individual.</p> <p>Aggression more controllable than SI</p> <p>Attributions of control over CB was lower if rater indicated that:</p> <ul style="list-style-type: none"> - Staff displayed positive attitude towards the client -The physical and social environment was appropriate - The overall approach to giving care seemed well structured. |

| | | | | | |
|-------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | | Controllability Beliefs Scale (CBS; Dagnan et al. 2004) | | |
| GIFFORD & KNOTT (2016) | To explore the effect of diagnostic label on attributions and emotion | N = 120 Mean age = 36.62 (SD=11.43) Gender = 75 female, 45 male Mean experience = 67% had between 1 and 3 years experience 'Private care service providers' | Method: watch one of three videos of a staff member talking about a fictional individual with CB, differing only in the diagnostic label (<i>Autism; Down's syndrome; and Unspecified ID</i>) Measures: CHABA (Hastings, 1997) | ANOVA | Less biomedical, more learned behaviour for UID than DS or Autism More positive emotions for autism and DS than UID More positive emotion in Autism |
| HILL & DAGNAN (2002) | To explore the relative impact upon helping intentions of attributions, emotions and coping style in response to challenging behaviour | N = 33 Mean age = unreported Gender = 25 female; 8 male Mean experience = 10.8 years (SD=10.3) Residential Day services | ERCB (Jones & Hastings, 2003) Method: Completed measures in response to vignette depicting aggression Measures: 2. Emotional response (anger & sympathy) rated on 7-point bipolar scale 3. Helping Intention; 7-point scale, on willingness to provide extra effort to the individual | Correlations Regression analysis for variables associated with intention to help | Significant relationship between internality & stability and sympathy – more sympathetic if view behaviour to be stable and external |
| JONES & HASTINGS (2003) | Assessed relationships between causal attributions and emotional responses | N = 123 Mean age = 35.92 (SD=9.4) Gender = 76 female; 47 male Mean experience = 48.2 months (SD=60.86 months) Residential Day services Community nursing team | Method: Participants viewed the video then asked to complete measures. Measures: Revised Causal Dimension Scale (CDS-II; McAuley et al., 1992) ERCB (as adapted by Jones & Hastings, 2003) | Spearman's Correlation | significant positive relationship between scores on the 'confident/relaxed' and controllable attributions Escape-maintained behaviour more likely to report controllable attributions ,as well as higher scores on the cheerful/excited confident/relaxed than attention maintained. |
| KLEINBERG & SCIOR (2014) | To assess the role of gender in influencing staff emotions and attributions, in response to aggression displayed by adults with | N = 160 Mean age = 36.5 (range 19-64) Gender = 83 female; 67 male; 10 undisclosed Mean experience = minimum | Method: Two x two (staff gender x service user gender) between subjects design Randomly assigned to male/female vignette by alternately being given | Chi-square Fisher's exact tests Principal component analysis | Attribution - Neither staff or service user gender influenced staff attributions Emotions: - Female participants reported feeling more fear/anxiety and less confident/relaxed than male participants, more |

| | | | | | |
|-------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | LD | 2 months Residential Day centres Short break services | questionnaire pack depicting male or female service user Asked to read a short vignette describing either a man or a woman with LD assaulting a staff member without an apparent trigger, and to imagine they were the staff member targeted Measures: ERCB (as adapted by Jones & Hastings, 2003) CDS-II (McAuley et al. 1992) | ANOVA | depression/anger than men. - Service user gender had no effect on staff emotional responses. |
| NOONE, JONES & HASTINGS (2006) | relationship between staff attributions and challenging behaviour causal variables | N = 23 Mean age = unreported Gender = 9 female; 14 male, Mean experience = 10.63 years (SD=7.20) Residential | Method: Two clients identified who engaged in aggressive behaviour, where function hypothesised to be different – A = escape and avoidance functions; B = attainment of tangible items Asked to complete ASQ's after witnessing an aggressive incident from the identified clients, rating each dimension on a seven-point bipolar rating scale from "very unlikely" to "very likely. For the purpose of analysis, a mean score was calculated to give a single averaged rating on each dimension Measures: ASQ, Peterson <i>at al.</i> (1982) | Wilcoxon Signed Ranks test | Causes of CB: - No difference between 2 clients for stable-unstable - Ratings differed for internal-external, personal-universal, controllable-uncontrollable. Client A – personable and controllable, B – more internal causes |
| ROSE & ROSE (2005) | To investigate impact of stress on attributions | N = 107 Mean age = 35.73 (SD=11.05) Gender = 76 female, 31 male Mean experience = 72.68 months (SD=81.04) Residential | Method: completed a self-report questionnaire Measures: Emotions: Likert scales, factor analysis ASQ Peterson <i>at al.</i> (1982) | Factor analysis Correlations | Stress had no impact on attributions Stress positively correlated with negative emotions Emotional exhaustion positively correlated with negative emotion Negative emotion positively correlated with unstable Empathy positively correlated with external |

| | | | | | |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | | General Health Questionnaire (GHQ, Goldberg 1972), Maslach Burnout Inventory (MBI; Maslach & Jackson, 1986) | | |
| SNOW, REYNOLDS LANGDON & (2007) | To investigate care staff causal attributions to SIB To examine relationships between cognitive variables and burnout. | N = 41 Mean age = 36.9 (SD=10.31) Gender = undisclosed Mean experience = undisclosed Inpatient | Method: participants took part in a semi-structured interview after reading vignettes Measures: Transcribed and coded using Leeds Attributional Coding System (LACS; Stratton et al. 1988) Demographic questionnaire MBI (Maslach & Jackson, 1986) | Wilcoxon Sign Ranked Test Spearman's rho | 440 attribution scores extracted Staff who had worked longer made significantly more internal and unstable attributions Significant negative correlation between frequency of stable attributions and emotional exhaustion |
| TYNAN & ALLEN (2002) | To examine the effects of SU level of ID on attributions of aggressive behaviour | N = 42 Mean age = not reported; 90% aged between 21 and 45 Gender = 25 female, 17 male Mean experience = 4 years 8 months (range 4 months-11 years) Residential | Method: Between-participants design. Measures: Demographic questionnaires Causal attribution questionnaire, previously used by Fenwick (1997) Likert scales | Mann-Whitney U-tests | Mild condition – service user perceived to have significantly more control over their behaviour. No significant difference in ratings of locus or stability Behaviour rated as significantly more challenging in severe condition. Participants in both conditions considered causes to be most likely to be due to emotional reasons or learnt behaviour. However biomedical causal factors were rated to be significantly greater in the severe ID condition |
| WEIGEL, LANGDON, COLLINS & O'BRIEN (2006) | To explore expressed emotion and attributions to challenging behaviour in a residential and day service placement | N = 15 Mean age = undisclosed Gender = undisclosed Mean experience = undisclosed Residential Day centres | CHABA (Hastings et al. 1997) Method: Interviews were transcribed and coded giving scores for criticism, hostility, emotional over-involvement, and warmth. Three blind raters with experience of EE coding coded. Measures: Modified version of the ASQ (Peterson <i>et al.</i> , 1982). Measure of EE (5 minute speech sample [FMSS], Magna <i>et al.</i> 1986). . | Wilcoxon sign test | - Significant positive correlation between personal-universal attribution and internal-external to client attribution - Significant negative correlation between uncontrollable-controllable by client attribution and personal-universal to the client Emotions - Significantly greater number of staff expressed High EE when talking about client with CB compared to no CB. - Made significantly more critical comments about client with CB, compared to client with no CB - Low EE – more likely to attribute CB as external to client, high EE more likely to attribute as internal - Low EE – more likely to attribute as uncontrollable |

| | | | | | |
|------------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| WILLIAMS ET AL (2015) | To see whether judgements of responsibility and control are mitigated by ability | N = 50 Mean age = 41.7 years (SD=11.4) Gender = 42 female, 8 male Mean experience = 8.9 years (SD=6.3) Supported living Residential | Method: Read vignettes depicting aggression. After reading each vignette, the participants completed: Measures: Likert scales for judgements of responsibility and emotional response | Kolmogorov–Smirnov Repeated measures ANOVA | - High EE – more likely to attribute a controllable Less responsibility if deemed to have communication difficulties |
| WISHART ET AL. (2013) | Whether emotion regulation style moderated the relationship between attributions and helping behaviour | N = 107 Mean age = 42 years (SD=10.9) Gender = 89 female, 18 male Mean experience = 12.8 years (SD=9.8) ‘Support organisations’ ‘ID online forums’ | Method: Completed either a paper questionnaire (56) or online questionnaire Measures: Emotion Regulation Questionnaire (ERQ; Gross & John, 2003). LACS (Stratton et al. 1988) | Pearson product-moment correlation coefficient | No significant relationships found |

Appendix F: Statement of Epistemological Position

The study was conducted from a contextual constructionist position. Researchers adopting this position reject the notion that one 'true' reality exists, in contrast with traditional realist frameworks (Madill *et al.*, 2000). Instead, 'reality' is thought to vary according to the context in which data is collected and analysed. Pidgeon and Henwood (1997) posit that knowledge will be affected by the participants' understanding, the researcher's interpretation, cultural meaning systems, and acts of judging particular interpretations as valid. As such, all accounts of knowledge are subjective, with the existence of alternative perspectives. However in light of this, there is an onus on the researcher to ground findings in the participants' actual data (Tindall, 1994).

In line with the contextual constructionist position, an Interpretative Phenomenological Analysis (IPA) approach was chosen. The approach is concerned with how people make sense of their lived experiences, and explores the experience in its own terms (Smith *et al.*, 2009). In IPA, both the participant and researcher are viewed as conscious beings, making sense of the world around them (Giorgi, 1995). In line with this IPA views research as a dynamic process, whereby the participants' are trying to make sense of their world, and the researcher is trying to make sense of the participants' sense making.

Finally within contextualist analysis, the researcher is encouraged to consider their own perspective from which they approached the research (Madill *et al.*, 2000). In this case, the researcher had prior experience of working with men with SCB as an Assistant Psychologist, though had not had direct experience of SCB being directed towards her. Within the role of Assistant Psychologist, the researcher had become aware of the tendency to place blame within the staff team for contributing to patients' behaviours, as well as the lack of structured space for feelings to be discussed.

References:

- Madill, A., Jordan, A., & Shirely, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91, 1-20.
- Pidgeon, N. & Henwood, K. (1997). Using grounded theory in research. In N Hayes (Ed.) *Doing qualitative analysis in psychology* (pp.245-273). Hove: Psychology Press.
- Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. Sage, London.
- Tindall, C. (1994). Issues of evaluation. In P. Bansister, E. Burman, I. Parker, M. Taylor, & C. Tindall (Eds.), *Qualitative Methods in Psychology: A research guide*, pp 142-159. Buckingham: Open University Press.

Appendix G: Correspondence from the Research Ethics Committee



University Ethics Sub-Committee for Psychology

20/04/2016

Ethics Reference: 5417-kjw40-neuroscience,psychologyandbehaviour

TO:

Name of Researcher Applicant: Kerry Cope

Department: Psychology

Research Project Title: Female care staff experiences of working with males with intellectual disabilities who display sexualised challenging behaviour: An Interpretative Phenomenological Approach

Dear Kerry Cope,

RE: Ethics review of Research Study application

The University Ethics Sub-Committee for Psychology has reviewed and discussed the above application.

1. Ethical opinion

The Sub-Committee grants ethical approval to the above research project on the basis described in the application form and supporting documentation, subject to the conditions specified below.

2. Summary of ethics review discussion

The Committee noted the following issues:

Despite the sensitive nature of the project, the applicant has taken care to address potential ethics issues.

3. General conditions of the ethical approval

The ethics approval is subject to the following general conditions being met prior to the start of the project:

As the Principal Investigator, you are expected to deliver the research project in accordance with the University's policies and procedures, which includes the University's Research Code of Conduct and the University's Research Ethics Policy.

If relevant, management permission or approval (gate keeper role) must be obtained from host organisation prior to the start of the study at the site concerned.

4. Reporting requirements after ethical approval

You are expected to notify the Sub-Committee about:

- Significant amendments to the project
- Serious breaches of the protocol
- Annual progress reports
- Notifying the end of the study

5. Use of application information

Details from your ethics application will be stored on the University Ethics Online System. With your permission, the Sub-Committee may wish to use parts of the application in an anonymised format for training or sharing best practice. Please let me know if you do not want the application details to be used in this manner.

Best wishes for the success of this research project.

Yours sincerely,

A black rectangular box redacting the signature of the Chair.

Chair

Appendix H: Correspondence from the Local Research Committee

E-mail: [REDACTED]

Date of NHS Permission: 22 April 2016

Mrs Kerry Cope
Trainee Clinical Psychologist
Leicestershire Partnership NHS Trust
University of Leicester, Clinical Psychology
104 Regent Road
Leicester
LE1 7LT

Dear Kerry

Study title: Female care staff experiences of working with males with intellectual disabilities who display sexualized challenging behavior: An interpretative phenomenological approach.

Sponsor: University of Leicester

IRAS/REC ID: N/A staff research

Thank you for submitting your project to the [REDACTED] Trust's R&D Department. The project has now been given NHS permission by:

Dr [REDACTED] R & D Director, on behalf of [REDACTED] Trust

NHS permission for the above research has been granted on the basis described in the application form, study protocol and supporting documentation. The following documents were reviewed:

| Document | Version |
|-----------------------------------------------|---------------|
| Advertisement Poster | 1.0, 03.03.16 |
| Participant Information Sheet | 1.0, 03.03.16 |
| Consent Form | 1.0, 03.03.16 |
| Recruitment letter for potential participants | 1.0, 03.03.16 |
| Recruitment letter for services | 1.0, 03.03.16 |
| Proposed Interview Schedule | 1.0, 03.03.16 |
| Proposal | 1.0, 03.03.16 |

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP [ONLY if applicable], and NHS Trust policies and procedures available

[REDACTED]

[REDACTED]

The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies. All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

Yours Sincerely

[REDACTED]

Head of Research and Innovation

cc.

Sponsor:

Appendix I: Informed Consent Form



Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: Female care staff experiences of working with males with intellectual disabilities who display sexualised challenging behaviour: An Interpretative Phenomenological Approach

Name of Researcher: Kerry Cope

Please initial each box

1. I confirm that I have read the information sheet dated (13.11.17; v6) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my employment or legal rights being affected. ☐
3. I understand that choosing whether to participate or not will not affect my employment. My employers, managers, colleagues, and the field supervisors needn't be aware that I have participated. However I am aware that should I choose to participate on work sites that it is possible colleagues might become aware that I have taken part in the study. ☐
4. I understand I have the right to withdraw any data associated with my involvement (including data I provided on the information sheet and during the interview) however I understand that this right to withdraw my data is time limited; my data cannot be withdrawn when the final transcription has been completed. ☐
5. I understand that sections of any of my anonymised data may be looked at by approved individuals from the study team and the University of Leicester, as the Sponsor, or their representatives where it is relevant to my taking part in research. I give permission for these individuals to have access to my data. ☐
6. I understand that if any safeguarding or child safety concerns are highlighted at any point during the interview, then the Chief Investigator would have a duty of care to pass this information on to the relevant bodies, without direct consent from myself. If this were to occur, the Chief Investigator will inform me that a safeguarding referral will be made. A safeguarding referral will then be made to the appropriate safeguarding team. ☐
7. I do / do not agree to be contacted for an additional interview if this is deemed necessary (Please delete as appropriate) ☐
8. I agree to take part in the above study. ☐

Name of Participant

Date

Signature

Name of Person
taking consent

Date

Signature



Participant Information Sheet

STUDY TITLE

Female care staff experiences of working with males with intellectual disabilities who display sexualised challenging behaviour: An Interpretative Phenomenological Approach.

INVITATION

I would like to ask you to consider taking part in my study to investigate female care staff experiences of working with males with intellectual disabilities who display sexualised challenging behaviour. Please take the time to read the following information before deciding whether you would like to take part in this study.

WHO IS CONDUCTING THE RESEARCH?

My name is Kerry Cope. I am a Trainee Clinical Psychologist completing my Doctorate in Clinical Psychology at The University of Leicester. I am conducting a research project for my thesis, as part of the academic requirements of the programme. My project is supervised by Dr [redacted] Clinical Psychologist, alongside Dr [redacted], Clinical Psychologist and Dr [redacted], Clinical Psychologist.

WHO CAN TAKE PART?

Female staff members, aged above 18, currently working in a healthcare environment who in the last year, have directly experienced sexualised challenging behaviour from a male service user with a learning disability.

DO I HAVE TO TAKE PART?

It is up to you to choose whether you wish to take part in this research study. Your decision will not affect your employment in anyway (employers will not be made aware of your decision).

WHAT WILL HAPPEN IF I CHOOSE TO TAKE PART?

With your permission, I will meet with you at your home or a nearby space to complete an interview at a time that is convenient for you. If you would rather be interviewed at your place of work, interviews will be undertaken outside of work hours such that care provided to service users is not interrupted and so that interviews will not be interrupted due to the need for staff to be on shift. Additionally, approvals would need to be gained from service managers to obtain rooms in which to conduct the interviews.

The interview will ask you about your experiences of supporting service users who engage in sexualised challenging behaviour towards staff. The interview would last between one and two hours. Conversation will focus on your experiences of working with male service users who have displayed sexualised challenging behaviour towards you. In discussing this, you would be able to choose how much or little you reveal about your own experiences and sexual identity outside of work. The interview could last up to two hours, and following this, you will be offered the opportunity for a debrief during which any arising concerns can be discussed. You can choose to stop the interview at any time. You may be asked if you would be willing to engage in a second interview if it is deemed relevant to gather further information on your perspectives and experiences. You can choose not to take part in the second interview if you



only want to meet with me once. Your decision regarding this would not affect prior participation.

The interviews will be audio-recorded then transcribed and anonymised. The data will be written up to meet the academic requirements for the University of Leicester Doctorate in Clinical Psychology. It is hoped the research will be published in a peer-reviewed journal and findings might be presented at relevant conferences. A summary of the study results can be sent to you if requested.

CONFIDENTIALITY/ANONYMITY

Your participation in the study is completely voluntary and confidential. Prior to starting the interview, you will be asked to sign a consent form. Your participation (or not) will not affect your employment. Employers, managers, colleagues, and field supervisors will not be made aware that you have participated in the study, however, please be aware that if you choose to be interviewed at your place of work it is possible colleagues might observe that you have participated in the study. Verbatim quotes from the interviews will be cited in the thesis and journal publication, however all names and identifiable information will be altered. No participant or service user identifiable information will be contained in any publication. All data will be stored securely at the University of Leicester, in a locked cabinet, in a locked office. All electronic and paper records will be destroyed five years after the completion of the research study, according to University of Leicester regulations. The data will be handled by myself and my clinical supervisor (Dr). Relevant sections of the data may be looked at by approved individuals from the study team and the University of Leicester, as the Sponsor, or their representatives, for monitoring and auditing purposes.

Some limits to confidentiality do apply. If any safeguarding or child safety concerns are highlighted at any point during the interview, I will have a duty of care to pass this information on to the relevant bodies, without direct consent from yourself. If this were to occur I would inform you as soon as possible that information would be shared.

PARTICIPANTS' RIGHTS

During the interviews you can choose what questions you will and won't answer and I will not put pressure on you to talk about anything you would prefer not to. You can also choose to end the interview early.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

Although the study might not benefit you directly, it is hoped the research will support understanding of the experiences of staff working with individuals who engage in sexualised challenging behaviour, which could lead to insights into care staff needs whilst fulfilling this role.

If you are selected to engage in the research you will be given a £25 gift voucher for each interview you take part in. This will be provided to you once the interview has been transcribed.

WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS OF TAKING PART?

The interview process may involve discussion of sensitive topics, however the study has been designed to ensure that the possible disadvantages and risks to you from taking part are



minimal (for example you can choose not to answer certain questions and you can elect to end the interview early).

This study has also been designed to cause minimal inconvenience to you in relation to your time and travel.

WHAT IF I AM HARMED BY THE STUDY?

It is very unlikely that you would be harmed by taking part in this type of research study. However, if you wish to complain or have any concerns about the way you have been approached or treated in connection with the study, you should ask to speak to Dr who will do their best to answer your questions.

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against University of Leicester but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

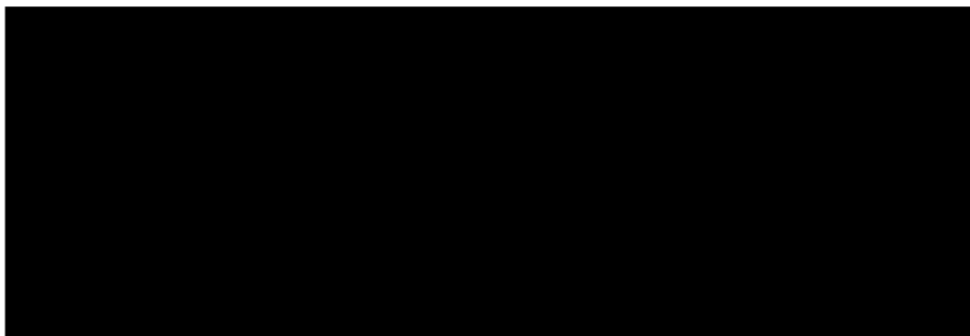
WHAT IF I WISH TO WITHDRAW FROM THE STUDY?

You may decide to stop being a part of the study up until the point when the final transcription has been completed. Withdrawing from the study will not impact upon your employment in anyway, and any data associated with your involvement, including the opt-in sheet, will be destroyed. If you wish to withdraw from the study, please contact myself using the details below.

WHO CAN I CONTACT FOR MORE INFORMATION?

For further information about the study, or any questions about the information provided here, please contact myself or my supervisors using the details below:

Kerry Cope (Trainee Clinical Psychologist)



WHAT HAPPENS NOW?

If you are interested in taking part in the study, please complete the opt-in form attached, and return to Kerry Cope in the stamped addressed envelope provided. You will then be contacted directly to discuss your participation in the study and to answer any questions you might have.



Opt in Form

Please complete and return the following if you are interested in taking part in the study. I will contact you on the details provided:

Name:

Contact Number:

Home Address:

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

Age:

18 – 30 []
30 – 40 []
40 – 50 []
50 – 60 []
60 + []

Job role:

.....

I am happy for interviews to be conducted at my home:

Yes [] No []

If interviews were to be conducted at my home, I would be able to guarantee a quiet, uninterrupted space

Yes [] No []

I can confirm that:

I am female

Yes [] No []

In the last year, I have directly experienced sexualised challenging behaviour from a male service user with a learning disability

Yes [] No []

Appendix K: Invitation Letters to Hospitals



Hospital Address

Date

Dear

My name is Kerry Cope. I am a Trainee Clinical Psychologist completing the Doctorate in Clinical Psychology at The University of Leicester. I am conducting a research project for my thesis, as part of the academic requirements of the programme.

I would like to ask you to consider whether your service would like to take part in my study, investigating female care staff experiences of working with males with intellectual disabilities who display sexualised challenging behaviour.

In brief, I am proposing to interview female care staff about their experiences of the above. In order to be eligible for the study, participants need to have worked with someone in the last year who has been perceived as displaying sexualised behaviour towards them. It is proposed that participants will be interviewed in their own time away from the work place. I have included a copy of the participant information sheet, detailing what the study would involve. Prior to recruiting participants I would like, with your permission, to come along and speak to the staffing team about the research and rationale for this.

If you are interested in taking part, please could you contact me on the email address below with a contact number so I can discuss this further with you, and to arrange a time for me to come and speak with the staffing team.

Should you require any further information before making a decision, I am more than happy to either meet with you, or speak to you over the telephone, to discuss this further.

I look forward to hearing back from you,

Kind regards

Kerry Cope
Trainee Clinical Psychologist
University of Leicester





Female care staff experiences of working with males with intellectual disabilities who display sexualised challenging behaviour

I would like to ask you to consider taking part in a study exploring the experiences of women care staff working with males with intellectual disabilities who display sexualised challenging behaviour.

Participation involves taking part in an interview to learn more about your experiences and how you make sense of them. You will be given a £25 voucher for taking part in the interview.

If you are interested in taking part in the study, please pick up the information sheet provided, or contact myself ([REDACTED]) for further information.



Proposed Interview Schedule

1. This is a research study looking at the experiences of women who've worked with men with learning disabilities who have displayed sexualised challenging behaviour towards them. Can I start off by asking you what 'sexualised challenging behaviour' means to you?

Possible Prompts: What makes the behaviour "challenging"?

2. Can you tell me about what it's like to support male service users with sexualised challenging behaviour?

Possible Prompts: Does anything make it more / less (of whatever they've said it's like); how does it feel to be working with them? What do you feel before you come on shift with a person showing SCB? Is it something you think about much outside of work? Are there any particular challenges or positives about supporting men displaying SCB? What makes that a particular challenge/positive? What effect does that have, on you, the client, wider staff team? What sense do you have as to why that might be happening?

3. Can you tell me about a particular time when you experienced sexualised challenging behaviour from a male service user?

Possible Prompts: What happened? Can you tell me more about what they did? What you did? How did you feel? What did others do? What were you thinking about at the time? Straight after? How did you make sense of what happened? Why do you think X did what he did? How did others make sense of what happened? How did the person with LD experience the incident? What is it like supporting X? Are there times it feels different? Particularly challenging? What sense do you make of what is going on then?

4. What life experiences or aspects of your identity make it easier or harder to support X / male service users with sexualised challenging behaviour

Possible Prompts: how important is that to you? Does this affect how you support X? is this something you give a lot of thought to?

5. What, if any, impact has this work had on you?

Possible Prompts: How does it make you feel? Has it changed the way you do things / view things? Inside of work? Outside of work? What support do you feel you have or don't have from within and inside work? What aspects of your own experiences do you find important when coping or struggling with the behaviour

6. What sorts of interventions have been more or less helpful for supporting your work with X?

Possible Prompts: How have service/policy/professional input influenced your work with X? Your understanding of X?

180 P3: It, it, I, for the first, just uncomfortable, uncomfortable because I didn't want to have to be felt uncomfortable

181 rude and turn around and say "look, please don't get that close to me, please don't", but, if, if it can't be rude

182 had to be said, it would have been said. Erm, but then it's my character, it, I, not my character, as not like me / natural for me to say it

183 I said, I'm not that sort of person, as my work colleagues, or someone else would say "give me some space", you know, and it, it could, but, it would depend on who had said that, if it was what patient expects you to say depends on how they hear it

184 normal for them to say that sort of thing, it don't come across as aggressive, or worried, it just wasn't intended

185 telling they say as it is, but - and, and that helped, that helped coz, and if it had come from a male, a male staff member, it was more, it sort of had more weight behind it. more impact coming from a male

186 I: OK. Why do you think that was, that it had more weight because it was a male?

187 P3: Erm, I don't know if it's the erm, authoritative figure, they, could be they had bit more males more authority

188 respect if it, it was a male that, that erm, had respect anyway, that's worked here a long time, authority + respect / length of time

189 and, had respect, erm, whether it's a pecking order, but, yeah, from a male staff member saying listen to males

190 to this specific person "give her some space, don't get that close", it just seemed to, seemed to listen to males

191 come across better, yeah. Er, and I didn't mind him saying it at all I was ok that he stepped in

192 I: OK. It sounded like you found that quite helpful - cut off

193 P3: It was helpful. I think if, if something like that, if it's a one off, it, when it was going on for a can deal with it myself if one off, if more persistent need support

194 couple of days, it, helps that your work colleagues know, you know.

195 I: Like they've got your back -

196 P3: Because it - it, you might feel like it's on your mind, and you don't want to make a fuss, you can't tell others. Need to "get on with it"

197 know, if, when you, you go out on garden to have a cigarette, and, er, there's no one else out

- 74 P1: The (sigh) the most thing I'm finding difficult now is the fact that we have got so many ^{Tenth}
- 75 paedophiles in this one hospital, and they're constantly at you, in your face, want, want, want ^{always there}
- 76 all the time. And then you'll, you know, the stories, the things that they'll, they're coming out ^{infamous!}
- 77 and saying, you take them out on leave and they're masturbating coz they've seen young
- 78 children, or they're doing this because they've heard a young child shout, or (pause) and the
- 79 thing that makes, it blows my mind coz I've got four granddaughters, erm, I think, how can I ^{can't understand}
- 80 work with these kind of people and then go home and be normal with them. Do you get, are ^{'granted'}
- 81 you, are you understanding?
- 82 I: Yeah, yeah, kind of the, coz of what, erm are they telling you this? Are they telling you that's
- 83 what's happening for them?
- 84 P1: Yeah, yeah, yeah, I mean there's, you know recently we've had a couple of guys that we've ^{'Some variance'}
- 85 , we've had to stop going on leave for that reason, one, you know, one's like as soon as he
- 86 spots a little girl or a little boy he's having to go to the toilet to masturbate them kind of things ^{no choice}
- 87 (pause) not taking, so you know, so you find it more difficult than if it were more (pause) adult,
- 88 if it, if, (sigh) what's the word? (trails off)
- 89 I: So if their sexual desires were towards adults rather than children?
- 90 P1: Yeah. That I could take a lot better it's just, I think you'll find with a lot of people here, that
- 91 that is what we're finding more difficult now. Because we have got (pause) two-thirds or three-
- 92 quarters of them, so (trails off)

Lots in one place.
overwhelming

What's what you want?

Paedophile
→ deviant?

Paedophile - yet talking
about young women.

non-gendered.

Diff. US +
them.

What is normal for me now?
→ different to 'other' normal.

What is
normal?

Can anyone understand this?
Difficult to explain

'incongruence'
felt when
coming for
Paedophiles

How to
be with
crimes

comp. anyone
understand.

Some worse than others.

No control → can only be stopped
by staff action.

Sexual
Deviancy

More acceptable if adult victim?

Innocence of
victims.

Young staff
children?
Innocence

high concentration of
'them'
More difficult due to 'child' victims

What is
'normal'?

importance of
being
understood

convergence
'coming
together'

Innocent
victims.
No
control over
behaviour

the
guilt
innocence?

Appendix O: Emerging Theme Development: Becca and Danielle

P2 – Becca's Case Summary

| Super-ordinate / Sub theme | Lines in original transcript | Key Words and Phrases |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | <ul style="list-style-type: none"> * Denotes pause in speech. denotes long pause * (....) Denotes words which have been removed for ease of reading, purposes of confidentiality, if they've not added meaning to the theme, or used when the researcher offered a response to the participant. * Phrases which felt very important for this participant |
| It's difficult to be caring towards men who are sexually inappropriate or sexual offenders <i>This theme is concerned with how Becca seemed to be grappling with a dilemma between her identity as a 'caring' nurse, whilst giving care to those whose behaviour others may view as "disgusting", and perhaps unworthy of care due to their past offences. This dilemma was also complicated by patients misconstruing care given as a sexual act. Becca appeared to try and reconcile these difficulties by viewing her role as "doing the right thing" for the patients and wider community</i> | | |
| We can't just be cold towards the patients, we have to be supportive, and comforting | 9-10 | I'm a nurse, I'm here to look after them |
| | 58-61 | I'm having any negative thoughts, I don't want that to come across to the patients coz I'm a nurse, and I am here to care for them so I don't want them to see anything, you know, that would make them feel, erm, <i>uncomfortable</i> , or, ashamed, you know, coming from me. |
| | 182-184 | I was <i>just</i> like trying to comfort him coz he was <i>distressed</i> by the noise, so I sort of thought ... it, we have to be, we can't just be cold towards the patients, we have to be supportive, and comforting |
| Having care and support misconstrued in a sexual manner | 143-146 | He became <i>distressed</i> because he doesn't like loud noises, and everything, and he <i>grabbed</i> my hand, so I thought he was grabbing my hand so he could be comforted, so I just sat and held his hand. Well he se-seemed to have an orgasm and he ejaculated |
| | 182-184 | We have to be supportive, and <i>comforting</i> , so, just, <i>be aware</i> that they may have sexual thoughts. |
| | 194-196 | later on he said "Were you trying to chat me up" he goes, "coz sometimes when women are chatting you up they ask about things like that" and I said "No I was just making conversation with you" |
| | 206-207 | maybe he got comfort from me holding his hand, but then he went a bit, became a bit sexualised |
| | 258-259 | Erm ... with these males here, I, I wouldn't go in for a lot of <i>hugging</i> , things like that, in case they, it made them display sexually inappropriate behaviour |
| You wonder if you're doing the right thing | 24-27 | Erm, it's difficult because, for example, with <i>paedophiles</i> and things, you think about, erm, the morality of it, because of the fact that they're harming children, or they have harmed children in the past, or they're having <i>thoughts</i> about harming children, and you wonder if you're doing the right thing by working with them |
| | 32-34 | |

P2 – Danielle's Case Summary

| Super-ordinate / Sub theme | Lines in original transcript | Key Words and Phrases |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | <ul style="list-style-type: none"> * Denotes pause in speech. denotes long pause * (...) Denotes words which have been removed for ease of reading, purposes of confidentiality, if they've not added meaning to the theme, or used when the researcher offered a response to the participant. * Phrases which felt very important for this participant |
| Viewing sexuality through the lens of intellectual disability <p><i>This theme is concerned with how Danielle made sense of why patients engaged in sexualised behaviours in light of their cognitive functioning. She made a clear distinction between those who were "higher" and "lower" functioning, tending to view the higher functioning individuals as more sexual beings whose behaviour was driven by sexual motivation, and saw the individuals who were lower functioning as being less of a sexual being, where sexual behaviours were more likely to be learnt, or as a consequence of a particular condition or historical sexual abuse. Furthermore, although there was some acknowledgement that lower functioning individuals may have "unmet sexual needs", this felt as though as it was of less importance to those individuals than other factors.</i></p> | | |
| Having a sexual drive (or not) | 36-37 | somebody is high functioning and is more for, a kick, or, something like that. |
| | 55-56 | obviously they may get some sort of, pleasure out of it. |
| | 143-148 | it may have even been like, the, unmet, you know sexual need or something, he might have been a bit more sexually frustrated at that time. Erm, it, it could have been a number of things. But I don't think it was meant, like, with in-intent, or, you know, with, obviously, obviously there was the intent that he had a question that he wanted to ask, and he- he acted on that, but I don't think he would have continued to like, push, if that makes sense, he was quite easy to re-direct. |
| | 154-156 | he obviously had, a need, or a desire that kind of overpowered, and he just needed, needed to address it |
| | 166-178 | it was the situation that really we weren't expecting at all, and with this person's characteristics and everything, erm, it was, the way in which he approached it, he was, he was quite a comical individual, erm, so, there was obviously the laughter side of things, everyone, there was also the element of: oh well I think, you know we don't need to worry about it because, you know (...) it's only him, so, so it's not going to go any further, we don't really need to worry about it, just need to make sure we keep a, like a, erm, what's the word, keep a, lid on it, don't let it go any more, any further (...) it wasn't really taken very seriously (...) but, it wasn't really deemed, you know, as a serious incident or anything like that. |
| | 189-190 | They, they sometimes make me feel a bit more uncomfortable, because those tend to be the people who are that little bit higher functioning, kind of are a little bit more sexually motivated |
| | 199-201 | they're all, kind of, up to no good, that they're all kind of, plotting something, or getting a kick, or that, you know, that's why they're sat there because everyone's walking past, it's kind of like, prime, place to sit, to see everybody |
| | 205-213 | The higher functioning, definitely, because it almost feels as if they're always one step ahead, (...) they've obviously got histories, they've got the pasts, they've got the sexual drive there, and, you know, will do what they can, in order to get, the satisfaction. |
| Being bound by autism | 88-93 | he had quite severe autism, and, erm, moderate learning disabilities, and he was very repetitive in his commenting, so he used to say the same routine phrases over and over again. However, sometimes other ones would come out of the blue. And this was the first occasion that we actually heard this comment come out of him, and then it continued from there forwards |
| | 107-109 | from that point forwards really, that became part of a routine, for that individual, every time he saw me, he would ask me those same questions over and over again |
| | 120-124 | from that point forward, it always, erm, when it happened again, then it obviously started to, not necessarily become, like, the norm, but, I was kind of expecting it every time I saw him, coz of how bound he was by his autism |
| | 126-128 | I think, because it had happened and, luckily the strategy that I used in that situation, it did divert him straight away, so, straight away that then became the routine, and that became the thing that we were able to, to do every time |
| | 133-134 | he would go to do it, and it was almost like he was waiting for that, that routine, that ritualistic pattern to kind of kick in |
| | 154-158 | There was obviously something that he was trying to communicate at that time, erm, he obviously had, a need, or a desire that kind of |

Appendix P: Superordinate Theme Development

| <p>"You wonder if you're doing the right thing"</p> <p>This theme is concerned with the tension the women seemed to battle with when thinking about providing care to men who engaged in sexually challenging behaviour. In doing so, the women portrayed a sense of wanting to give care whilst wondering if the men deserved care, having their care misconstrued as a sexual act, and finally thinking about what they did to feel ok in giving such care.</p> | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Thinking about the morality of it</p> <p>Women spoke about a desire they had to give care. This seemed to stem from a sense of having an identity as a caring individual, hence them wanting to work in health care. However, this was coupled with a tension they appeared to feel in giving care to men whom were inherently viewed as "disgusting" or "bad". The women seemed to make parallels between the men in their care, and that of paedophiles – perhaps as a reflection of the nature of the men's historical behaviours. In viewing the men as "paedophiles" this led to a tension as to whether such individuals deserved care due to both moral reasons, as well as how others may perceive the women for giving care to the men.</p> | <p>Wanting to help and getting nowhere We can't just be cold, we have to be supportive and comforting Having pride in my job Being calm and caring towards patients Importance of relationships Seeing sexualised behaviour as purposeful acts Being in control of their behaviour Feeling an incongruence in caring for someone who has committed a sexual offence You wonder if you're doing the right thing Worrying what others will think of me It's more extreme than I imagined Being made to feel disgusted Feeling resentful towards patients Finding it more difficult to cope with sexually inappropriate behaviour from higher functioning patients</p> |
| <p>Needing to be more careful</p> <p>The women spoke about experiencing the care they gave as being misconstrued as sexual acts, leading to the women questioning how they should be with, and give care, to individuals. At times this was linked to a feeling of personal responsibility for causing the behaviour.</p> | <p>Worrying my behaviour may have contributed to sexual behaviour Having care and support misconstrued in a sexual manner Wanting more than I can give Questioning my role in (managing) patients' behaviour</p> |
| <p>Justifying giving care</p> <p>Finally, within this theme the women portrayed as sense of mechanisms they used in order to allow themselves to give care to individuals whom perhaps they felt were not altogether deserving of care. Secondly, the women appeared to be searching for a reason for the inappropriate sexual behaviour, and in doing so appeared to make allowances for the individual's behaviour. In doing so it felt as though it was easier to justify giving care if it was believed the patient was not altogether responsible for behaviour</p> | <p>Feeling an incongruence – they can change Believing patients are capable of change Trying to give the benefit of the doubt Separating patient, behaviour and history It's their normal Seeing sexualised behaviour as a need for a relationship Trying to make sense of sexualised behaviours Understanding it's how they communicate Making patient's aware their behaviour is inappropriate Trying to find a reason Viewing SCB as a result of historical abuse Being bound by autism Having a sexual drive (or not) Being accountable for their actions (or not)</p> |

Appendix Q: Contributions to Themes

| Theme | Anna | Becca | Callie | Danielle |
|--------------------------------------------|------|-------|--------|----------|
| Doing the right thing | | | | |
| Thinking about the morality of it | ✓ | ✓ | ✓ | ✓ |
| Justifying care | ✓ | ✓ | ✓ | ✓ |
| Being more careful | | ✓ | ✓ | |
| Always looking for danger | | | | |
| Fearing the unknown | ✓ | | ✓ | ✓ |
| Feeling unsafe | ✓ | ✓ | ✓ | ✓ |
| You've gotta protect them | ✓ | ✓ | ✓ | ✓ |
| No one really cares about the staff | | | | |
| Feeling like you don't matter | ✓ | ✓ | ✓ | ✓ |
| Wanting support | ✓ | ✓ | | ✓ |

Appendix R: Chronology of Research Process

| Activity | Timeline |
|-------------------------------------------------------------------------|-------------------------------|
| Consultation with research supervisor | November 2014 |
| Development of research proposal | December 2014 – December 2015 |
| Peer review of research proposal Service user reference group review | January 2016 |
| Obtaining sponsorship | January 2016 |
| Submission to university ethics | March 2016 |
| Submission to local NHS R&D board | March 2016 |
| Approvals from ethics and R&D | April 2016 |
| Recruitment, interviewing participants, transcription | April 2016 to October 2018 |
| Maternity leave | October 2016 to October 2017 |
| Further recruitment attempts | October 2017 to March 2018 |
| Analysis | October 2017 to March 2018 |
| Write up period | March 2018 to June 2018 |
| Thesis submission | June 2018 |
| Preparation for Viva | July 2018 |
| Dissemination of findings Poster presentation preparation | July 2018 to September 2018 |