

Northumbria Research Link

Citation: Rippon, Daniel (2018) The Development of a Theoretical Framework on Work Related Stress in Health and Social Care Professionals who Manage Behaviours that Challenge. Doctoral thesis, Northumbria University.

This version was downloaded from Northumbria Research Link:
<http://nrl.northumbria.ac.uk/id/eprint/39770/>

Northumbria University has developed Northumbria Research Link (NRL) to enable users to access the University's research output. Copyright © and moral rights for items on NRL are retained by the individual author(s) and/or other copyright owners. Single copies of full items can be reproduced, displayed or performed, and given to third parties in any format or medium for personal research or study, educational, or not-for-profit purposes without prior permission or charge, provided the authors, title and full bibliographic details are given, as well as a hyperlink and/or URL to the original metadata page. The content must not be changed in any way. Full items must not be sold commercially in any format or medium without formal permission of the copyright holder. The full policy is available online: <http://nrl.northumbria.ac.uk/policies.html>

The Development of a Theoretical
Framework on Work Related Stress in
Health and Social Care Professionals who
Manage Behaviours that Challenge

Daniel Rippon

PhD

2018

The Development of a Theoretical
Framework on Work Related Stress in
Health and Social Care Professionals who
Manage Behaviours that Challenge

Daniel Rippon

A thesis submitted in partial fulfilment of the
requirements of the University of Northumbria at
Newcastle for the degree of Doctor of Philosophy

September 2018

Abstract

Providing direct health and social care services to people who exhibit behaviours that challenge can be a highly stressful occupational demand. Existing literature has suggested that health/social care professionals who work in settings such as Mental Health, Dementia Care, Autism and Learning Disability services could be prone to encountering incidences where care recipients exhibit behaviours that are perceived as being challenging. There are a number of existing occupational stress theories. However, none of these theories have been developed specifically to explain the conditions under which stress occurs for frontline health/social care staff who are required to manage incidences of behaviours that challenge in their role. Thus, the primary aim of this thesis was to develop a theoretical framework that illustrated the *causes of* and *protective factors against* work related stress in frontline staff who provide care for people who exhibit behaviours that challenge.

In the current research programme, an exploratory sequential mixed methods research design was employed to enable the development and investigation of a theoretical framework on work related stress and the management of behaviours that challenge. The initial phase of this project comprised a Grounded Theory study, which led to the development of the Therapeutic Engagement Stress Theory (TEST). TEST illustrates how an interplay of organisational factors, work place environments, colleagues, service users and qualities intrinsic to health/social care professionals can impact the capacity for frontline staff to therapeutically engage with care recipients who exhibit behaviours that challenge. The core category within TEST indicated that the extent to which health/social care professionals are able to

engage therapeutically with care recipients, who exhibit behaviours that challenge, can determine the levels of work related stress experienced.

The subsequent aims of this thesis was to investigate the TEST framework using appropriate Quantitative methods. This was to ascertain if the capacity to therapeutically engage with care recipients, who exhibit behaviours that challenge, could genuinely influence the levels of work related stress experienced by frontline health/social care professionals. It was also necessary to investigate if the TEST model could be used effectively in applied settings to tease out the work related factors that could either facilitate or inhibit frontline staff to therapeutically engage with care recipients who exhibit behaviours that challenge. Thus, the next phase of the mixed methods research programme involved operationalising each of the categories and core category, within the TEST model, using pre-existing quantitative measures. Quantitative studies were conducted to investigate specific components of the TEST model in a sample of mental healthcare professionals who provided direct services to people who exhibit behaviours that challenge. It was observed that factors such as work place settings, quality of professional relationships with care recipients and propensity to have repetitive negative thoughts could influence stress levels experienced by mental healthcare professionals through affecting their capacity to engage therapeutically with patients.

Further exploration of the TEST model was conducted to investigate work related stress in professional dementia carers who provided care for residents within Nursing Home settings. It was observed that the capacity to engage with residents who have Dementia fully mediated a positive correlation between the fear of being negatively evaluated by colleagues and perceived work related stress. Higher levels of perceived organisational support were also shown to correlate with lower levels of

stress being reported by professional dementia carers. However, a non-significant correlation was observed between perceived organisational support and capacity to engage with residents who exhibit behaviours that challenge.

Finally, a study was conducted to demonstrate the extent to which professional dementia carers are vulnerable to the deleterious consequences of chronic biological stress as ascertained through analysis of hair cortisol concentration. It was observed that professional dementia carers, who manage behaviours that challenge, had significantly higher levels of hair cortisol concentration in comparison to people who work in University settings and students studying at undergraduate level.

This research project has provided novel contributions to existing literature through development and investigation of a theoretical framework using a robust mixed methods approach, in order to optimally understand the articulated experiences of health/social care professionals regarding stress and the management of behaviours that challenge.

Table of Contents

List of Tables.....	1
List of Figures.....	2
Published Work.....	8
Acknowledgements.....	9
Declaration.....	10

Part A

Chapter 1: A review of behaviours that challenge within health and social care professions and work related stress.....	11
1.1 Behaviours that challenge and work related stress in health and social care professions.....	11
1.2 Applying an exploratory sequential mixed methods research design.....	14
1.3 The rationale for conducting a Classic Grounded Theory study to explore the work related factors that potentially cause and offset stress within health and social care professionals who manage behaviours that challenge.....	15
1.3.1 Classic Grounded Theory.....	16
1.3.2 Aims and objectives of the Classic Grounded Theory study.....	18
1.4 Method.....	19
1.4.1 Design Approach.....	19
1.4.2 Participants.....	19
1.4.2.1 Purposeful sample.....	21
1.4.2.2 Theoretical sample.....	21

1.4.3	Materials.....	25
1.4.4	Procedure.....	26
1.4.5	Procedure for Analysis.....	27
1.4.6	Additional Participant Demographic Information.....	29
1.5	Results and Discussion of the Developed Theoretical Framework Concerning Work Related Stress and the Management of Behaviours that Challenge.....	33
1.6	The facilitating and inhibiting effects of Organisational Factors on Staff Interactions with Service Users and the Impact upon Work Related Stress.....	35
1.6.1	Multi-agency working.....	36
1.6.2	Sharing responsibilities and service user specific knowledge with external organisations.....	37
1.6.3	Partnership organisations that communicate risk.....	39
1.6.4	Partnership organisations that regularly rotate key communicators of service user specific knowledge.....	41
1.6.5	Partnership organisations that fail to communicate risk.....	44
1.6.6	Working with external organisations who do not assume caregiver responsibilities.....	46
1.6.7	Organisational change and increased occupational demands.....	51
1.6.8	Organisations that employ the use of restrictive practices to manage	

	incidences of behaviours that challenge.....	56
1.6.9	Communicating and care planning the use of restrictive practices, as a last resort, with relevant regulatory bodies.....	60
1.6.10	The mandatory provision of post-incident debriefs.....	62
1.6.11	Summary of how organisational factors may influence the capacity for health/social care professionals to therapeutically engage with service users and levels of work related stress.....	67
1.7	The facilitating and inhibiting effects of Workplace Settings on Staff Interactions with Service Users and the Impact upon Work Related Stress.....	73
1.7.1	Safe Prevention and De-escalation of Behaviours that Challenge.....	74
1.7.2	Settings that do not assist staff in the prevention of behaviours that challenge.....	76
1.7.3	Settings that comprise of multiple service users who exhibit behaviours that challenge.....	79
1.7.4	Distractions from delivering care.....	80
1.7.5	Perceived containment of behaviours that challenge.....	82
1.7.6	Members of the public within community settings.....	87
1.7.7	Summary of how organisational factors may influence the capacity for health/social care professionals to therapeutically engage with service users and levels of work related stress.....	89

1.8	The facilitating and inhibiting effects of Colleagues on Staff Interactions with Service Users and the Impact upon Work Related Stress.....	93
1.8.1	The Amelioration of Difficult Interactions with Service Users...	94
1.8.2	Informal Debriefing with Colleagues.....	96
1.8.3	Colleagues who have shared experiences of Behaviours that Challenge.....	99
1.8.4	Understanding the Triggers and Prevention of Behaviours that Challenge.....	101
1.8.5	Working with Colleagues who do not understand the causes of Behaviours that Challenge.....	104
1.8.6	Working with colleagues who exhibit unhelpful emotions and negativity.....	106
1.8.7	Terminology used by Colleagues to Describe Service Users.....	108
1.8.8	Resistance to the application of innovative methods to manage Behaviours that Challenge.....	111
1.8.9	Colleagues who avoid their duties as health/social care professionals.....	115
1.8.10	Unsupportive colleagues and workplace bullying.....	117
1.8.11	Summary of how colleagues can facilitate or inhibit therapeutic work with service users and influence the work related stress levels experienced by health and social care professionals.....	121
1.9	The Facilitating and Inhibiting effects of Staff Interactions with Care Recipients and the Impact upon Work Related Stress.....	127

1.9.1	Encountering Service Users who Exhibit Violence and Aggression.....	127
1.9.2	Exposure to bodily fluids.....	129
1.9.3	Repetitive vocalisations.....	131
1.9.4	Deliberate self-harming behaviours.....	133
1.9.5	Service users who become attached to specific members of staff.....	136
1.9.6	Service users who do not engage with therapeutic interventions.....	138
1.9.7	Enhancing knowledge through engaging with service users.....	141
1.9.8	Summary of how interactions with care recipients can elicit or offset work related stress.....	144
1.10	The Intrinsic Factors of Frontline Health & Social Care Professionals Staff and their impact on Interactions with Service Users and Work Related Stress.....	147
1.10.1	Inexperienced health and social care professionals.....	147
1.10.2	Perceiving that care recipients are in control of their Behaviours that Challenge.....	150
1.10.3	Repetitive Negative Thinking.....	152
1.10.4	Openness and honesty in the disclosure of limitations.....	155
1.10.5	Using humour.....	157
1.10.6	Summary of qualities intrinsic to health/social care professionals and the capacity to engage with care recipients who exhibit behaviours that challenge.....	160
1.11	Strengths and Limitations of the Grounded Theory study.....	161

1.11.1 Summary of the Grounded Theory Study.....162

Part B

Chapter 2: Investigation of Therapeutic Engagement Stress Theory using
Quantitative methods.....165

2.1 Quantifying the Core Category.....165

2.2 Overview of quantitative studies to explore the TEST model...170

Chapter 3: The Influence of Repetitive Negative Thoughts, and Perceived
Conflict towards Care Recipients, on the Capacity to Therapeutically Engage
with Patients who Exhibit Behaviours that Challenge and Work Related
Stress.....173

3.1 Background.....174

3.2 The propensity to have repetitive negative thoughts on incidences of
behaviours that challenge.....175

3.3 Perceived conflict with patients who exhibit behaviours that
challenge.....178

3.4 Research questions and hypotheses.....179

3.5 Method.....180

3.5.1 Design.....180

3.5.2 Participants.....181

3.5.3 Materials.....183

3.5.3.1 Core category of Therapeutic Engagement Stress Theory (TEST).183

3.5.3.2	Repetitive Negative Thinking.....	183
3.5.3.3	Perceived conflict with care recipients who exhibit behaviours that challenge.....	184
3.5.4	Procedure.....	184
3.5.5	Statistical Analyses.....	185
3.6	Results.....	186
3.6.1	Capacity to therapeutically engage with patients and work related stress.....	186
3.6.2	Perceived conflict with care recipients who exhibit behaviours that challenge.....	187
3.6.3	Repetitive Negative Thinking and Perceived Work Related Stress.....	188
3.6.4	Capacity to therapeutically engage with patients and repetitive negative thinking.....	189
3.6.5	Mediation Analysis.....	190
3.7	Discussion.....	192
3.7.1	Capacity to engage, perceived conflict and work related stress.....	192
3.7.2	Repetitive negative thoughts, capacity to engage with patients and work related stress.....	194
3.7.3	Strengths and Limitations.....	196

3.7.4	Conclusion.....	199
-------	-----------------	-----

Chapter 4: The Impact of Workplace Settings on the Perceived Capacity to Therapeutically Engage with Patients who Exhibit Behaviours that Challenge and Work Related Stress.....201

4.1	Background.....	202
-----	-----------------	-----

4.2	Method.....	206
-----	-------------	-----

4.2.1	Design.....	206
-------	-------------	-----

4.2.2	Participants.....	206
-------	-------------------	-----

4.2.3	Materials.....	208
-------	----------------	-----

4.2.4	Procedure.....	208
-------	----------------	-----

4.2.5	Statistical Analyses.....	208
-------	---------------------------	-----

4.3	Results.....	209
-----	--------------	-----

4.4	Discussion.....	211
-----	-----------------	-----

4.5	Strengths and Limitations.....	213
-----	--------------------------------	-----

4.6	Conclusion.....	214
-----	-----------------	-----

Chapter 5: The Influence of Organisational Factors and Colleagues on Professional Carers' Capacity to Therapeutically Engage with Residents who have Dementia.....217

5.1	Background.....	219
-----	-----------------	-----

5.2	Organisational factors, therapeutic engagement with residents who have dementia and work related stress.....	220
-----	--	-----

5.3	The impact of perceived negative evaluation from colleagues on the capacity to therapeutically engage with residents and work related stress within professional dementia carers.....	221
5.4	Method.....	224
5.4.1	Design.....	224
5.4.2	Participants.....	224
5.4.3	Materials.....	225
5.4.4	Procedure.....	227
5.4.5	Statistical Analyses.....	227
5.5	Results.....	228
5.5.1	Therapeutic Engagement and Work Related Stress.....	228
5.5.2	Organisational Support.....	229
5.5.3	Fear of negative evaluation from colleagues in the workplace.....	230
5.5.4	Mediation Analysis.....	232
5.6	Discussion.....	234
5.6.1	Fear of Negative Evaluation from Colleagues.....	235
5.6.2	Perceived organisational support and the capacity to engage therapeutically with residents who exhibit behaviours that challenge.....	238
5.6.3	Conclusion.....	240

Chapter 6: Hair Cortisol Concentration and Work Related Stress within Professional Carers of People with Dementia.....	241
6.1 Work related stress and health.....	241
6.2 Method.....	244
6.2.1 Design.....	244
6.2.2 Participants.....	244
6.2.3 Collection of hair samples.....	245
6.2.4 Procedure.....	245
6.2.5 Statistical analyses.....	246
6.3 Results.....	246
6.4 Discussion.....	248
6.4.1 Strengths and limitations.....	252
6.4.2 Conclusion.....	254
Chapter 7: General Discussion of Project Findings.....	255
7.1 Recap of the project aims.....	255
7.2 Summary of findings.....	256
7.3 Original contribution to knowledge.....	262
7.4 Limitations and future directions.....	264
7.5 Conclusions.....	269
References and Appendices.....	271

List of Tables

Table 1.1. Demographic information and characteristics of participants within both the purposive and theoretical sample who took part in the Classic Ground Theory study.....	29
Table 3.1. The occupations of participants who took part in the current study.....	182
Table 3.2. The length of time, in months, that the participants had worked as a mental healthcare professional.....	182
Table 4.1. The occupations of participants.....	207
Table 4.2. Descriptive and inferential statistics for between subjects t-test.....	210
Table 5.1. Details concerning job titles and behaviours deemed as being most challenging for participants.....	225
Table 6.1. Means and standard deviations of HCC levels (pg/mg) observed within professional dementia carers, academic/support University staff and Undergraduate students.....	247
Table 6.2. Means and standard deviations of scores observed on the Perceived Stress Scale (Cohen, Kamarck & Mermelstein, 1983) as reported by professional dementia carers, academic/support University staff and Undergraduate students.....	248

List of Figures

Figure 1.1 The steps of the exploratory sequential mixed methods research design employed to explore work related stress within health and social care professionals who manage behaviours that challenge.....	15
Figure 1.2 Flow chart regarding sampling strategy.....	24
Figure 1.3 Therapeutic Engagement Stress Theory.....	33
Figure 1.4 The current section reports how organisational factors can either inhibit or facilitate health/social care professionals in their capacity to engage therapeutically with care recipients who exhibit behaviours that challenge.....	35
Figure 1.5 Illustration of how subcategories informed the developed categories concerning organisational factors and their influence on the capacity for health/social care profession to engage therapeutically with care recipients who exhibit behaviours that challenge.....	68
Figure 1.6. The current section reports how work place settings can either inhibit or facilitate health/social care professionals in their capacity to engage therapeutically with care recipients who exhibit behaviours that challenge.....	73
Figure 1.7. Illustration of how workplace environments can influence the capacity to therapeutically engage with service users who exhibit behaviours that challenge and the levels of work related stress within frontline health and social care staff.....	90
Figure 1.8. This section reports how colleagues can facilitate or inhibit health/social care professionals in their capacity to therapeutically engage with care recipients who exhibit behaviours that challenge and also influence work related stress.....	93

Figure 1.9. Illustration of how workplace colleagues can influence the capacity for frontline staff to therapeutically engage with service users who exhibit behaviours that challenge and the levels of work related stress within health/social care professions.....**122**

Figure 1.10. This section discusses participants experiences of how care recipients can either inhibit or facilitate health/social care professionals in their delivery of caring interventions for people who exhibit behaviours that challenge.....**129**

Figure 1.11. Illustration of how direct interactions with service users can influence the capacity for frontline staff to therapeutically engage with care recipients who exhibit behaviours that challenge and the levels of work related stress within health/social care professions.....**144**

Figure 1.12. This section reports participants experiences of how the intrinsic qualities of health/social care professionals could influence their capacity to engage with care recipients who exhibit behaviours that challenge and levels of work related stress.....**147**

Figure 1.13. Examples of the qualities intrinsic to health/social care professionals that can influence the capacity to therapeutically engage with care recipients who exhibit behaviours that challenge and levels of work related stress.....**160**

Figure 1.14. Therapeutic Engagement Stress Theory.....**163**

Figure 2.1. Core category within Therapeutic Engagement Stress Theory.....**166**

Figure 2.2. Quantitative measures used to tap into the core category of Therapeutic Engagement Stress Theory.....**170**

Figure 2.3. The categories concerning workplace settings, care recipients and intrinsic factors were investigated within a population of mental healthcare professionals who manage behaviours that challenge.....171

Figure 2.4. The categories concerning organisational factors and colleagues, regarding their impact upon the core category in the TEST model, were investigated within a population of professional carers of people who have dementia who manage behaviours that challenge.....172

Figure 3.1. The component of the TEST model that was investigated to ascertain the relationships between propensity to experience repetitive negative thoughts, perceived capacity to engage with patients who exhibit behaviours that challenge and work related stress.....175

Figure 3.2. The current section also aimed to explore how perceived conflict with care recipients, who exhibit behaviours that challenge, could influence levels of work related stress.....178

Figure 3.3. Illustration of the significant negative correlation observed between perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge and work related stress.....187

Figure 3.4. Illustration of the significant positive correlation between perceived conflict with patients who exhibit behaviours that challenge and work related stress experienced by mental healthcare professionals.....188

Figure 3.5. Illustration of significant positive correlation between levels of repetitive negative thinking on work related issues and self-reported occupational stress.....189

Figure 3.6. Illustration of the significant negative correlation between perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge and propensity to have repetitive negative thoughts.....	190
Figure 3.7. An illustration of the non-mediated (A) and partially mediated pathways between propensity to have repetitive negative thoughts, perceived capacity to engage with patients and work related stress.....	191
Figure 3.8. Core category within Therapeutic Engagement Stress Theory.....	193
Figure 3.9. Suggested longitudinal mediation analysis to ascertain how changes in the capacity to engage with patients could influence propensity to have negative thoughts and work related stress.....	197
Figure 4.1. The components of TEST investigated and reported in this section.....	203
Figure 5.1. The current chapter focused on the categories concerning organisational factors and colleagues.....	218
Figure 5.2. The current study aimed to investigate the ‘Organisational ‘component of the TEST model to ascertain the relationships between levels of perceived organisational support, capacity to engage therapeutically with residents and work related stress within professional dementia carers.....	220
Figure 5.3. The current study aimed to investigate how the perception of being negatively evaluated by colleagues could influence capacity to engage therapeutically with residents and work related stress experienced by professional dementia carers.....	222

Figure 5.4. Significant negative correlation between the perceived capacity to engage therapeutically with residents who exhibit behaviours that challenge and work related stress.....229

Figure 5.5. Illustration of negative correlation between perceived organisational support and work related stress within professional dementia carers.....230

Figure 5.6. Observed positive correlation between fear of being negatively evaluated in the workplace and perceived work related stress.....231

Figure 5.7. Negative correlation between fear of being negatively evaluated by colleagues in the work place and the perceived capacity of professional dementia carers to engage therapeutically with residents who exhibit behaviours that challenge.....232

Figure 5.8. An illustration of the full mediation of perceived capacity to therapeutically engage with residents who exhibit behaviours that challenge between fear of negative evaluation from colleagues and work related stress.....233

Figure 5.9. Core category within the TEST model.....235

Figure 5.10. Interventions that encourage collaborative working with colleagues and reduce notions of being negatively evaluated could increase capacity to engage with residents, who have BPSD, and thus reduce work related stress.....238

Figure 5.11. There is a need to develop quantitative measures consisting of items that are specific in tapping into how the categories influence the core category within the TEST model.....239

Figure 6.1. Protective factors that may facilitate professional dementia carers in their capacity to engage with residents and offset work related stress.....250

Figure 6.2. Future studies could consider both biological and perceived indicators of stress when investigating the TEST model.....252

Figure 7.1. Illustration of Therapeutic Engagement Stress Theory.....256

Figure 7.2. Higher capacity to therapeutically engage with patients, who exhibit behaviours that challenge, was shown to correlate with lower levels of perceived stress within mental healthcare professionals.....257

Figure 7.3. The propensity to have repetitive negative thoughts illustrated how factors that are intrinsic to mental healthcare professionals may influence their capacity to engage therapeutically with patients and work related stress.....258

Figure 7.4. BTC denotes Behaviours that Challenge. Chapters 3 and 4 demonstrated how Workplace Settings and Care Recipients can influence the core category within the TEST model.....260

Figure 7.5. The capacity to engage with residents who exhibit behaviours that challenge was shown to fully mediate the relationship between fear of being negatively evaluated by colleagues and work related stress.....261

Figure 7.6. Measures used to tap into the core category of the TEST model.....266

Figure 7.7. The next stage of the research programme, as informed by this thesis, will be to develop measures, which consists of items that are specific to tapping into each category and core category in the TEST model.....267

Published Work

At the time of writing, the following scientific communication has occurred from this programme of research:

Rippon, D. Smith, M., McDonnell, A., McCreddie, M., Bristow, M. & Wetherell, M. (2018, September). Hair Cortisol Concentration and Work Related Stress within Professional Carers of People with Dementia. Presented at British Psychological Society Psychobiology Section Annual Scientific Meeting, Cumbria.

Acknowledgements

Firstly, I would like to acknowledge my partner Natalie and two sons, Ethan and Ryan-Isaac. I would particularly like to thank Natalie for all of her proof reading over the past three years. I would also like to thank my parents, Kath and Kevin Brown, and my brother Luke for their support throughout.

I would like to thank my two internal supervisors, Dr Mark Wetherell and Dr Michael Smith, for providing me the opportunity to continue my research interests as part of a PhD programme. You have been a great supervision team, who have provided me with both the autonomy and guidance when required throughout my PhD.

I would also like to thank my two external supervisors, Professor Andrew McDonnell and Dr Michael McCreadie. It is with great sadness to say that Dr Michael McCreadie passed away earlier in 2018. His work will continue to emanate in the field of Autism and I am grateful for our conversations during the earlier stages of my PhD programme.

I would also like to thank Professor Ian Andrew James for his support and supervision throughout my time of working as a practitioner and researcher at the Newcastle Challenging Behaviour Service – Northumberland, Tyne and Wear NHS Foundation Trust. Your philosophy concerning the safe prevention of behaviours that challenge continues to inspire my work and I look forward to our continued collaboration.

Finally, I would like to thank each and every health/social care professional who took part in the studies as part of my PhD programme. You all do a monumental job.

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the Faculty Ethics Committee on 22nd March 2016.

I declare that the word count of this Thesis is 58,919 words

Name: Daniel Rippon

Signature:

Date:

Part A

Chapter 1: A review of behaviours that challenge within health and social care professions and work related stress.

This first chapter introduces the occupational issue of providing formal care for people who exhibit behaviours that challenge and work related stress within health and social care professions. The rationale and aims for conducting a Classic Grounded Theory (CGT) study as the initial phase of this mixed methods research programme are also presented. In keeping with the CGT methodology, an extensive literature review was not conducted prior to the collection of qualitative data. This was to ensure that the developed theoretical model was informed by the articulated experiences of participants concerning the causes of and protective factors against work related stress in health/social care professionals who provide care for people who exhibit behaviours that challenge.

1.1 Behaviours that challenge and work related stress in health and social care professions

Behaviours that challenge have been defined as any behaviour of such intensity, frequency or duration as to compromise the wellbeing of the individual exhibiting the behaviour, or others, which can lead to the implementation of restrictive/aversive interventions or exclusion (Royal College of Psychiatrists, 2007). Providing care for people who exhibit behaviours that challenge has been identified as a prominent occupational hazard that can impact the levels of work related stress experienced by health and social care professionals (Schablon, Zeh, Wendler, Peters, Wohlert, Harling & Nienhaus, 2012). Work related stress has been described as the harmful response to

excessive pressures and demands that professionals experience as a result of their occupation (Health and Safety Executive, 2017). Between 2014 and 2017, the industry sector with the greatest incidences of absenteeism due to work related stress in the UK was observed to be in occupations associated with the delivery of health and social care (Health and Safety Executive, 2017). Work related stress was also the most commonly reported reason for healthcare professionals, such as Nurses, to consider leaving their profession (NHS Staff Council, 2012). It has also been observed that alongside people who work in protective services, such as Policing, professionals who work within health and social care services encounter the most incidences of violence at work in comparison to employees who work in other industry sectors in the UK (Health and Safety Executive, 2016). It is therefore necessary to gain an understanding of the work related factors that can potentially influence the stress levels experienced by health/social care professionals who provide care for people who exhibit behaviours that challenge.

Previous research has suggested that overt acts of physical aggression towards health/social care professionals can occur in such situations where a care recipient does not have the capacity to fully comprehend or accept the care that is being administered due to impaired cognition (Winstanley & Whittington, 2004). In accordance to the Mental Capacity Act (2005) the capacity to comprehend, consent to, and accept treatment can potentially be impacted in patients experiencing cognitive impairments due to symptoms associated with brain injuries, stroke, dementia, learning disabilities, mental health diagnoses and delirium. Existing literature has indicated that the highest incident rates of care recipients directing aggressive behaviours towards health and social care staff can occur within settings such as Older Adults (Schablon, Zeh, Wendeler, Peters, Wohlert, Harling & Nienhaus, 2012),

Mental Health, Learning Disability and Autism services (National Institute for Health and Clinical Excellence, 2015) in comparison to other general hospital settings. It has been recognised that within some Nursing Home, Mental Health and Learning Disability services, the majority of frontline staff can be vulnerable to experiencing moderate to high levels of perceived stress due to the demand of providing care for people who exhibit physical aggression (Franz, Zeh, Schablon, Kuhnert and Nienhaus 2010). Thus, there is a need to ascertain the work related factors that could potentially serve as protective factors in negating stress for health/social care professionals who are exposed to aggressive behaviours within their occupation.

Existing literature has suggested that behaviours, other to that of physical aggression, can also be perceived as being challenging for frontline health/social care staff. Schablon, Zeh, Wendler, Peters, Wohlert, Harling and Nienhaus, (2012) observed a significantly higher incident rate of not only physical but also verbal aggression being directed towards health/social care staff working in Older Adult inpatient services in comparison to professionals working in general hospital settings. Work related stress was identified as being most prominent in professionals that reported to have encountered care recipients who exhibited either physical or verbal aggression on a daily basis within the workplace. This would suggest that verbal aggression, as exhibited by care recipients, is a behaviour that can also be perceived as being challenging for frontline health/social care staff. Previous research has also suggested that regular exposure to other unhelpful behavioural symptoms such as apathy to engage in treatment interventions (Schmidt, Dichter, Palm & Hasselhorn, 2012) and screaming (Miyamoto, Tachimori & Hiroto, 2010), can be detrimental to the wellbeing of health/social care professionals. Self-Injurious Behaviours exhibited by children with Autism (Baghdadli, Pascal, Grisi & Aussilloux, 2003); repetitive vocalisations in

adults with an Intellectual Disability (Matson & Rivet, 2009); and Impulsivity in people with a diagnosis of Bipolar Disorder (Hurley, 2008), have all been identified as behavioural symptoms that some health/social care professionals may deem as being challenging. This indicates that health/social care professionals who work in specialism, such as Older Adults, Mental Health, Learning Disability and Autism services may be exposed to a number of different behavioural symptoms that could be perceived as challenging. Existing literature has indicated that working in professions that consist of providing care to people with unhelpful behavioural symptoms can be stressful. Thus, the current thesis aimed to develop a theoretical framework that was explicitly informed by the experiences of health/social care professionals to provide explanations for the causes of and protective factors against work related stress within frontline staff who provide care for people who exhibit behaviours that challenge in the workplace.

1.2 Applying an exploratory sequential mixed methods research design

The current research program employed an exploratory sequential mixed methods research design in order to develop and investigate a work stress theory relevant to health/social care professionals who manage behaviours that challenge. Exploratory sequential mixed methods designs involve the collection and analysis of data, which then informs the data collection strategy for subsequent studies (Mertens, 2005). This can comprise of conducting an initial qualitative study, which informs the development of an initial theory that can then be tested using appropriate quantitative methodologies (Hanson, Creswell, Plano Clark, Pettko & Creswell, 2005). Such research designs can ensure further rigour to the process of theory development through using quantitative methods to demonstrate support or refine theoretical frameworks that have been informed by qualitative approaches (Guettermann,

Babchuk, Howell-Smith & Stevens, 2017). Cresswell (2015) has also stated that within exploratory sequential mixed methods research designs, analysis of qualitative data can inform the battery of quantitative measures that are appropriate in testing a given theory. Thus, the current study aimed to develop a theoretical framework, using Classic Grounded Theory methodology, which was then to be tested using appropriate quantitative methodologies.

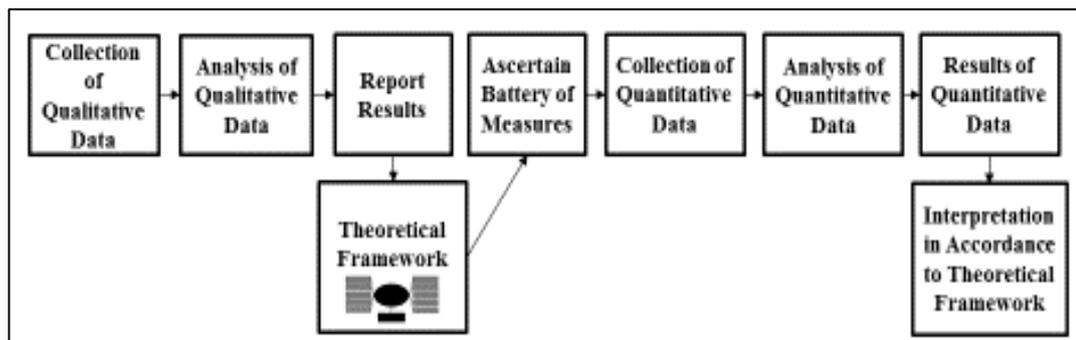


Figure 1.1 The steps of the exploratory sequential mixed methods research design used to explore work related stress in health and social care professionals who manage behaviours that challenge.

1.3 The rationale for conducting a Classic Grounded Theory study to explore the work related factors that potentially cause and offset stress in health/social care professionals who manage behaviours that challenge.

There are several existing theories that provide propositions as to how stress can occur within general workplace settings. The Person-Environment Fit model (French & Kahn, 1962) purports that work related stress can occur when employees perceive a discrepancy between personal needs and the way in which the working environment fulfils employee needs. The Demand-Control-Support model (Karasek & Theorell, 1990) suggests that the amount of stress experienced is dependent upon levels of work related demands, perceived level of control to complete tasks and the amount of

support that is available to employees in their profession. The Transactional Model of Stress and Coping (Lazarus & Folkman, 1984) suggests that work stress levels are dependent upon internal cognitive processes and the way in which employees cognitively appraise work related challenges. According to this model, *primary* and *secondary* appraisals of a stressor illustrates the process as to how stress can potentially manifest. The primary appraisal phase concerns how people evaluate a particular stressor. The secondary appraisal phase illustrates the process of how people can evaluate their own ability or available resources to cope with the perceived stressor. Although the Transactional Model of Stress and Coping is a widely used model in the field of occupational stress, there is a need to ascertain and illustrate the specific stressors in professions that concern the safe management/prevention of behaviours that challenge. It is also necessary to ascertain under which specific conditions health/social care professionals could perceive that they do not have the ability to cope with the stressors that could occur alongside the safe management/prevention of behaviours that challenge. There is also an essential requirement to identify strategies that could be implemented in health/social care professions as a means to negate the work related stressors that are detrimental to the wellbeing of frontline staff who provide care for people who exhibit behaviours that challenge. The rationale for using a Grounded Theory study, as part of this thesis, was that it provided an opportunity to identify the stressors that are specific to the management/prevention of behaviours that challenge, as informed by the articulated experiences of frontline health/social care staff. As indicated by Hastings (2010), there is also a need to develop a theoretical framework that provides illustrations of how work related stress could be reduced in professions that concern the safe management of behaviours that challenge, rather than just focussing on how occupational stress occurs. Thus, there is a need to explore the

articulated experiences of frontline health/social care staff to identify methods that could be applied in health/social care settings to support employees as a means to offset any identified work related stressor.

According to Equity Theory (Adams, 1965), work related stress can occur when employees perceive that they provide more professional input into their interpersonal relationships and employing organisation than the amount of rewards received. In terms of carer stress, Equity Theory has been used to explain how the process of providing informal care for family members can be stressful. Baikie (2002) illustrates how providing care for a spouse with dementia can cause the informal carer to experience diminishes in the marital relationship as the care recipient begins to lose capacity to provide emotional support and intimacy. Thus, stress could occur within informal carers who do not receive the same level of care or support from spouses or family members. However, it is unclear as to whether frontline health/social care staff would expect the type reciprocity from care recipients who exhibit behaviours that challenge as found in informal cares of spouses or family members. Thus, there is a need to ascertain if frontline health/care professionals, who encounter behaviours that challenge, experience any disparities in their profession in terms of the level of input that they provide and receive from their occupation. If this is an issue, there is a need to firstly ascertain the specific sources that may cause frontline staff, who manage behaviours that challenge, to perceive that they put more into their occupation than they receive. There is also a need to develop a theoretical framework that could illustrate methods to reduce any disparities that could cause frontline staff to experience the notion of providing more professional input than the occupational rewards being received.

These existing work stress theories provide differing explanations as to why stressors occur in workplace settings (Devereux, Hastings & Noone, 2009) and have not been developed specifically to explain work related stress within professions that consist of providing health and social care to people who exhibit behaviours that challenge. It has also been acknowledged that there is an essential requirement to develop theoretical frameworks as a means to direct research relevant to the role of frontline health/social care professionals and work related stress (Hastings, 2010). Therefore, an initial aim of this thesis was to develop a theoretical framework that was informed by the experiences of professionals who provide health and social care for people who exhibit behaviours that challenge as a means to provide nuanced explanations for work related stress in this professional group and to underpin subsequent studies in the field of research.

1.3.1 Classic Grounded Theory

Glaser and Strauss (1967) developed Classic Grounded Theory (CGT), which is a methodology of analysing data as a means to develop a theoretical framework that illustrates, explains and proposes methods of how people resolve core problems that are specific to a social phenomenon of interest. There are four key criteria that must be adhered to as a means of developing conceptualisations of a social phenomenon using CGT, which are **fit**, **understanding**, **generalisability** and **control** (Glaser & Strauss, 1967).

The term 'fit' means that the developed theoretical framework should be relevant and applicable to the people who are specifically attached to the social phenomenon being investigated. Given this basic principle, it was necessary to use the CGT methodology as a means of identifying a core problem that could explain work related stress within

professions specifically where people provide health and social care to recipients who exhibit behaviours that challenge.

The criterion of ‘Understanding’ is to ensure that the people who are associated with the social phenomena that is being investigated can understand the developed theoretical framework (Glaser, 1978). It is therefore pertinent to use CGT methodology as a means to develop a theoretical framework that can be easily understood by health and social care professionals and clearly explains the causes of and potential strategies to offset stress within professional groups who provide formal care for people with behavioural symptoms.

The criterion of ‘Generalisability’, in accordance to CGT, advocates that the developed theory should be able to be applied across a number of different settings and situations as a means to explain and propose resolutions for a particular problem (Glaser, 1996). It was therefore useful to use a CGT methodology as a means to develop a theoretical framework that posited the work related factors that contribute to and offset stress across the varying health and social care settings where professionals provide care for people who exhibit behaviours that challenge.

The final criterion of ‘Control’ indicates that the developed theoretical framework can be used by people associated with the social phenomenon being investigated as a means to develop hypotheses and inform strategies to overcome a particular problem within applied settings. Thus, an aim of this thesis was to develop a theoretical framework that could be applied practically as a means to assist with the identification and informing strategies to negate stressors for health/social care professionals who manage behaviours that challenge.

1.3.2 Aims and objectives of the Classic Grounded Theory study for the current thesis

1. The initial study for this thesis aimed to develop a theoretical framework, using CGT methodology, that illustrated a core issue and also provided propositions for the causes of and protective factors against work related stress for health/social care professionals who manage behaviours that challenge as part of their role.

2. In accordance with the CGT methodology, an extensive literature review was not conducted prior to data collection in order to ensure that the core issues and potential strategies to negate work related stress were entirely informed by the participants (Glaser, 2003). Relevant literature will therefore be discussed in relation to the qualitative data collected and the developed theoretical framework. For the purpose of reflexivity and transparency, it must be noted that I have previously worked in NHS Challenging Behaviour and community/inpatient mental healthcare services. However, this previous experience was useful when conducting the CGT study, as the researcher must have some awareness of what preliminary questions to ask participants (Walker & Myrick, 2006) and where to begin the sampling process (Coyne, 1997) in order to collect data that is relevant to the research topic being investigated.

3. The developed theoretical framework will also be used to generate hypotheses, some of which will be tested using quantitative methods as part of the current research programme, as a means to add knowledge to the area of work related stress within health/social caring professions and the management of behaviours that challenge.

The research question for the CGT study within the current thesis was ‘What are the work related factors that influence stress levels experienced by health and social care professionals who provide care for people who exhibit behaviours that challenge?’.

1.4 Method

1.4.1 Design Approach

The Classic Grounded Theory (Glaser & Strauss, 1967) methodology was utilised as a means to develop a theoretical framework that illustrated the occupational issues for professionals, who provide health and social care for people who exhibit behaviours that challenge, regarding the causes of and protective factors against work related stress.

1.4.2 Participants

A theoretical sampling strategy was employed in accordance with data collection protocols for conducting a Classic Grounded Theory study. Theoretical sampling is a procedure that consists of the ongoing collection/analysis of data, coding of transcripts and reflection to inform who to recruit subsequently as a means to develop theoretical categories that illustrate the core concerns of the participants attached to the social phenomenon being investigated (Glaser, 1978). As part of the CGT methodology, it is recommended that a purposive sampling strategy is initially employed as a means to develop theoretical categories before commencing with the theoretical sampling process and identification of a central problem as explained by the emerging theory (Brekenridge & Jones, 2009). In the context of the current thesis, theoretical categories encapsulated work related factors and how they potentially influence stress levels within health and social care professionals who manage behaviours that challenge. It was therefore necessary to begin the study by recruiting a purposeful

sample of health and social care professionals as a means to ascertain the theoretical categories, or work related factors, that could provide possible explanations for the causes of and protective factors against work related stress. Once this was completed, theoretical sampling commenced as a means to collect qualitative data to verify the work related factors and identify a central problem (core category) that could provide explanations as to the factors that potentially contribute to and offset stress in health social care professionals who manage of behaviours that challenge. Participants in the theoretical sample were shown and asked to comment on the developing theoretical framework to ascertain if it was indicative of explaining work related stress in their profession. An integral inclusion criterion for the purposeful and theoretical sample was that participants were required to provide health or social care duties for people who exhibit behaviours that challenge in a professional capacity. In order to gain opportunities for recruiting participants, I contacted former employers at organisations that provide treatments and assessments for people who exhibit behaviours that challenge. I also presented the aims of this study at relevant board meetings within organisations that were appropriate for the research topic under investigation as a means to obtain approval to recruit frontline health/social care staff.

It has been posed that focus groups allow researchers to obtain a breadth of data concerning the research topic under investigation, whereas 1:1 interviews enable participants to discuss their experience of a particular phenomenon in greater depth (Lambert & Loiselle, 2008). Therefore, focus groups were initially conducted within both the purposeful and theoretical sampling phases of data collection to explore the breadth of participants' experiences regarding work related stress and the management of behaviours that challenge. The initial focus group that was conducted was in the purposeful sampling phase of data collection was beneficial in developing the

interview schedule, and generating questions that were conducive in exploring work related stress and the management of behaviours that challenge in health/social care settings. Thus, the focus groups enabled participants to articulate the aspects of their profession that served to either cause or negate work related stress. 1:1 semi-structured interviews were conducted to conclude both the purposeful and theoretical sampling phases of data collection. Thus, the 1:1 semi-structured interviews enabled me to have more focussed discussions with participants, which facilitated the development of a theoretical framework that was indicative of work related stress and the management of behaviours that challenge.

1.4.2.1 Purposeful sample

The purposeful sample comprised the following participants and the method in which the data were collected is presented in chronological order below.

A focus group with 10 professional community mental health support workers for working age adults who were employed within the third-sector. This focus group comprised of 6 females (mean age = 45.33 years, SD = 12.42) and 4 males (mean age = 51.75 years, SD = 14.34).

A 1:1 semi-structured interview was conducted with a female Staff Nurse, aged 53 years, who worked within a Children and Younger Person's Mental Health Inpatient setting.

A 1:1 semi-structured interview was conducted with a female Staff Nurse, aged 27 years, who worked within a Learning Disability inpatient setting.

A 1:1 semi-structured interview was conducted with a female Support Worker, aged 20 years, who worked within a Children and Younger Person's Mental Health Inpatient setting.

1.4.2.2 Theoretical sample

Theoretical sampling was employed once the data from the purposive sample had been collected, transcribed, coded and the categories/work related factors that could potentially explain the causes of and protective factors against stress had been tentatively identified. Theoretical sampling consisted of conducting further focus groups/interviews with suitable health and social care professionals as a means to reach data saturation of the developed categories, and to formulate the overall theoretical framework. The beginning of each focus group or 1:1 semi-structured interview, within the theoretical sampling phase, consisted of showing and explaining the developed theoretical framework to participants before commencing with the interview schedule. The theoretical sample consisted of the following participants and the method in which the data was collected is presented in chronological order below.

A focus group with four female support workers who worked within community and residential Autism services (mean age = 45 years, SD = 16.99).

A focus group with five female support workers who worked within community and residential Autism services (mean age = 36.20 years, SD = 8.07).

A focus group comprising a Clinical Psychologist (male, aged 38 years), and a Challenging Behaviour Nurse (female, aged 53 years), who both worked within Older Adult Community Services, and a Directorate Manager of Community services (female, aged 49 years).

A focus group comprising of support workers who used non-invasive psychological approaches in the management of behaviours that challenge with Autism community services, consisting of one male aged 24 years and four females (mean age = 31 years, SD = 9.42).

A focus group that consisted of a Clinical Nurse Specialist (male, aged 46 years), a Lead Trainer in the management of behaviours that challenge, (male, aged 52 years), an Assistant Psychologist (male, aged 28 years), and two support workers (1 male aged 24 years and 1 female aged 24 years) who worked within a Learning Disabilities Residential Service.

A focus group consisting of one male Team Leader (aged 38 years), two female Team Leaders (mean age = 51.50, SD = 2.12), 1 male support worker (aged 25 years), and a female support worker (aged 21 years) who worked within an Autism community service.

A focus group consisting of a Needle Exchange Assistant (male, aged 45 years), Community Clinical Manager (female, aged 28 years), Drug Rehabilitation Lead (male, aged 61 years), Duty Worker (female, aged 54 years) and a Clinical Lead (female, aged 32 years) who worked within a Drug and Alcohol rehabilitation service.

A 1:1 interview was conducted with a male Registered Mental Health Nurse (aged 34 years), who worked within Organic Inpatient and Older Adult community services.

A 1:1 interview was conducted with a male Behaviour Nurse Specialist (aged 53 years), who worked within Autism services.

A 1:1 interview was conducted with a female Support Worker (aged 34 years), who worked within a Community Mental Health service for working age adults. This participant also took part in the first focus group as part of the purposeful sample.

Finally, a 1:1 interview was conducted with a female Support Worker, who worked within a Community Mental Health service for working age adults. This participant also took part in the first focus group as part of the purposeful sample.

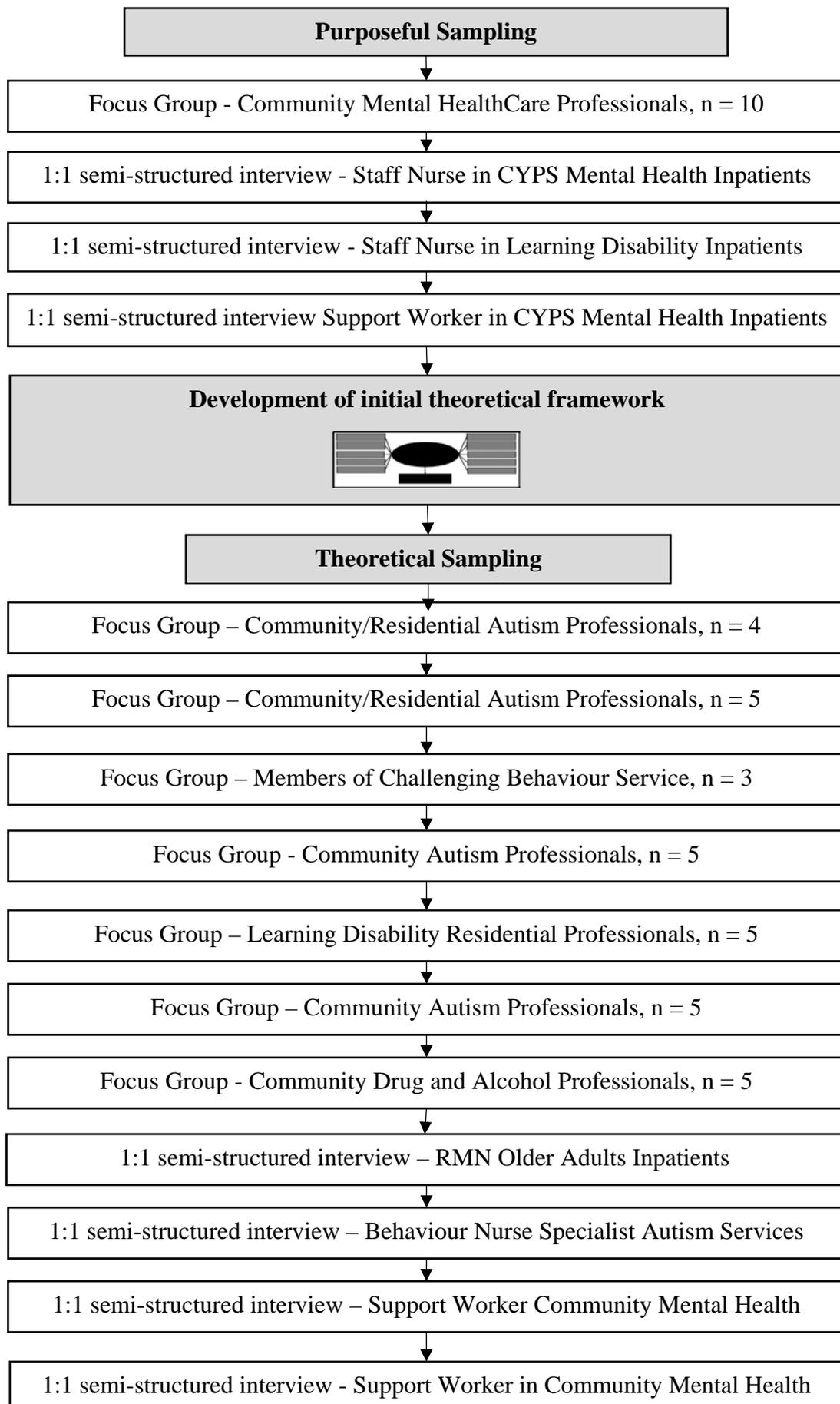


Figure 1.2. Flow chart regarding sampling strategy.

1.4.3 Materials

An initial interview schedule was developed and utilised to guide discussion in the first focus group with community mental health support workers. The data collected from each focus group and 1:1 semi-structured interview informed the continual adaptation of the interview schedule throughout the purposeful and theoretical sampling stages. This was to enable the iterative exploration of the commonalities and different perspectives of participants throughout data collection. A digital Dictaphone was also used to record the focus groups and interviews.

To obtain participant characteristics relevant to work related stress, the Perceived Stress Scale (Cohen, Karmarck & Mermelstein, 1983) was administered. The Perceived Stress Scale (Cohen, Kamarck & Mermelstein, 1983) was developed as a self-reported measure to tap into levels of subjective stress as experienced over a preceding month. The PSS comprises 10 items and requires participants to state the extent to which they had experienced subjective stress over the previous month. Participants are required to respond on a 5 point Likert scale ranging from 0 = never to 4 = very often. For the purpose of this study, participants were asked to consider the 10 items of the PSS in relation to their occupation. For instance, item 1 reads on the PSS 'In the last month, how often have you been upset because of something that happened unexpectedly?' Participants were required to consider such items in relation to their occupation and state to what extent they had become upset due to something that had happened unexpectedly at work. The scores derived from the PSS range from 0 – 40, with higher scores indicating greater levels of perceived stress experienced

over the month prior to the date of data collection. The PSS taps into a single construct, perceived stress, with a Cronbach's alpha being reported at 0.85.

Participants were also asked to complete a demographic information sheet, which asked for age, gender, length of time in current role, duration of time in their current or similar role and the behaviours that were deemed to be most challenging when exhibited by care recipients.

1.4.4 Procedure

This study was granted ethical approval from the Research and Ethics Committee at the University of Northumbria at Newcastle. This project was also registered and approved by the Research and Development department at Northumberland, Tyne and Wear NHS Foundation Trust who agreed for their employees to take part in this study. A multi methods approach to data collection was used in which focus groups and 1:1 semi-structured interviews were conducted. All participants were asked to attend a private room within their place of work to meet with the researcher. Participants were provided with an information sheet and a full briefing regarding the aims of the study. A group briefing was provided where focus groups were conducted, whereas for 1:1 interviews, participants were briefed on an individual basis by the researcher. Once the briefing had been completed, participants were asked to sign an informed consent sheet to document their agreement to take part in the study. Participants were then asked to complete a demographic information sheet and to write down the type of behaviour that is perceived to be most challenging to manage as part of their role. Participants then completed the Perceived Stress Scale. Participants then handed in the completed demographic information sheet and questionnaires to the researcher. The researcher notified participants that the digital Dictaphone would be switched on to

then begin the recording of the focus group or 1:1 semi-structured interview. A semi-structured interview schedule was used, comprising of open ended questions, as a means to direct the discussion of the focus groups/1:1 interviews that was relevant to the aims of the study. Socratic questioning was also used to avoid participants from using single word answers, to encourage elaboration on any discussion points that had been made and to ensure that responses were relevant to the research aims. The focus groups and 1:1 interviews lasted approximately 90 minutes each. Once the focus groups/1:1 interviews had ceased, participants were notified the Dictaphone had been stopped/switched off, were then provided with a debrief sheet and thanked for their time.

1.4.5 Procedure for Analysis

The process of comparative analysis was adhered to, in accordance with CGT methodology (Glaser & Strauss, 1967), as a means to explore the experiences of participants who worked across a number of different settings/specialisms. The commonalities within participants' articulated experiences were identified and applied to develop a theory that explained work related stress in the context of providing care for people who exhibit behaviours that challenge. As part of the purposeful sampling phase of data collection, comparative analysis consisted of coding the transcripts of the focus group and 1:1 semi-structured interviews to ascertain the common and conflicting perspectives of participants, across the various settings, concerning how work related factors potentially impacted stress levels experienced. Coding of the transcripts involved consideration of the qualitative data with the following questions in mind: 'What are the participants describing?'; 'What do the participants care about?'; 'What are the participants worried about?'; 'What are the participants trying to do?' and 'What explains the different behaviours, thoughts and actions of the

participants?'. Following the data collection from the purposeful sample, theoretical categories were developed that illustrated the work related factors that could potentially contribute to or offset work related stress within participants. Comparative analysis of the transcripts then continued throughout the theoretical sampling phase of data collection to verify if the theoretical categories/work related factors were relevant to health and social care professionals across a number of different specialisms in explaining work related stress and the management of behaviours that challenge. Theoretical sampling involved collecting sufficient data to saturate the theoretical categories, generate hypotheses and develop the core category that illustrated the central problem for health and social care professionals in terms of work related stress and the management of behaviours that challenge. Once data saturation had been achieved, in that data collection had ceased to provide novel insights regarding work related factors and how they influence stress levels in health/social care professionals, a research report was written to illustrate the emergent theoretical framework in relation to participants' articulated experiences and existing literature.

1.4.6 Additional Participant Demographic Information

Table 1.1 provides some additional demographic data on the participants who took part in the Grounded Theory study.

Table 1.1 Demographic information and characteristics of participants within both the purposive and theoretical sample who took part in the Classic Ground Theory study.

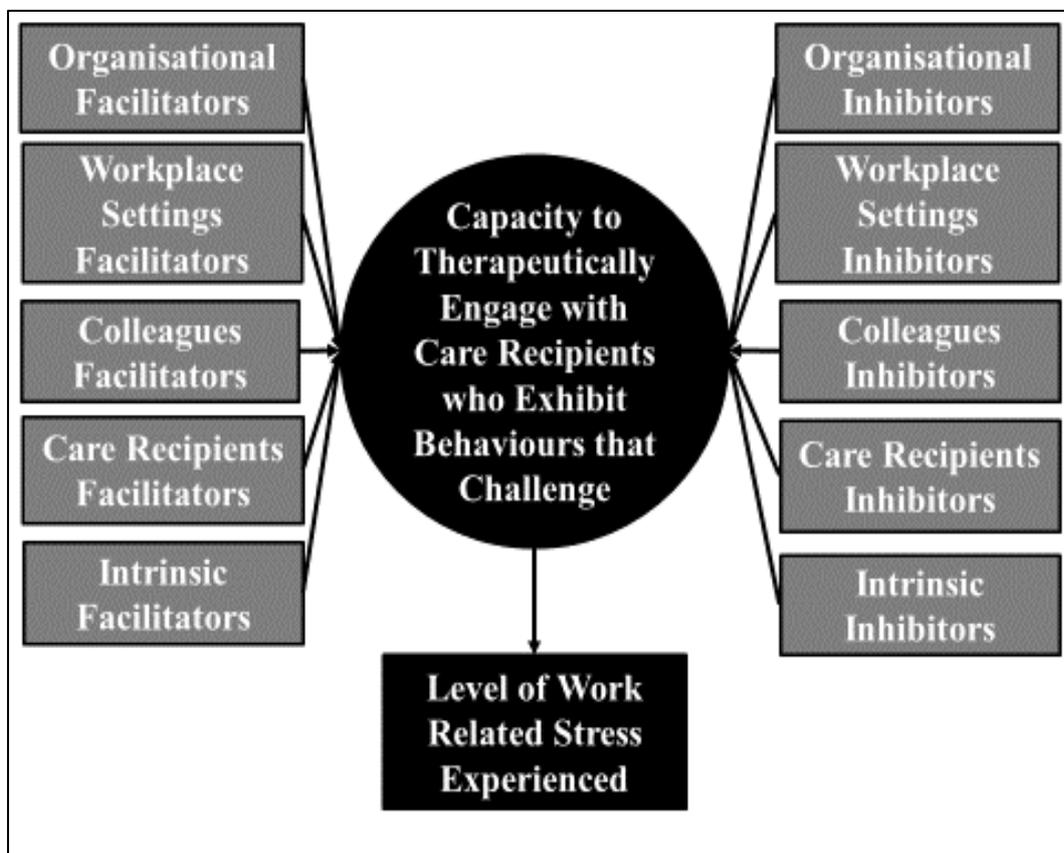
Characteristics	n	%
Gender		
Female	31	66
Male	16	34
Age		
20 - 29	14	29.8
30 - 39	7	14.9
40 - 49	13	27.7
50 - 59	9	19.1
60+	4	8.5
Role		
Support Worker	24	51.1
Clinical Lead	8	17
Nurse	6	12.8
Senior Support Worker	4	8.5
Duty Worker	2	4.3
Clinical Psychologist	1	2.1

Assistant Psychologist	1	2.1
Trainer in Behaviours that Challenge	1	2.1
Specialism		
Autism Community & Residential services	20	42.6
Working Age Adult Mental Health Community services	10	21.3
Intellectual Disability Residential services	5	10.6
Drug & Alcohol Community Services	5	10.6
Older Adult Community Services	2	4.3
Children and Younger People's Mental Health	2	4.3
Inpatient services		
Intellectual Disability Inpatient services	1	2.1
Older Adults Inpatient and Community services	1	2.1
Community Mental Health service	1	2.1
Behaviour deemed to be most challenging to manage		
Verbal Aggression	18	38.3
Physical Aggression	11	23.4
Self Injurious Behaviours	7	14.9
Apathy to engage with treatment interventions	5	10.6
Repetitive Vocalisations	3	6.4
Lying (being deceitful)	1	2.1
Vandalism	1	2.1
Spitting	1	2.1

The descriptive statistics in Table 1.1 suggested that the majority of participants deemed verbal aggression to be the most difficult behaviour to manage in their professions when exhibited by care recipients. A minority of participants purported that such behaviours as being lied to, vandalism and spitting were behaviours that were the most difficult behaviours to manage in health or social care settings.

1.5 Results and Discussion of the Developed Theoretical Framework Concerning Work Related Stress and the Management of Behaviours that Challenge

The following section will demonstrate how the articulated experiences of participants informed the development of categories, the central core category and overall theoretical framework as a means to provide explanations to the causes of and protective factors against work related stress in frontline staff who manage behaviours that challenge. Analysis of the qualitative data set, using Grounded Theory methodology led to the development of the Therapeutic Engagement Stress Theory (TEST) (Figure 1.3).



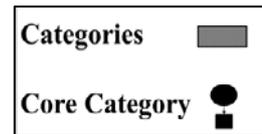


Figure 1.3. Therapeutic Engagement Stress Theory.

After coding the transcripts, the core category indicated that the capacity at which health/social care professionals are able to engage therapeutically with care recipients who exhibit behaviours that challenge, can determine levels of work related stress experienced. The capacity to therapeutically engage is defined by the extent to which health/social care professionals are able to administer care interventions that elicit beneficial outcomes for the care recipient. TEST posits that organisational factors, work place settings, colleagues, care recipients and qualities intrinsic to health/social care professionals can influence the ability for frontline staff to engage with care recipients who exhibit behaviours that challenge. The following sections will provide discussions of participants' articulated experiences to illustrate how the categories, within the TEST model, either inhibit or facilitate successful therapeutic engagement with care recipients who exhibit behaviours that challenge; and how these processes can potentially offset or elicit work related stress.

NB The term service user will be used to describe care recipients, as this was the nomenclature used by most of the participants.

1.6 The facilitating and inhibiting effects of Organisational Factors on Staff Interactions with Service Users and the Impact upon Work Related Stress

The following subsection will illustrate how organisational factors have the potential to either assist or inhibit frontline staff to therapeutically engage with service users who exhibit behaviours that challenge. In relation to the current study, organisational factors are defined by how the cultures, policies and procedures of employing organisations can affect the caring practices and levels of work related stress experienced by frontline staff who provide care for people who exhibit behaviours that challenge.



Figure 1.4. The current section reports how organisational factors can either inhibit or facilitate health/social care professionals in their capacity to engage therapeutically with care recipients who exhibit behaviours that challenge.

1.6.1 Multi-agency working

The process of partnership working with external health/social care organisations, and how this influences the capacity to engage with service users and work related stress, was a common feature across the qualitative data set. There have been a number of health initiatives in the UK that have advocated for the collaborative working between health and social care services, one example being the NHS Five Year Forward View (Naylor, Alderwick & Honeyman, 2015), to ensure the provision of holistic care packages to service users who have multiple needs. It has been recognised that people with long-term conditions can often experience symptoms that are caused or perpetuated by concurrent biological, psychological and social factors (Coulter, Roberts & Dixon, 2013). The biopsychosocial model of care was first introduced by Engel (1977) who stated that biological, psychological and social factors should all be considered by healthcare professionals when assessing, diagnosing and treating patients. Thus, it has been advocated that the contribution of expertise from multiple services is essential in ensuring the delivery of holistic care packages that successfully meet the biological, psychological and social needs of services users (Humphries, 2015). The ideal model for collaborative working between health and social care services is to ensure that service users receive thorough assessments, appropriate interventions, and regular monitoring throughout treatment (Edwards & Miller, 2003). This notion of collaborative working is also embedded in law as the Health and Social

Care Act (2012), which states that health and social care services have an obligation to collaborate with external agencies to ensure the delivery of holistic care packages that meet the biopsychosocial needs of service users. However, such multiagency working is dependent upon the quality of communication and collaboration between all health and social care services within a given network (Cunningham, et al., 2011). Therefore, it is imperative for frontline staff to liaise and collaborate with partnership organisations as a means to comply with governmental initiatives that advocate for the integration of health and social care services.

1.6.2 Sharing responsibilities and service user specific knowledge with external organisations

Firstly, some participants stated that working within a network of services could be beneficial in negating work related stress as it provided outlets to share caregiver responsibilities and patient specific knowledge with partnership organisations.

“Participant 24: A lot of the stress is due to taking responsibility for things that aren’t yours. The moment you take responsibility for something you cannot control, that is the moment your stress levels will increase. If you look at it that way, you have to share responsibility with other agencies and most of the people [service users] we are involved with have a range of different professionals involved and you need to use them.”

(Participant 24 - Consultant Clinical Psychologist)

Participant 53: On the ward, I do get to spend some time with the patients and get to know them a bit better. If I know that person as much as I can from a nursing point of view or a challenging behaviour point of view, then I am going to be able to do my job better with regards to being able

to implement interventions and provide a successful discharge. [It helps to] successfully teach and discuss with the staff on discharge in different care settings how they can tweak their approaches to meet that person's needs. It's important for me to have had that therapeutic relationship with the patient [on the ward], and I can transfer that [patient specific knowledge] over within my communication to the care staff in the nursing homes. It's about helping them [care staff in nursing homes] to find solutions and approaches that are going to help them in their everyday practice."

(Participant 53 - Registered Mental Health Nurse)

These views indicated that collaborative working with partnership organisations may prevent situations of assuming excessive caregiver responsibilities and provide opportunities to share patient specific knowledge that may help to negate triggers for behaviours that challenge. This is consistent with the notion that sharing caregiver responsibilities with partnership organisations can be helpful in ensuring frontline staff do not work beyond their own remit and provides opportunities to learn skills from professionals employed by external agencies (Pinkney, et al., 2008). Informal carers of people with dementia who perceive higher levels of caregiver responsibility have shown to also experience greater levels of self-reported stress (Vedhara, Shanks, Wilcock & Lightman, 2001). Thus, it could be imperative for frontline health and social care professionals to have an awareness of their professional remit and share caregiver responsibilities with partnership organisations accordingly as a means to reduce work related stress. The current study also indicated how the process of sharing knowledge with partnership organisations could assist with the effective management of behaviours that challenge symptoms. Given that exposure to behaviours that

challenge can be stressful for employees (Bonner, Lowe, Rawcliffe & Wellman, 2002), multiagency working that consists of sharing patient specific knowledge to prevent incidences of these behaviours may also be conducive in negating work related stress within frontline staff.

1.6.3 Partnership organisations that communicate risk

Participants also articulated the importance of sharing knowledge of the potential risks attached to the behavioural symptoms of service users, with partnership organisations, as a means to ensure the safety of frontline staff.

“Participant 31: Going back historically there’s still maybe five or six people who go around this town on a regular basis who have reputations as baby grabbers and this is on their support plans or on their risk assessments or on their care plans for things that they did in school. So the first thing that anybody finds when they first look at the risk assessment is baby grabber and they did it when they were kids. They haven’t done it since but that’s the first thing you read and that’s the first thing you see and that has always been my experience. That’s what has stuck to that person. You get introduced to him and the first thing you’ll be told by the support worker is “He did this”. You will get the negative before you get the positive every single time and we are probably guilty of that as much as anybody because I think from a management point of view, you have to give everybody the information because if we don’t give the information and something happens... “Well you didn’t tell us”, that starts creating stress for everybody.”

(Participant 31 - Team Lead for a Community Autism Service)

“Participant 54: We don’t throw anybody into a service just because they have a primary diagnosis of Autism. If there are other factors that are going on, other difficulties, then we won’t necessarily take them. So we’ve reduced that horror story, or that risk of the horror story. But we also have the obligation to warn our staff. What we’ve found is that you really need a thorough introduction from the current people [external organisation] working with that individual. A good relationship with the person making the referral, usually a Social Worker, means that we can actually present to staff what could potentially happen if you don’t follow the plan. We develop a plan that is consistent with the way that we are familiar with. I think we have done that reasonably well to protect staff. But people who have been referred here have had great difficulties and have had chequered lives, they have gone through all sorts of trauma and they come to us and is it any surprise that they present with the range of behaviours that they do? But we’ve had that liaison [with the external organisation] and we’ve had the time with the person making the referral. When I think of the most recent admissions that comes to mind... one of the key factors is our development manager is extremely good at working through the process and making sure that everybody gets the fullest picture possible of new referrals. She will liaise with the Social Worker who made the referral. So I would say our development manager has been key in some of the more complex cases.

Interviewer: Yeah, and that’s how the organisation is protecting their staff?

Participant 54: Yes, ultimately it's protecting the staff which is then giving the best service to the new person coming in."

(Participant 54 - Behaviour Nurse Specialist)

These quotes indicate that communicating risk with partnership organisations can help to prepare frontline staff and develop strategies to either prevent or safely de-escalate incidences of behaviours that challenge in the work place. Social Services in the UK have reported that the sharing of information between relevant partnership organisations, in accordance with confidentiality protocol, can be integral in reducing the risk of service users experiencing harm or neglect (Hunt & van der Arend, 2002). Given that exposure to behaviours that challenge can be detrimental to the wellbeing of frontline staff (Bonner, Lowe, Rawcliffe & Wellman, 2002), communication of the known behavioural symptoms of service users between partnership organisations may also be essential in informing preventative strategies to ensure the safety of health and social care professionals.

1.6.4 Partnership organisations that regularly rotate key communicators of service user specific knowledge

Some of the participants in the current study also articulated that having designated members of staff, whose role was to communicate with partnership organisations, can also enable services to consider if they are able to successfully meet the needs of service users and develop care plans accordingly. It has been suggested that centralising communication links between key professionals within a given network can be beneficial in harnessing collaborative working between health and social care services (Mendel, Damberg, Sorbero, Varda & O' Farley, 2009). Health initiatives that have promoted integrative working between health and social care organisations have

advocated for the use of Care Co-ordinators to serve as a single point of contact to ensure cohesive communication between services within a given network of care delivery (Humphries, 2015). The role of the Care Co-ordinator can be effective in ensuring successful integrative working between hospital and community services (Stewart, Wilson, Bergguist & Thorburn, 2012). However, some participants discussed that the process of obtaining pertinent information on service users from partnership organisations can be difficult in situations where the role of Care Co-ordinator had been rotated between multiple professionals.

“Participant 6: I was working with a chap with ADHD [Attention Deficit Hyperactivity Disorder], then he got a new diagnosis. I was working with him for about eight months and in that time he had about four different Care Co-ordinators as well which wasn’t helpful because nobody really got time to get to know him. The other ones [previous Care Co-ordinators] were doing home visits and things like that and for some reason, she [current Carer Co-ordinator] wouldn’t. Anyway, she [current Care Co-ordinator] was getting me to bring him to her office and this lad couldn’t get on buses. So I was taking him up there for meetings. Anyway, she wouldn’t visit him at home, she was saying that something was flashing up on the system not to visit him at home and I was like “Why?”. There had been violence issues in the past between him and his ex-wife. I’d worked with him for eight months and then all of a sudden you’re telling me that I should be careful working with him at home. I suppose that impacted on how I worked with him from then. We had to do a whole new risk assessment and everything. I had to stop lone working for quite a while and work in twos”

(Participant 6 - Support Worker within a Community Mental Health Service)

“Participant 8: Everybody’s [service users’] workers are changing all of the time. We had one lad who had three different CPNs [Community Psychiatric Nurses] in six months, so when we tried to get care plans off people [Care Co-ordinators] it was like “Oh no, we don’t have one, or we haven’t got that yet”. I had somebody who needed support on the ward and we always say “Are there any risks?”. I was told “No, no, no, there is no risks”. Then when I went in to see them [service user] and he is telling me his history, he told me that just in his previous hospital admission a few weeks before, he took a staff member hostage. But then the staff I spoke to didn’t know about that and you are thinking “Well that staff member didn’t know”. But that’s the difficulty, there’s a lot of people usually working with one service user, or they are in and out of various different services. So I think to get a fully rounded picture is quite difficult at times...That is probably one of the biggest challenges that we face is that multidisciplinary team working, it is difficult.”

(Participant 8 - Support Worker within a Community Mental Health Service)

The current study illustrated the difficulties of when partnership organisations had regularly rotated the Care Co-ordinator who was responsible for collating and communicating information that was essential in informing frontline staff of any known risks associated with the behavioural symptoms of service users. Extracts from the data set illustrated that the failure of partnership organisations to communicate

service user specific knowledge could potentially lead frontline staff to engage in assessments and therapeutic interventions without accounting for the potential risk attached to patients who have previously exhibited behaviours that challenge. Centralising communicative links between key professionals within a given network can become compromised when one of the key communicators leaves their post or changes their role (Gold, Doreian & Taylor, 2008). This would suggest that the ideal of centralising communicative links through such key professionals as Care Co-ordinators (Humphries, 2015) may not always be apparent within the practice of health and social care delivery through multiagency working.

1.6.5 Partnership organisations that fail to communicate risk

The implications of such dysfunctional communication between partnership organisations is that frontline staff may only learn about the risks of behaviours that challenge after engaging with the service users concerned. Thus, the lack of briefing from partnership organisations could place frontline staff in vulnerable situations with newly referred service users who have previously exhibited behaviours that challenge and presented as risking the wellbeing of others.

“Participant 48: What’s more scary is when you don’t get that information and you are in a room with somebody. If you don’t have that information well in advance and you are sat in a room with somebody and then they tell you something of concern, then that’s scary.

Interviewer: Ah right, so just not having any information can be more stressful?

Participant 48: Yeah, sometimes you do get that lack of information. I have had people who have been released from prison and you get very,

very little information that you would need before they come in for an assessment.

Participant 50: Risky.

(Participant 48 – Drug Rehabilitation Lead

Participant 50 – Needle Exchange Assistant)

“Participant 8: It is that omission of information [from external organisations making the referral], that’s what makes it more difficult because when you find out later it is like “Well this does change things”. We have had it where some information is missing and then we have sorted out housing for somebody. But then it comes to light later on that they can’t actually move into there because they had a criminal record. There’s a lot of supported accommodation that have quite stringent rules and that has happened.”

(Participant 8 - Support Worker within a Community Mental Health Service)

There have been well-documented cases of where organisations have failed to communicate pertinent information with partnership services, leading to the fatal outcomes of service users concerned (Laming, 2003). The current study has also suggested that working with partnership organisations who fail to communicate information regarding risk can place frontline staff in potentially precarious and stressful situations with service users who have behavioural symptoms. Some of the participants articulated that they learnt about risks of behavioural symptoms after engaging with service users and therefore had commenced with assessment procedures or therapeutic interventions without accounting for risks attached to the behaviours

that challenge of concern. Healthcare organisations that have inadequate safety procedures for frontline staff can also potentially harness cultures where service users do not receive optimal standards of care (Katz-Navon, Naveh & Stern, 2005). Thus, multiagency working that consists of inadequate safety procedures, whereby partnership organisations fail to communicate risks of behaviours that challenge, could also potentially result in frontline staff having difficult interactions with service users; thus eliciting work related stress.

1.6.6 Working with external organisations who do not assume caregiver responsibilities

Participants also discussed how the delivery of therapeutic interventions to service users can be further complicated when partnership organisations are either inconsistent or negligent in their acceptance of caregiver responsibilities.

“Participant 6: I’ve just had a lady, she is suicidal, has depression and anxiety. Anyway, she couldn’t return to the flat where she was living. She’s got a gambling addiction as well which has been going on for a long time which has got a hell of a lot worse since she’s been down. So she has debts up to her eyeballs. Anyway, because she couldn’t go back to her flat, I said “well look, I’ll try and get you into some supported accommodation”. I started looking about. Basically the ward said “right, you can stay on the ward until [participant 6] finds you something”. Then 2 days later the ward manager says “sorry, you can’t stay on the ward, you are going to be discharged tomorrow”. So I had to set her up in an emergency interview with a supported accommodation. But the type of supported accommodation is for single homeless people. So she is in there now but I

need to get her moved to somewhere that's more suitable for her mental health, she needs a lot more support than they're giving her. So she is going to have to move again. But I had to do that because the ward manager said "she needs to be off the ward". They were telling her one thing "oh you can stay on the ward" and you think "oh great" and then the next minute they are saying something else and just messing with their heads."

(Participant 6 - Support Worker within a Community Mental Health Service).

"Participant 49: We have more problems with other services denying that people have mental health problems. That's probably one of our great griefs is that we believe that somebody has a problem that mental health should address and they don't necessarily agree with that..."

Participant 48: ...and it's just a drug and alcohol issue, it's not mental illness.

"Participant 49: It's a massive problem working in addiction services, trying to actually get people to access mental health because they don't want to know.

Interviewer: So is the problem more with the joint up working with other services?

Participant 49: Yeah, well I think its people's understanding that having a dependency on a drug or on alcohol is an illness. I think that some people don't have the understanding of it. So they think that the drugs or alcohol addiction is the prevalent problem and they won't work with them unless

they address that. I think that sometimes people need a lot of professionals around them to be able to address it, not somebody just bouncing their referral from team to team to team...

***Participant 48:**...They do admit that when you go to the untoward incidents meetings when somebody has died and they'll go "oh mental health should have seen them"... "Oh yes you should have". Which is not a lot of help when they're dead really."*

(Participant 49 - Community Clinical Manager

Participant 48 – Drug Rehabilitation Lead)

Having a shared understanding of and commitment to meeting the biopsychosocial needs of service users has been shown to encourage cohesive multiagency working between primary care services (Goñi, 1999). However, the successful delivery of healthcare through multiagency working can become compromised in situations where an individual service within a collaborative network aims to fulfil organisational goals to the detriment of ensuring the biopsychosocial wellbeing of service users (D'Amour, Goulet, Labadie, Martin-Rodriguez & Pineault, 2008). The current study also indicated that the process of working with partnership organisations that place organisational goals, such as freeing up bed space within inpatient services, ahead of ensuring the wellbeing of service users could inhibit frontline staff to deliver optimal care. Furthermore, working within a network of services where partnership organisations do not engage or acknowledge that service users require input from multiple services to ensure their biopsychosocial wellbeing, can potentially elicit stress within health/social care professionals who value the delivery of holistic care packages. Some participants articulated that the failure of partnership organisations to

assume caregiver responsibilities could trigger situations where service users become frustrated with the standards of care being delivered and exhibit behaviours that challenge.

“Participant 48: When you go into working partnerships, that’s a massive stressor as well because you go into partnership with a service that say that they can provide X, Y and Z and then when you’ve signed the dotted line, they can’t provide X, Y and Z, so your service still feels it. The patients...they don’t understand that, they don’t know what’s going on in the background, they don’t get that the other organisation can’t do what they said they would do so then that impacts the patients. They don’t make that connection so then people get angry with us. We don’t explain to them that we’ve lost 30% of our workforce in the last year by putting more and more money into other organisations that said they could do what they were going to do. So working in partnership is a massive stressor for our services.”

(Participant 48 – Drug Rehabilitation Lead)

“Participant 6: I’ve started to warn people that they cannot rely on them [external Community Mental Health Service], just to prepare people that they might not help in any sort of way, which is what’s happening. I’ve just had a lassie down stairs breaking her heart to me. She was on our floating support for months and she was doing canny. So she went off our floating support and she’d been in today to meet her advocate because she’s at crisis point as they’ve [Community Mental Health Service] discharged her from services and she can’t get any help.

***Interviewer:** Do you think if a team is not doing their job, like you say the Community Mental Health team, do you think people might lose trust in you as well if they are not getting a service from one organisation?*

***Participant 6:** It's not an issue of trust but we get the backlash and the anger, we get all the distress. We are the ones who have to pick up the pieces. That room I was telling you about that got trashed, the mental health team wouldn't help him.*

***Interviewer:** So when that person trashed the room, that was the result of the mental health team not helping him?*

***Participant 6:** Yeah, yeah. That's the second time that he's done it and that's a result of them [Crisis Team] not stepping in when they've needed to and now we've had to discharge him because he was warned last time that if he does that again, he has to go. We didn't want to [discharge him] because he was doing really well here. You can call them [Crisis Team] but they're not stepping in and I am finding it a hell of a lot more with people with borderline personality disorder. The mental health team are just backing off."*

(Participant 6 - Support Worker within a Community Mental Health Service)

Sharing resources, such as staff, funding and buildings can be pivotal in harnessing successful collaboration between health and social care services (Townshley, Watson & Abbott 2004). However, the current study has illustrated situations where health and social care professionals were required to collaborate with partnership organisations who did not have the anticipated expertise or were not willing to provide

meaningful input to the care plans of service users. It was suggested that partnership organisations that did not assume anticipated caregiver responsibilities could trigger service users to exhibit overtly aggressive behaviours, which would require management from the frontline staff who remained actively involved in the delivery of care as necessary. Given that exposure to aggressive behaviours can elicit emotional exhaustion in formal carers (Evers, Tomic & Brouwers, 2002), it is concerning that frontline staff may encounter service users who exhibit aggression as a result of partnership organisations not fulfilling their anticipated caregiver duties. Thus, the wellbeing of frontline staff could become compromised when a partnership organisation does not provide anticipated care, expertise or any meaningful input to the delivery of service users' care plans.

1.6.7 Organisational change and increased occupational demands

The previous subsection has illustrated how governmental initiatives that promote the integration of health and social care services can impact the professional practices and levels of work related stress experienced by frontline staff. Participants also articulated how changes to health/social care service delivery could influence their capacity to therapeutically engage with care recipients and levels of work related stress experienced. Health initiatives that have focussed on the restructuring of the National Health Services (NHS) through the reduction of inpatient beds (Alderwick, Dunn, McKenna, Walsh & Ham, 2016) could also have the potential to impact the practices and wellbeing of frontline health and social care staff. It has been estimated that the number of NHS hospital beds has reduced from 299,364 to 142,568 between the years of 1987/8 and 2016/17, where the largest of reductions have occurred within Mental Health, Learning Disability and Older People's inpatient services (Ewbank, Thompson & McKenna, 2017). This has placed greater emphasis on ensuring that

community/residential services have the necessary resources to deliver optimal healthcare to people with Mental Health conditions and Learning Disabilities to prevent unnecessary admissions into NHS inpatient wards (Edwards, 2014). Reduction of NHS beds has also led to an increase in the number of older people accessing health/social care services within either primary care, their own home or care home settings (Ewbank, Thompson & McKenna, 2017). The reduction of NHS beds has coincided with frontline staff, who work in such settings as care homes, being required to provide care for residents with behavioural symptoms of increasing complexities (Banerjee, 2009). Thus, participants discussed how such reforms to the NHS, and other partnership services, has influenced organisational changes within their employing organisations in order to accommodate service users with behavioural symptoms of increasing complexities.

Participant 6: *My colleague said she thinks that we've had more to deal with this year in this service than we've had in the last eight years and to be fair, she's right. The people are getting more complex, we are getting different referrals from different places now as well, whereas previously they would all be referred from care co-ordinators. Now we are doing a lot more partnership working where they can come from a lot of different places.*

(Participant 6 - Support Worker within a Community Mental Health Service)

Participant 18: *I think the level of service users we have now is completely different to when I first started eight years ago. We had*

complex service users when I started eight years ago but now we have things to consider other than just the autism.

Participant 16: *We are getting a lot more with mental health issues.*

Interviewer: *Why has that change happened do you think?*

Participant 18: *Funding, money.*

Participant 16: *It's all funding because the way we get funding has changed. It is changing again. So it went to local authority and obviously they are not willing to give money as easy now. We also get referrals now from hospitals but we never used to.*

Interviewer: *How's that impacted the staff?*

Participant 18: *Massively because service users come with more needs now than before. You used to be able to cope with just the Autism or maybe ADHD [Attention Deficit Hyperactivity Disorder] or dyslexia, they weren't a problem. But now you have got mental health [related symptoms] where they may self-harm, they are taking drugs, alcohol, becoming more non-verbal, there is more personal care involved.*

Participant 16: *A lot of staff have said that the people who are coming into the service are very different to how they used to be....*

Participant 15: *...there was not nearly as many people who were low functioning as there are now"*

(Participants 15, 16, 17 and 18 - Support Workers Community

Autism Service)

The current study indicated that organisational changes that consist of amending the referral criterion to the extent that frontline staff are required to engage with service users who have more complex healthcare needs, could potentially increase the occupational demands placed on frontline health and social care professionals. Employees can potentially resist complying with organisational change when experiencing work related stress as caused by excessive occupational demands (Vakola & Nikolaou, 2005). Thus, frontline staff may resist organisational changes that involve engaging with service users who are perceived to have behavioural symptoms beyond their expertise.

However, positive correlations have been observed within employees of hospital services between levels of self-efficacy and readiness to engage with organisational change (Cunningham, et al., 2002). Engaging in behaviour management training programmes has shown to potentially increase the self-efficacy of parents to successfully prevent or safely manage the behavioural symptoms of children with Asperger's syndrome and reduce incidences of behaviours that challenge within informal care settings (Sofronoff & Farbotko, 2002). Therefore, provision of the necessary support and training could be integral in ensuring staff have the required skills and efficacy to successfully engage with organisational changes that consists of engaging with service users who have behavioural symptoms that are more complex than previously experienced. However, some of the participants indicated that they did not receive adequate training as a means to cope with organisational changes that comprised of delivering care for service users with behavioural symptoms of increasing complexities.

“Participant 21: We didn't have much training at the time. We were obviously very much an Autism service. But we had people come through

the door fresh out of hospital who obviously had the mental health diagnosis. Sometimes we had to get mental health training because we couldn't always distinguish what was their mental health and what was there Asperger's or their Autism. So we had a bit of training on that. But we still keep saying that we need more in depth mental health training because we are a service in transition, we now have people come and go from hospital [Mental Health Inpatient service]"

(Participant 21 - Support Worker Residential Autism Service)

"Participant 18: I think it's causing a lot more frustration. Funding from the government is making us take in these service users that we would not normally have. [Previously] They would have gone to a different service, so sometimes it is difficult. I honestly don't think we have had the right training yet for mental health. This service is specific to Autism. Mental Health is different.

Participant 16: We had a meeting yesterday and I think that there is talk that they are going to do some mental health training soon.

Participant 17: We get in-house training. But mental health...we've had a little last year. But the extent of the service users that we have got, I think we need more [training].

(Participants 16, 17 and 18 - Support Workers Community Autism Service)

The British Industrial Society (2001) has advocated that any organisational change should coincide with the delivery of appropriate training to support and fulfil the occupational needs of employees. However, the current study indicated that

organisational change without the provision of appropriate training can potentially elicit uncertainties within frontline staff on how to successfully engage with service users. This raises some concerns, given that any uncertainties experienced by employees during organisational change can potentially elicit work related stress (Michie, 2002). Thus, frontline staff may experience work related stress as a result of organisational change when employers do not provide adequate training on how to therapeutically engage with service users who have conditions and behavioural symptoms that were previously beyond the remit and expertise of employees.

1.6.8 Organisations that employ the use of restrictive practices to manage incidences of behaviours that challenge

Participants articulated how organisational policies on the management of behaviours that challenge could impact the quality of therapeutic interactions that professional carers had with their service users. The way in which frontline staff prevent or de-escalate incidences of behaviours that challenge can be determined by organisational policies and procedures (Stokes, 2000). It is recommended that healthcare professionals utilise preventative or non-invasive de-escalation strategies before considering the use of restrictive practices to manage incidences of behaviours that challenge (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Restrictive practices can consist of prolonged manual holding, mechanical restraints (cuffs and emergency response belts), seclusion and pharmacological restraints (NICE Guidelines 10, 2015). Participants discussed how the use of pharmacological restraints to manage behaviours that challenge can potentially impact the capacity for frontline staff to engage therapeutically with service users.

“Participant 53: It’s [pharmacological restraints] what they know and it’s their comfort zone. It’s their comfort zone and it’s easier. It’s much easier to pop a pill for somebody so they sit and are no bother for the day than to look at people’s needs, what they are and how to address them effectively, which is much more work. The institution is in a task-oriented environment that people are used to. Psychological approaches...it’s an alien concept. I mean some of the stuff is so low level, it’s just about what you are already doing, write it down on some paper just so everyone is aware of what works [in preventing incidences of behaviours that challenge] and can follow that plan. But when you suggest these things, you’d think that you had three heads”.

(Participant 53, Registered Mental Health Nurse)

“Participant 54: I am thinking of a particular case [where] it didn't have enough positive risk-taking. It wasn't so much about using medication to keep people quiet, it was to restrict their activity so that the individuals don't go out so much. Because we don't know what will happen out there [in community settings] but if you keep everybody in here, we'll have the incidents [of behaviours that challenge] but they'll be incidents that we recognise”

(Participant 54 - Behaviour Nurse Specialist)

It has been observed that people with Learning Disabilities who access institutional care settings receive more pharmacological interventions for behavioural symptoms than those who are cared for by community services (McGillivray & McCabe, 2005). This would indicate that people accessing institutional services either experience more

severe behavioural symptoms that may warrant pharmacological interventions or that the use of medication to manage behaviours that challenge are determined by institutional policies. It has been acknowledged that although pharmacological interventions can be effective in de-escalating incidences of behaviours that challenge, their use may not address the underlying causes of behavioural disturbances and can also be harmful for some service users (Banerjee, 2009). The current study indicated that the use of pharmacological restraint to sedate service users can inhibit frontline staff to gain an understanding of the underlying causes or unmet needs that underpin behavioural disturbances in service users. This is concerning given that identifying and fulfilling the unmet biopsychosocial needs of service users may be effective in preventing incidences of behaviours that challenge (Cohen-Mansfield, 2000). Participants also considered how the process of using restrictive practices to manage behaviours that challenge can potentially result in non-therapeutic interactions with service users which can cause work related stress.

“Participant 53: I think restraint is a stressful thing for any member of staff. I don’t think people understand enough around pharmacological or mechanical restraints. I think they just see it as hands on, forced care or restraint to prevent aggression and to maintain safety, which is horrible. I think people don’t realise how much they do restrain. If somebody is on one to one, eyesight or arms-length [observation level], you will hear staff say that they are sick of wandering around with this person so they’ll encourage them to “come on, sit down, sit down” without realising how that is impacting on the person’s presentation”.

(Participant 53, Registered Mental Health Nurse)

“Participant 14: I think it is stressful, especially when you have got young people who are screaming at you to get off them. Nobody wants to be held against their will and it is stressful. It is not a nice thing to do to anybody, never mind a young person who is mentally unwell and has a learning disability and doesn't really understand what is going on. I think it is quite stressful”.

(Participant 14: Staff Nurse Mental Health Inpatient Service)

Within some healthcare organisations, mechanical or pharmacological restraints have been used as common practice to manage the behavioural symptoms of service users who have complex health and social care needs rather than being utilised as an absolute last resort (Webber, McVilly & Chan, 2011). The routine use of restrictive practices could potentially conflict with the values of such professions as Nursing, which advocates that practitioners should ensure patient autonomy, beneficence, justice and non-maleficence (Beauchamp & Childress, 2001). It has been argued that the use of restrictive practices can have minimal therapeutic benefit and actually restrict autonomy or cause service users to experience further harm (Andrews, 2006). The use of restrictive practices can also potentially elicit re-traumatisation (Lu, et al., 2011) and physical pain within service users (Hawkins, Allen & Jenkins, 2005). Thus, the use of restrictive practices could conflict with the professional values of staff who are required to use them to de-escalate incidences of behaviours that challenge in compliance with organisational policies on the management of behavioural symptoms (Bigwood & Crowe, 2008). It has also been debated that health and social care organisations have an obligation in harnessing cultures to ensure that the use of restrictive practices to manage incidences of behaviours that challenge do not veer into

abusive practices towards service users (McDonnell, Breen, Deveau, Goulding & Smyth, 2014).

1.6.9 Communicating and care planning the use of restrictive practices, as a last resort, with relevant regulatory bodies

Some participants discussed the ethical dilemmas and fear of litigation that they have experienced when considering or applying the use of restrictive practices to manage behaviours that challenge.

“Participant 31: If something goes wrong, people start getting fearful for their job. So if I do something wrong, I might lose my job and it creates a little fear factor or a little bit of stress and anxiety which then impacts on daily decisions. I know when I first started doing this job, everything that I thought I did wrong in terms of behaviour management was “How is this going to affect my job, am I going to be able to continue?”. Those are the thoughts that I had and it takes managers to say “No, no, no that’s fine what you did”. It’s only when you get to a certain level of experience where you realise “I was doing everything properly” but at the time I didn’t realise that”.

(Participant 31 - Team Lead for a Community Autism Service)

“Participant 53: I was just in an assessment on Friday for a community referral and this gentleman has a stoma bag and sometimes he loosens it and he gets covered. The staff have said that they have to hold his hands to stop him being aggressive and they probably do. But then you need to contact the local authority and add that to his DOLs [Deprivation of Liberty Safeguards], let the safeguarding team know that this is what you

are doing, making sure that specific capacity assessments have been done, that they have got his best interests around it and that they have discussed it with his next of kin and wife and that it's all care planned and it's always the last resort in that situation. Because if somebody does walk past the room and happens to see you holding his hands, reports you to CQC [Care Quality Commission], where do you stand? Whereas if the CQC see that you have all of that in place, then they'll probably be impressed."

(Participant 53, Registered Mental Health Nurse)

The current study indicated that using restrictive practices can potentially elicit frontline staff to consider whether methods used to de-escalate incidences of behaviours that challenge were appropriate in comparison to the risk presented by service users concerned. Given the well-documented cases of injuries/fatalities associated with the use of restrictive practices within health/social care settings, the way in which frontline staff deploy restrictive interventions to manage behaviours that challenge are often subject to intense scrutiny (Paterson, et al., 2003). Within the UK, health and social care services are required to engage in regulatory processes as overseen by the Care Quality Commission (CQC) as means to negate any unlawful use of restrictive practices on service users (Mental Health Act, 2005). The current study has illustrated the importance of liaising with relevant organisations to ensure that the practices used to manage behavioural symptoms are appropriate and not excessive in comparison to the risks presented by services users who exhibit behaviours that challenge. The World Health Organisation has stated that restrictive practices should only be used by healthcare professionals when they have been thoroughly care planned and in situations where preventative and non-invasive de-escalation strategies have been deemed ineffective in managing incidences of

behaviours that challenge (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). There are strict regulations regarding the use of restrictive practices on service users with behavioural symptoms who may lack capacity to consent to treatment as stipulated in the Mental Capacity Act's (2005) Deprivation of Liberty Safeguards (DOLs). Local authorities are required to conduct DOLs assessments to ascertain if the application of suggested restrictive practices by frontline staff are actually in the best interests of care recipients (Mental Capacity Act, 2005). The current study suggested that liaising with the relevant regulatory bodies and ensuring that local authorities have conducted the required DOLs assessments is necessary in avoiding potential litigation that can coincide with the use of restrictive practices that have not been authorised or overtly care planned. Thus, the process of engaging with the necessary regulatory procedures can be beneficial in negating work related stress through ensuring that any restrictive practices used to manage behaviours that challenge have been authorised and are in the best interests of service users.

1.6.10 The mandatory provision of post-incident debriefs

It has been posed that the provision of post incident debriefs can be beneficial in informing organisational policies and strategies on reducing the need to use such restrictive practices to manage behaviours that challenge within health and social care services (Haimowitz, Urff & Huckshorn, 2006). Post incident debriefs can provide opportunities for staff to discuss and review incidences of behaviours that challenge in order to develop working practices that prevent further exacerbation of behavioural symptoms within the service users concerned (Sutton, Webster & Wilson, 2014). The current study also suggested that organisations that provide post incident debriefs, as mandatory, can be helpful in assisting frontline staff to engage in reflective practices to ascertain strategies to prevent further incidences of behaviours that challenge.

“Interviewer: Do you find that helpful, having the debriefs?”

Participant 14: Yes, I think it is. You can look at what might have worked better or worked well. If it worked well, then you can use that approach in the future to stop further incidences. Or if something didn't work, you know not to do that again.

Interviewer: So it is good having debriefs to learn and try and prevent further incidences of behaviours that challenge?”

Participant 14: Yeah, it helps to reflect back on it I suppose. Our debriefs are normally meeting with our ward manager. He would ask “What happened?” and we would just describe the incident and we would go from there. He would ask, “So why did you do that? Do you think that worked well?”

Interviewer: Do you find that having that debrief is good for emotional support too?”

Participant 14: Yeah, I think that it does. You feel that sometimes after an incident...you are really hot and you are really like “oh my god” and you have that sigh of relief that it's come to an end. I think just having 10 or 15 minutes away off the floor, as it were, is good. It gives you a chance to calm because if an incident ends up in a restraint or seclusion, the adrenaline starts pumping and it is good to just have that bit of time away and reflect on what happened”.

(Participant 14: Staff Nurse Mental Health Inpatient Service)

“Participant 54: Most of the time it is actually better to have that debrief, it helps you to stay [working] with that person [service user]. Having worked in situations in which those incidents are seen as some kind of fracture in the relationship, the pressure can be placed on the staff to try and force their way back into that service user’s life. If there is no debrief, you can be just blasted back in there to work with that service user again and be told “It’ll build character”. These are all lies. Without debrief, staff won’t just be able to get there and work with that service user and it certainly won’t build character”.

(Participant 54 - Behaviour Nurse Specialist)

Participants suggested that the process of having a formal debrief with a senior member of staff immediately following an incident of behaviour that challenges can be helpful in facilitating reflective practice, achieving homeostasis and continuing therapeutic work with service users concerned. Providing debriefs for staff immediately after they have encountered incidences of behaviours that challenge may be conducive in ensuring employee safety and wellbeing (Huckshorn, 2004). Reductions in the use of restrictive practices have also been observed within Children’s and Younger People’s inpatient services as a result of providing immediate post incident debriefs for both staff and service users as mandatory (Azeem, Aujla, Rammerth, Binsfield & Jones, 2011). This would suggest that organisational support through the provision of immediate post incident debriefs may not only help staff in terms of their professional practice and wellbeing, but may also decrease incidences in which carers are required to consider/use restrictive practices.

However, some participants discussed the impact on employee wellbeing when organisations do not have strict protocol to ensure that staff receive post incident debriefs immediately following incidences of behaviours that challenge.

*“Participant 52: I would say that [debriefs] is something you can’t always do because of the demands in terms of time. An example of that was dealing with something the other week. I had somebody kicking off in reception and very violent in terms of the way that they were talking, behaving and being threatening. But the problem was, there were lots of other people in reception, things that needed to be dealt with and other people were waiting to be seen by staff. It was really difficult and I went home that day feeling pretty awful. The last couple of weeks I have been a bit wobbly because of that incident. I mean I am fine now, I’m getting there again but it does affect you and if we’d had the time to talk about it there and then, I might have actually gone home feeling better. But I didn’t. I actually shut down that weekend at home because it was just one too many incidences. It wasn’t particularly worse than some of the others that I’ve had, it was just one too many at the wrong time... We were short staffed and there was a client and another person who was with her who was a male and so she was verbally abusive. He was verbally abusive and I asked him to leave. He kept coming back in and he made threats. She called me a snotty nosed c**t. It does make you feel very angry when somebody treats you like that when you are standing there being very professional saying “Please don’t use that language”. There was also a little bit of a miscommunication and I was under the impression that the police were on the way, but they weren’t. Normally with those things I would be fine. But*

for some reason, that one got to me and I'm not really sure why. But I went home. I felt wobbly walking up the street and I was worried that I might bump into them outside in the street. I rang home and spoke to my bloke, not to tell him about what happened as such, but just to talk to somebody while I walked to the bus stop, until I got onto the bus to go home, until I felt safe”.

(Participant 52 – Support Worker in Community Service)

“Participant 44: I remember I had quite a rough day on a Friday. I didn't get a debrief before I went home and it was running through my head all weekend. I had to just talk to a friend about it. But really, I should have had that support before I left work. It was very important to have had a proper debrief”.

(Participant 44 – Assistant Psychologist in Learning Disability Residential Service)

Previous research has also shown that not all healthcare organisations, that provide assessment and treatment for people who exhibit behaviours that challenge, ensure the delivery of post incident debriefs for frontline staff as mandatory (Needham & Sands, 2010). The current study suggested that the failure for organisations to provide post incident debriefing can potentially cause frontline staff to ruminate on incidences where services users have exhibited behaviours that challenge, become socially withdrawn and experience low mood. Rumination has been defined as repetitive thought process that can inhibit active problem solving, elicit fixation on issues of concern and focus attention on sources of distress (Nolen-Hoeksema, 1991). Thus, ruminative thinking following incidences of behaviours that challenge may prevent

frontline staff to successfully reflect on professional practice, problem solve and develop strategies to negate the behavioural symptoms of service users concerned. However, it has been suggested that post incident debriefs that consist of root cause analysis can be beneficial in facilitating frontline staff to engage in problem solving as a means to identify and consider strategies to negate triggers for behaviours that challenge within mental health inpatient services (Lewis, Taylor & Parks, 2009). Thus, failure to provide post-incident debriefing could be missed opportunities for organisations to support staff to engage in reflective practices/problem solving as a means to address the behavioural symptoms of service users and offset unhelpful rumination on incidences of behaviours that challenge. However, it must be acknowledged that the way in which debriefs are offered and conducted requires thorough consideration given that discussion of traumatic events, such as incidences of behaviours that challenge, can potentially elicit further trauma (Litz, 2008) within staff involved in challenging incidences. In addition, some healthcare organisations may not use standardised guidelines when providing staff with post incident debriefs (Needham & Sands, 2010). Thus, there is a need to develop a clear understanding as to what debriefs, immediately following incidences of behaviours that challenge, should consist of as a means to successfully provide emotional support, offset work related stress and facilitate staff to engage in reflective practices on their therapeutic work.

1.6.11 Summary of how organisational factors may influence the capacity for health/social care professionals to therapeutically engage with service users and levels of work related stress

This section of the thesis has discussed the articulated experiences of participants, in relation to relevant literature, to illustrate how some organisational factors can influence the core category within the TEST model.

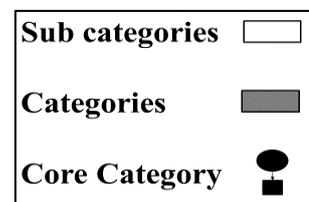
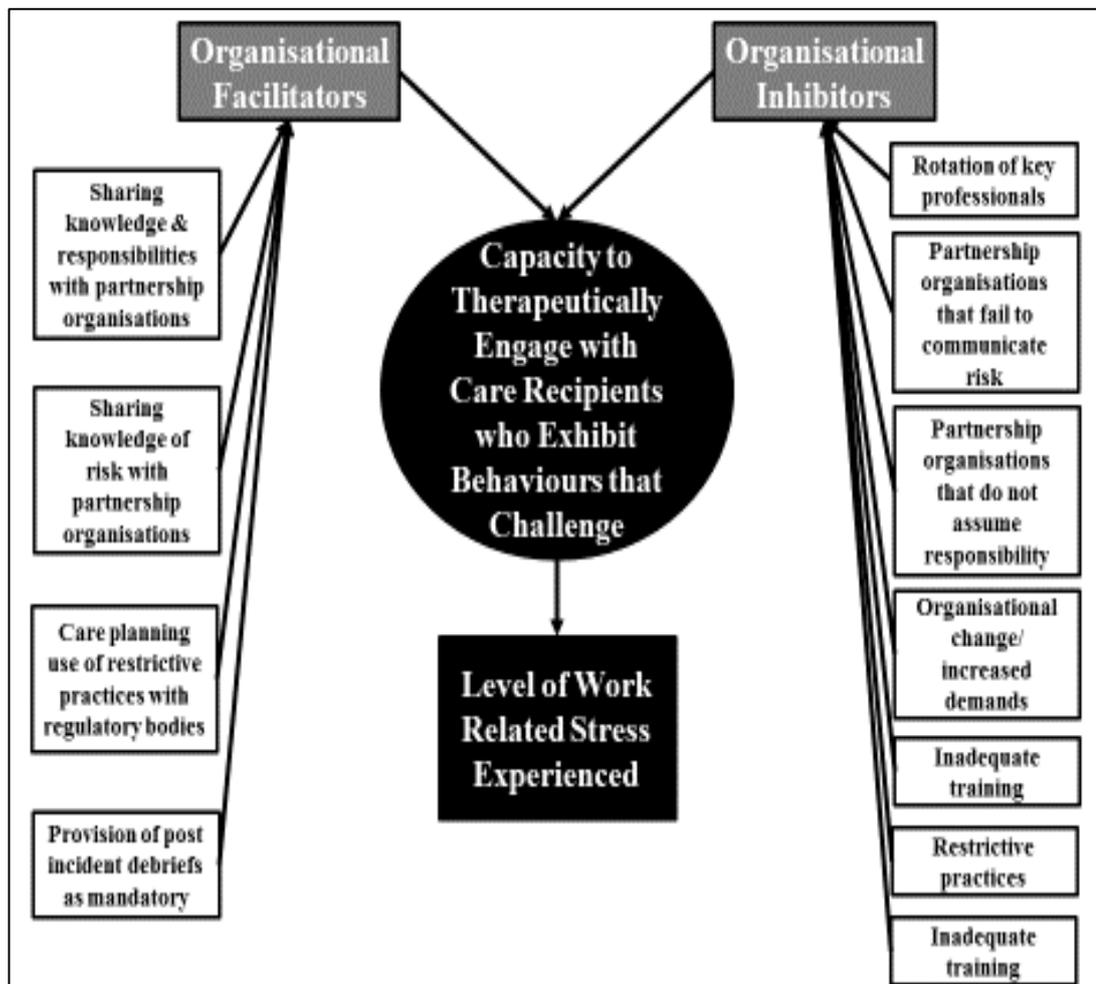


Figure 1.5 Illustration of how subcategories informed the developed categories concerning organisational factors and their influence on the capacity for health/social care profession to engage therapeutically with care recipients who exhibit behaviours that challenge.

The current study indicated that the organisational culture, policies and procedures of health/social care organisations have the potential to either facilitate or inhibit frontline staff to therapeutically engage with service users of who have behavioural symptoms. The participants articulated experiences, as discussed in this section, indicated that the following organisational factors may be conducive in facilitating staff in their capacity to engage therapeutically with service users and therefore offsetting stress:

- Working alongside partnership organisations that contribute to the delivery of biopsychosocial care packages and communicate patient specific knowledge can be helpful in assisting frontline staff to deliver caregiver duties.
- Partnership working with external services can be beneficial for frontline staff in situations where external organisations are committed to fulfilling their area of expertise and are acceptant of their caregiver responsibilities.
- Clear identification of and liaison with key professionals, within external organisations, may be beneficial in ensuring the effective communication of any known risks of behaviours that challenge and sharing of expertise as required for the successful delivery of biopsychosocial care plans and preventing work related stress.
- Work related stress attached to fears of litigation can be nullified through complying with the necessary regulations, as employed by external regulatory bodies, to ensure that any restrictive practices used have been approved and are only used as a last resort as a means to reduce risk of harm to service users and members of staff.
- The provision of mandatory debriefs immediately following incidences of behaviours that challenge can be beneficial in facilitating reflection on

professional practices and strategies to successfully engage in subsequent interactions with service users who have behavioural symptoms.

However, this section has provided the following illustrations of how organisational factors could potentially inhibit health/social care professionals in their ability to engage with service users and thus contribute to the manifestation of work related stress:

- Having the perception that partnership services aim to fulfil organisational goals, such as freeing up bed spaces, before considering the biopsychosocial needs of service users.
- Working with partnership organisations that do not accept their caregiver responsibilities.
- Working with partnership organisations that do not have the anticipated expertise or resources to provide meaningful input to the delivery of service user care plans.
- Working with partnership organisations that regularly rotate the professionals designated to collate and share information regarding services users' clinical history can lead to situations where frontline staff begin engaging with clients with no knowledge of their behavioural symptoms.
- The lack of sharing pertinent information by partnership organisations can lead to situations where frontline health and social care staff learn about risks of behaviours that challenge after engaging with the service users concerned.
- Organisational changes that result in providing care for service users with behavioural symptoms, which are deemed beyond the expertise of participants,

were identified as being a potential occupational stressor that could inhibit the successful delivery of therapeutic interventions.

- Organisational changes that do not include the delivery of appropriate training as a means to support staff to reduce the difficulties that coincide with providing care for service users who exhibit behaviours that challenge of increased complexity.
- Working within organisations where restrictive practices can be used to de-escalate incidences of behaviours that challenge, which could potentially fracture professional relationships with care recipients and thus contribute to work related stress.
- The fear of litigation that can coincide when using restrictive practices, in accordance with organisational policies, could also potentially elicit work related stress.
- Failure of organisations to provide post incident debriefs immediately following incidences of behaviours that challenge, as mandatory, can result in frontline staff experiencing in their capacity to continue working with service users who have exhibited unhelpful behavioural symptoms, thus contributing to work related stress.

Further exploration regarding the influence of perceived organisational support on the capacity to engage therapeutically with service users who exhibit behaviours that challenge and work related stress was investigated using quantitative methods as reported in Chapter 5 of this thesis.

1.7 The facilitating and inhibiting effects of Workplace Settings on Staff

Interactions with Service Users and the Impact upon Work Related Stress

The following section will provide explanations as to how the process of providing care for people who exhibit behaviours that challenge, within such environments as inpatient wards, residential and community settings can potentially impact the levels of work related stress experienced by frontline health and social care staff. The category of workplace settings was defined by participants' experiences of how the characteristics of their working environments can influence the capacity to engage with care recipients who exhibit behaviours that challenge and work related stress.

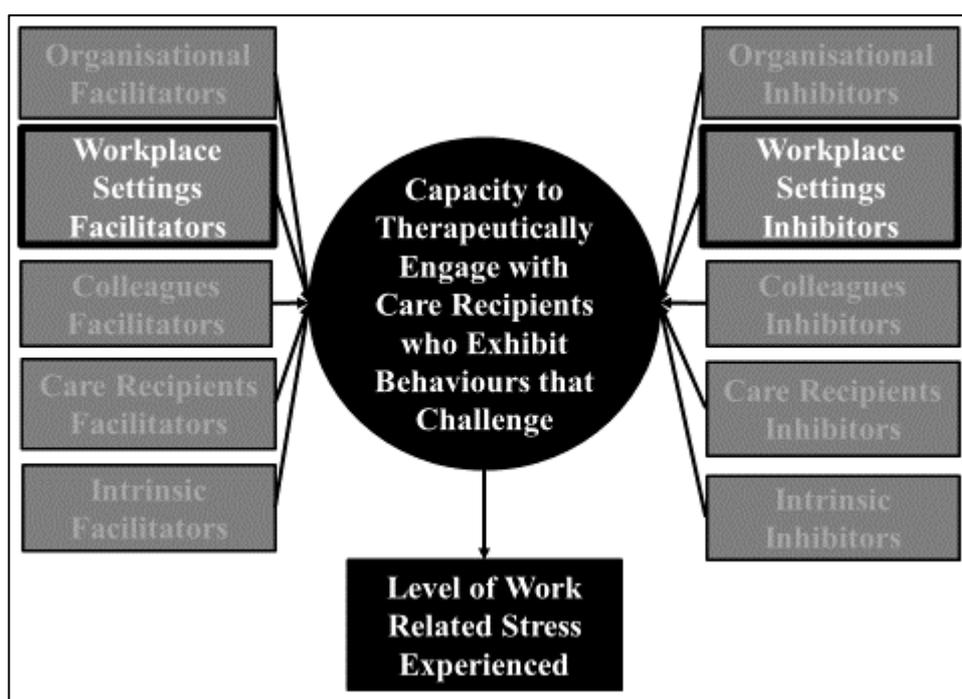


Figure 1.6. The current section reports how work place settings can either inhibit or facilitate health/social care professionals in their capacity to engage therapeutically with care recipients who exhibit behaviours that challenge.

1.7.1 Safe Prevention and De-escalation of Behaviours that Challenge

Participants articulated that providing care within environments that are specifically designed to facilitate the assessment and treatment of particular patient populations could be beneficial in assisting staff to implement preventative strategies to negate incidences of behaviours that challenge and engage therapeutically with service users.

“Participant 53: I have worked in a unit that has been specifically designed for dementia. For patients, you never met a closed door. So they weren’t constantly trying to rattle doors and hit one end of the corridor, turn around and come back hit another and have that frustration. It went round in a circle. You had massive options of pocket lounges with different sensory equipment in and different ranges of activities to try and engage and distract. And then you had a really good garden area and stuff like that. You could take patients outside. You could always find somewhere quiet. You could always find somewhere meaningful for the patients to go instead of a corridor or a lounge which has always got people in. That’s why environment is so important because it allows you to do those preventative techniques. If you’ve got the environment to work with, then you can prevent incidences from occurring. You can use all of those proactive approaches that’s identified through the person centred care planning. If you’ve got the right environment, then you have got a really, really good resource to be able to effectively communicate [with service users], do your job and offer care. You can just adapt to situations better.

Reassure, distract, orientate, you can use all the different tools to prevent incidences from happening. If you can change the environment to a way that it needs to be for the person with dementia, then you are laughing really.”

(Participant 53 - Registered Mental Health Nurse)

“Participant 21: What helps the stress is working in the building that's been specifically designed for the client group. We have soundproofing in the clients' rooms. Clients have separate flats and we have lots of communal areas. The building I work in is specifically designed for our client group which takes away some of the stress because when you are talking about the incidences that are happening in communal areas, it is designed that they already live within their flats. They are free to move about and we assist them in that way [living independently]. Working in a building, that is so highly designed, lessens all that stress. Where I worked previously, things were 20 times worse for myself and I was stressed because of that. Where I work now has been designed with a purpose and it shows because all of that thought process has gone into it before anybody even moved into it. It has had a massive impact on how we deal with incidents”

(Participant 21 - Support Worker in an Autism Residential Service)

The above extracts indicated that long-term healthcare settings, such as inpatient and residential services, that have been designed to accommodate service users to engage in meaningful activities, could be beneficial in assisting frontline staff to implement person centred approaches as a means to prevent incidences of behaviours that

challenge. Person centred care is a philosophy of health and social care which advocates that therapeutic interventions should be informed by the values and tailored to meet the idiosyncratic needs of each individual service user (Health Foundation, 2014). In relation to dementia care, Kitwood (1997) developed a model of person centred care, which stipulated that healthcare environments should provide opportunities to engage in activities that are meaningful and converge with the personal interests of care recipients. Within nursing homes for people with dementia, the ability to distract service users from encountering triggers, through engaging in meaningful activities, can be effective in reducing symptoms of agitation and preventing incidences of behaviours that challenge (Moniz-Cook, Stokes & Agar, 2003). Ensuring that service users are able access privacy when taking residence within a long-term healthcare setting can also be conducive in negating agitation and aggressive behaviours (Zeisel, et al., 2003). Thus, working within settings in which the environment can be modified to provide opportunities for privacy and facilitate activities that are relevant to the personal values of services users could assist frontline staff to implement person centred care strategies to prevent incidences of behaviours that challenge. Thus, long-term care institutions that comprise of features that provide staff with outlets to engage therapeutically with care recipients may also be conducive in offsetting work related stress within formal carers.

1.7.2 Settings that do not assist staff in the prevention of behaviours that challenge

However, some participants discussed the difficulties of providing care within institutions that do not enable frontline staff to modify the environment as a means to deliver therapeutic interventions that are tailored to meet the idiosyncratic needs of service users and prevent incidences of behaviours that challenge.

“Interviewer: Do you think you can do that [prevent or distract service users from exhibiting behaviours that challenge] on the ward where you are working now?”

Participant 53: Not really, it depends on the ward because some are better than others. You get wards that were built for other purposes. So you’ve got one massive long corridor with bedrooms coming off it and one big lounge.

Interviewer:..and that’s not appropriate?

Participant 53: It’s not designed specifically, yeah.

Interviewer: Why do you think that environment is potentially stressful for staff?

Participant 53: Because there’s not much to play with. There’s not much for members of staff to be able to become creative with it and look how they can facilitate different experiences and activities for the patients. You need a good room to get away and get some good work done with the patients. But that doesn’t exist.

(Participant 53 - Registered Mental Health Nurse)

“Participant 15: Where I work, there are three floors and three flats. But we haven't got the soundproofing so you can hear everything that goes on in the building. All of the staff work across the three floors but we are allocated to different people at different times. You can be running between flats and someone will say “Have you got a minute, this is happening?”. They might want your advice even though you are busy

trying to work with someone else [another service user]. You are then dealing with someone else as they want a bit of advice or can't quite deal with something. So you are stepping in there when you are supposed to be with another service user. It is very easy to get distracted in there”.

(Participant 15 - Support Worker in an Autism Residential Service)

The extracts above indicated that working within an environment, which was not designed specifically for a particular patient group, may inhibit staff from being able to employ person centred strategies as a means to prevent or de-escalate incidences of behaviours that challenge in a non-invasive manner. Within mental health forensic settings, boredom and lack of opportunities to engage in meaningful activities has been reported as a potential cause for service users to exhibit physical and verbal acts of aggression towards frontline staff (Meehan, McIntosh & Bergen, 2006). The loss of autonomy and independence that can coincide with the process of being admitted and receiving care within a long term care institutions can also potentially cause service users to exhibit behaviours that challenge (Ling, et al., 2015). Thus, the process of providing care in long-term care institutions that are devoid of providing staff with opportunities to use person centred approaches, could potentially inhibit staff from implementing interventions that are convergent with the specific needs of service users. Further, work related stress may occur within frontline staff who are unable to modify service users' environment accordingly as a means to prevent incidences of behaviours that challenge from occurring.

1.7.3 Settings that comprise of multiple service users who exhibit behaviours that challenge

Participants also articulated the difficulties of employing person centred care strategies to prevent behaviours that challenge within such settings as inpatient wards and residential services in which multiple service users reside during their treatment and assessments.

“Participant 18: In ours [residential care setting] it can have a domino effect. If you’ve got one person who is particularly vocal, they don’t even need to be in the same room as the other person because if you’ve got someone who is downstairs in the lounge absolutely screaming and shouting their head off, then this can cause a domino effect. The initial sort of stress is getting them to calm down or finding out what the trigger is, what the cause is and if there anything that you can do to stop it. If that isn’t contained in a certain amount of time, you are very much aware that you are going to end up having another incident upstairs with another service user. So the knock-on effect can be quite stressful”.

(Participant 18 - Support Worker in an Autism Residential Service)

“Participant 24: What also causes upset is feeling like people are being warehoused as well. The fact that you come through life and you live in a family within your own little environment and suddenly for some reason when you get dementia, we seem to think that we should put these people into an institution. Well, you want to know what the problem with this is? Well, you are putting people together where their personalities clash and

there's too many of them. It is cheaper to house in bigger environments but are these environments right? There should be smaller environments".

(Participant 24 - Consultant Clinical Psychologist)

The highlighted extracts indicated that healthcare settings that consist of multiple service users residing together during treatment can potentially elicit environments in which care recipients can present as triggers for others to exhibit behaviours that challenge. Providing care for multiple service users within a single setting is a potential issue in terms of ensuring the wellbeing of frontline staff who provide care for people who exhibit behaviours that challenge. It has been purported that identifying and fulfilling the health/social care needs of service users may be conducive in negating incidences of behaviours that challenge within nursing home settings (Moniz-Cook, 2003). However, the extracts above have illustrated that frontline staff may experience difficulties in ascertaining the causes of behaviours that challenge during situations where multiple service user are exhibiting behavioural symptoms concurrently. This would suggest that work related stress could occur within frontline staff who are unable to identify the underlying causes for unhelpful behavioural symptoms and employ person centred interventions accordingly due to working within healthcare settings where single incidences of behaviours that challenge could involve multiple service users.

1.7.4 Distractions from delivering care

Participants discussed how such healthcare environments as acute inpatient wards and long-term care settings can consist of distractions that could disrupt the successful delivery of therapeutic work with service users and potentially elicit work related stress.

“Participant 53: I mean I think anybody who works on an organic ward....if you didn’t get stressed then I would be wondering what is up with you because it is very, very stressful. There are a lot of distractions on the ward that prevents you being able to have that personal interaction, the one to one, with patients. It is very difficult, so that can be stressful in itself. It is stressful being on an organic unit”

(Participant 53 - Registered Mental Health Nurse)

“ Participant 14: Our nursing office is really busy and if you were going up to the office to type up an incident or just to do your notes or something and there's people coming in and out, there is the phone ringing, there are secretaries asking questions, then the alarm goes off, it can be a lot to deal with. I find myself reading through my notes thinking “oh that must've been when I got distracted because that doesn't make any sense”. So I have to go back to it. So there are distractions. I think that sometimes you can feel like smashing the phone up when it starts ringing and you are getting distracted. I think sometimes you feel like you are chasing your tail and the fact that if you are being distracted by another incident and you are having to come back and finish writing up the last incident or finish writing up notes and then start something else, it can be quite stressful. You feel like you are just going from one thing to the next if the ward is clinically active”.

(Participant 14 - Staff Nurse Mental Health Inpatient Service)

The extracts above have illustrated that wards and residential healthcare settings can comprise of various distractions, such as attending to emergency response alarms,

phone calls and unscheduled queries from colleagues. The current study would also suggest that the requirement to document incidences of behaviours that challenge can be perceived as a distraction from delivering therapeutic interventions. The completion of such administrative tasks as documenting incidences of behaviours that challenge can reduce the amount of time that frontline staff can designate to the delivery of therapeutic interventions to service users. Distractions such as ambient noises in the workplace have shown to significantly reduce concentration, work rate and increase levels of fatigue within employees who work within office environments (Witterseh, Wyon & Clausen, 2004). The current study has illustrated various sources of ambient noises that can occur within health and social care settings, such as emergency response alarms, that do not only serve as mere distractions but also require frontline staff to respond accordingly. The extracts above have indicated that the presence of and the requirement to respond to distractions can potentially disrupt the delivery of planned 1:1 therapeutic interventions with service users, which can be perceived as being stressful for frontline staff who value the delivery of person centred care strategies. This would suggest that working within health and social care settings that consist of distractions, to the extent of disrupting the successful delivery of planned therapeutic interventions, could potentially elicit work related stress within frontline staff.

1.7.5 Perceived containment of behaviours that challenge

Despite the distractions that can occur when providing care within institutional settings, some of the participants articulated that there can be less risk and lower levels of perceived stress experienced when managing incidences of behaviours that challenge within such environments as inpatient wards and residential services as opposed to community settings.

“Interviewer: So you find it easier to manage behaviours that challenge when you are back in the residents’ home [residential care setting]?”

Participant 16: Yeah we do because you've got the backup. You have got other people [colleagues] with you. You are not one to one and I think, well personally for me, a lot of the stress has come from when you are doing the one to one working [in a community setting]. Don't get me wrong, our unit is based around a lot of one to one working, but it is when you have worked with certain individuals and you know what their triggers are in here [residential care setting]. But if they still want to do something and you are taking them out [into a community setting], it's always on the back of my mind if things escalate and I am on my own.

Interviewer: Right, but in the residents’ home I take it that you have got the peer support, you've got the support of staff?

Participant 16: Yeah and it is more contained because obviously you have got everybody with the same knowledge of that person [service user] and it is very much contained. In the public, you just don't know what will happen if things escalate”.

(Participant 16 - Support Worker in an Autism Residential Service)

“Participant 14: On a ward, you know the patients. You know that if it does end up becoming physical [service user exhibits physical aggression], you have got a response team to manage that situation. On the street, you have got no idea what to do if a person starts screaming at you. You don't know how to deal with it. Obviously there are techniques that you pick up, but you haven't got that help from a response team.

(Participant 14 - Staff Nurse Mental Health Inpatient Service)

These views indicated that the presence of colleagues, as apparent within inpatient, residential and care home settings, can be beneficial for frontline staff in terms of offsetting the work related stress that can coincide with encountering incidences of behaviours that challenge. The above extracts suggest that the presence of colleagues is a fundamental feature that is apparent within such healthcare environments as inpatient wards and residential care services, but can be absent when providing formal care giver duties within community settings. The above extracts indicated that working within institutional settings that consist of emergency response teams, and where colleagues have a shared understanding of service users, can be perceived as being beneficial in reducing the risk of harm and negating work related stress when managing incidences of behaviours that challenge.

However, the process of encountering incidences of behaviours that challenge as a lone worker within community settings can potentially place frontline staff in precarious situations and elicit work related stress. Furthermore, the current study indicated how exposure to behaviours that challenge, when providing care as a lone worker within community settings, can have detrimental consequences on the capacity of frontline staff to engage therapeutically with service users concerned.

“Participant 23: I was put with a certain female [service user]. From day one, she really took a dislike to me and it got to the point where I had to say “I am not going to take her out [in the community] on my own anymore”. I have been pushed into the middle-of-the-road twice with a car coming. She spat in my face. She's done everything. There was one day, there was a brand-new car there and she had me by the hair flinging me

over the bonnet and all I was thinking was “God, if I scratch this car I can't afford to get it fixed, it is not pay day for another couple of weeks”. She was flinging me over the top of this car and I still got put with her every day, for one reason or another. Even if there were other female members of staff, I would get put with her on my own. I was sent out all the time on my own with her and I could pinpoint where she would start. She would be fine walking up the road but as soon as she got to the local hospital...

Participant 21: *...I bet your stress levels were going up like that.*

Participant 23: *As soon as I got around the corner and I could see the hospital, I used to just think “Well here we go”. In the end, I did have to take time off work because I thought “I can't cope with this anymore”.*

(Participant 21 & 23 - Support Workers in Residential Autism Service)

Participant 20: *Say you went out to [assist a service user to attend] the cinema, then it can be a lot more stressful. Even before you have set off. You are taking somebody that you know that can display a challenging behaviour, not on a rare occasion but does it daily, constantly and repetitively. You know that you are taking them out into this public situation and obviously you are worried for them, you are worried for yourself as well. You are worried about how it is perceived by others, especially if you have to intervene physically. You are worried about what Joe Public are going to do.*

Participant 22: *It is how other people see you as well isn't it? Because you know that if you have to physically restrain somebody if they are trying to*

hit you, you know that what you are doing is right because you have had the training where just somebody passing on the street could think “Oh they shouldn't be doing that”. It is hard”.

(Participant 20 & 22 - Support Workers in Residential Autism Service)

The above extracts illustrate how lone working and managing incidences of behaviours that challenge in community settings can potentially diminish the capacity for frontline staff to engage therapeutically with service users concerned and also elicit work related stress. The experience of being physically assaulted by service users has shown to have negative consequences on the way in which healthcare professionals engage in their occupation and can also elicit such post-traumatic symptoms as rumination on incidences of violence in the workplace (Gates, Gillespie & Succop, 2011). The current study would also suggest the process of assisting service users to engage in community activities can cause frontline staff to worry about the potential for behaviours that challenge to manifest within public settings. Intrinsic processes, such as the propensity to worry and ruminate about interactions with service users who exhibit behaviours that challenge, will be discussed in more depth within Chapter 3 of this thesis. However, the extracts above indicate that the difficulties of encountering behaviours that challenge, as a lone worker within community settings, can be compounded by not having colleagues present to assist with the containment and de-escalation of incidences.

1.7.6 Members of the public within community settings

Some of the participants illustrated that such challenges as the continual assessing of risks, containing incidences of behaviours that challenge and being challenged by members of the public can be perceived as work related stressors when providing caregiver duties within community settings.

***Participant 42:** One of the residents that I work with, he was banging his head off the window of the bus in public and the public came over concerned to help. Our staff were nervous that they had been doing something wrong and the public would intervene in aid of the disabled person.*

***Participant 41:** I was in the immediate aftermath, it may have been the same incident or a similar one, where the member of the public said to the staff in question that he was outraged. He didn't think that the member staff handled it as well as he could have done. It turns out that the individual [member of the public] and the man in question had a daughter with an intellectual disability. So the threat was that it would be reported to the radio program or the national airwaves. So you could imagine how stressful that was. But that was born out of concern and the right motivation. But for staff, it was extremely, extremely stressful. I was doing my best. The easier option obviously was to say "Oh well, let's not go out. Let's just stay in and say the bus isn't working or something".*

(Participant 41 - Nurse in a Learning Disability Residential Service

**Participant 42 - Assistant Psychologist in a Learning Disability
Service)**

“Participant 23: You are still left with the anxiety and the stress of the situation itself and the distress of anybody intervening or someone phoning the police or someone thinking that you are assaulting the service user. There is endless possibilities of what could be happening. People can jump to the wrong conclusion and they might think they are being helpful, but they could make it worse. You have got all of that going on in your head, thinking that it may or may not happen. You can go out [assist a service user to engage in community activity] and have a perfectly wonderful time when nothing happens. But you have still got that in the back of your mind of what could happen as a result of going out”.

(Participant 23 - Support Worker in Residential Autism Service)

The above extracts illustrate the difficulties of providing care in the community when members of the public have witnessed incidences of behaviours that challenge. It was suggested that the process of being challenged by members of the public can potentially cause staff to consider becoming risk averse and avoid the task of assisting care recipients to engage in community settings as a means to negate work related stress. It has been advocated that health and social care services should promote the social inclusion of people diagnosed with mental health conditions, learning disabilities and autism through assisting service users to pursue personal interests by accessing mainstream activities within communal settings (Royal College of Psychiatrists, 2009). The person centred model of care also stipulates that the care plans of people accessing mental health, learning disabilities and autism services should be informed by the values of the service users concerned (Health Foundation, 2014). This would suggest that when deemed appropriate, frontline health and social care staff may be required to assist service users to spend time outside of institutional

settings as a means to promote social inclusion and deliver care packages that are consistent with the personal values/interests of care recipients. However, employees may avoid engaging in occupational tasks that are perceived as being stressful in order to ensure and maintain wellbeing (Penney & Spector, 2005). This could mean that the perceived stress associated with assisting service users to engage in community activities could lead to frontline staff to consider avoidant or risk averse behaviours, such as indicating to care recipients that there is no transportation to facilitate leave from institutional settings. Such risk averse strategies may therefore inhibit frontline staff from delivering standards of care that are conducive in meeting the biopsychosocial needs and ensuring the social inclusion of service users who exhibit behaviours that challenge.

1.7.7 Summary of how organisational factors may influence the capacity for health/social care professionals to therapeutically engage with service users and levels of work related stress

The category of Workplace Settings has provided some explanations as to how the working environments of frontline health and social care professionals can influence levels of work related stress experienced and the way in which staff engage therapeutically with service users who exhibit behaviours that challenge.

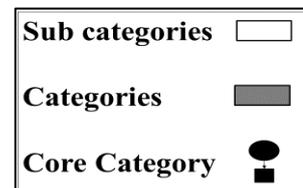
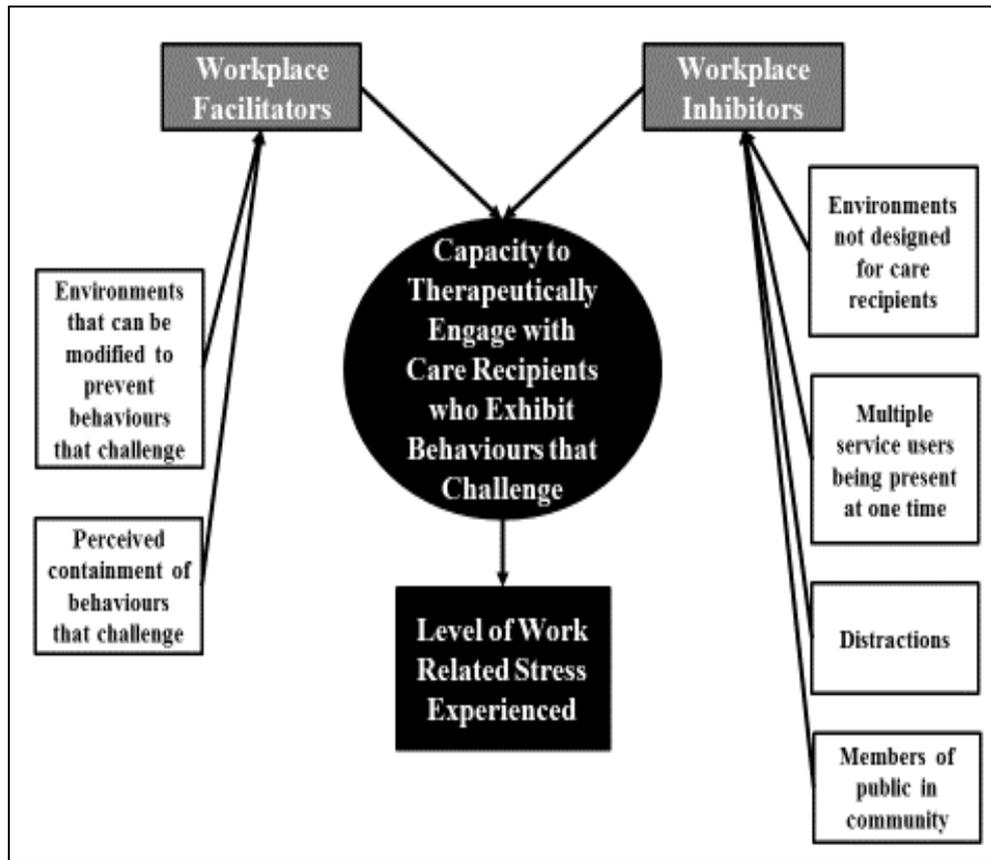


Figure 1.7. Illustration of how workplace environments can influence the capacity to therapeutically engage with service users who exhibit behaviours that challenge and the levels of work related stress within frontline health and social care staff.

This section has indicated that the following factors, associated with the work place settings of health/social care professionals, may facilitate staff in their capacity to therapeutically engage with care recipients who exhibit behaviours that challenge and offset stress:

- Healthcare settings, which comprise of environments that enable frontline staff to use person centred strategies to prevent incidences of behaviours that challenge, was conducive in offsetting work related stress.
- The common characteristic of having colleagues present within such settings as wards, residential care and nursing home services was beneficial for frontline staff in reducing risk of harm and negating work related stress when required to de-escalate incidences of behaviours that challenge.
- The management of behaviours that challenge could be more considered and contained within institutional healthcare services in comparison to when providing formal care within community settings.

However, the following factors illustrated how the workplace settings for some health/social care professionals may inhibit therapeutic engagement with care recipients who exhibit behaviours that challenge and contribute to work related stress:

- Institutional care settings can consist of unplanned distractions, such as emergency alarms and incidences of behaviours that challenge, which could disrupt frontline staff in their delivery of planned therapeutic interventions.
- The implementation of person centred care strategies, as a means to meet the biopsychosocial needs of care recipients and prevent incidences of behaviours that challenge, could be difficult within long-term care settings that consisted of multiple service users.
- The process of managing incidences of behaviours that challenge as a lone worker in community settings can potentially inhibit the successful delivery of therapeutic interventions to the service users concerned and elicit work related stress.

- The perception of being challenged by members of the public, whilst managing incidences of behaviours that challenge in the community, can be a work related stressor that could potentially elicit frontline staff to become risk averse and avoid supporting service users to continue their engagement in communal activities.

Given that work related stressors can occur within both institutional and community services, it is necessary to gain a further understanding as to how the differing health and social care settings can potentially influence the capacity for frontline staff to engage therapeutically with service users who exhibit behaviours that challenge. Chapter 4 of this thesis reports a quantitative study that aimed to ascertain differences between community and ward based mental healthcare staff regarding the perceived capacity to therapeutically engage with care recipients who exhibit behaviours that challenge and levels of work related stress.

1.8 The facilitating and inhibiting effects of Colleagues on Staff Interactions with Service Users and the Impact upon Work Related Stress

The following section will provide discussion on how workplace colleagues can either facilitate or inhibit the capacity for frontline staff to engage therapeutically with service users who exhibit behaviours that challenge, as informed by the articulated experiences. Discussion will also be provided as to how the influences that work colleagues have on the delivery of therapeutic interventions can potentially offset, trigger or perpetuate work related stress within health/social care professionals who manage behaviours that challenge.

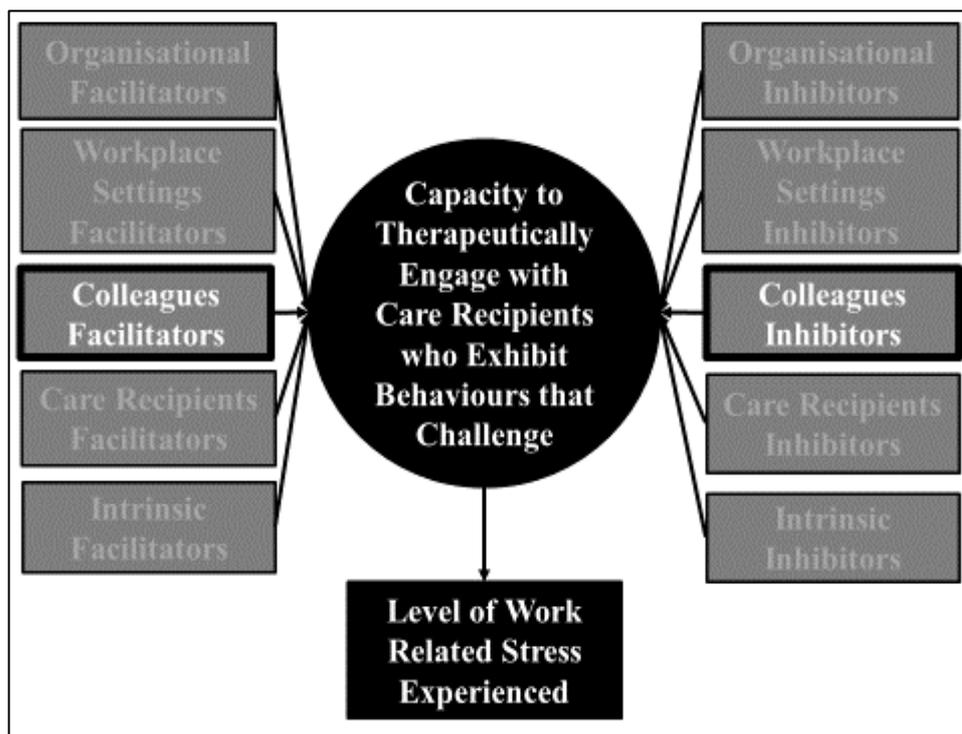


Figure 1.8. This section reports how colleagues can facilitate or inhibit health/social care professionals in their capacity to therapeutically engage with care recipients who exhibit behaviours that challenge and also influence work related stress.

1.8.1 The Amelioration of Difficult Interactions with Service Users

Some of the participants indicated that the difficulties, which can coincide when engaging in direct interactions with service users, who have a history of exhibiting behaviours that challenge, could be ameliorated through the presence and assistance of colleagues.

“Interviewer: So how does that affect you when you get that referral in, what do you do to ensure your safety?”

Participant 48: You just find another person [colleague] to go in with you and if you get a bit grief, pull your alarm and call the police.

Participant 51: It depends on what information you have. Sometimes you get information and you think “this is going to be tricky”. There’s no doubt about it.

Participant 49: What we tend to do is plan things. If we see a new person [service user] or if there’s something tricky that we are going to have to discuss with the person [service user], you arrange to see that person on a day, in a unit where there are staff around and available. You see people in twos. You just make other people aware that there might be an issue and you get prepared to deal with it in advance. It’s going to come up in our world a lot because, unfortunately, a lot of people who use substances get themselves into bother and trouble as well. There’s a good proportion of people who have tasty histories”.

(Participant 48 – Drug Rehabilitation Lead

Participant 49 – Community Clinical Manager

Participant 51 – Community Nurse)

“Participant 10: I took the clinical team lead with me and said “Would you come to this with me while I speak with this child [about the reason for being admitted onto a Children and Younger People’s psychiatric ward]. I actually told him [Clinical Team Lead] that he was there supporting me and when we came away, I said to him “I have found that really, really, really hard” and he said “you did the right thing”. So although he [service user] was very upset at that point, later on in the day he seemed alright”.

(Participant 10 – Registered Mental Health Nurse)

The above extracts indicated that the presence and assistance of colleagues can be an effective protective factor against work related stress during situations where frontline staff are required to enter into a dialogue with service users, which could potentially trigger incidences of behaviours that challenge. It was also suggested that frontline staff may seek support from colleagues in order to meet the anticipated challenge of engaging with service users who have a history of exhibiting behaviours that challenge. It has been recognised that the process of anticipating a given challenge can be sufficient in eliciting a biological stress response through elevated levels of cortisol secretion (Wetherell, Lovell & Smith, 2015). The quotes above would suggest that anticipating the challenge of entering into difficult interactions with service users is a common occurrence within the occupations of providing health and social care to people who exhibit behaviours that challenge. This is concerning, given that chronic elevation of cortisol secretion throughout the day can coincide with complaints of experiencing ill physical health and higher levels of perceived stress (Lovell, Moss &

Wetherell, 2011). However, the current study would suggest that the presence and support of colleagues may offset the work related stress that can coincide when anticipating the challenge of engaging in dialogue with service users, in which the content of discussion may trigger behaviours that challenge. Thus, colleagues who provide the support necessary when interacting with service users, who have a history of exhibiting behaviours that challenge, may help to nullify such consequences of chronic work related stress as incidences of ill physical health.

1.8.2 Informal Debriefing with Colleagues

However, some participants stated that when behaviours that challenge do occur, then informal discussions with colleagues who were present at the incident can also be effective in reducing levels of work related stress.

“Participant 18: We had a service user who was threatening to jump out of his bedroom window and it was awful. It was an absolutely horrendous shift. But I was on with two very experienced members of staff. I felt I was absolutely useless and my stress levels were off the charts and I said “I can't deal with this, I can't do this job” after that incident. But sitting down with those two members of staff and talking everything through helped me to understand that service user because he was new to everyone as well. But I did have thoughts of not going back into work and having to face that one service user again. My stress levels were way up because I didn't know how I was going to cope with him again. But it was the two staff I was on night shift with, who were with me, we just sat and had a cup of coffee and talked about it and filled in the paperwork and I was [saying] “I am so sorry, I was absolutely useless. I didn't know what I was doing”,

and they were like “No, no, you were brilliant”. I was quite new [to the role] but they just gave me reassurance that I hadn't done anything wrong, I handled it really well. I was so stressed when I entered the building the next day [after the incident], but after half an hour, I actually worked with that same service user and we had a brilliant night. So it does help when you have those people [colleagues] around you”.

(Participant 18 - Support Worker in an Autism Residential Service)

“Participant 12: I talk to my colleagues about it [incident of behaviour that challenges] and I will say “did I do anything wrong there?”. I get along really well with my colleagues and they wouldn't be afraid to tell me “actually you did this, you could have done that better”, which would actually make me feel better”.

(Participant 12 - Registered Mental Health Nurse)

Section 1.6.10 has illustrated that working within organisations that ensure the delivery of immediate post incident debriefing can enable frontline staff to continue in their professional practices and be beneficial in negating work related stress. However, the extracts above would suggest that informal debriefs with colleagues, who are present during incidences of behaviours that challenge, may also be beneficial in enabling frontline staff to continue their delivery of therapeutic interventions to service users concerned and reduce work related stress. Previous research has suggested that the process of discussing work related issues with colleagues, who are experiencing similar occupational demands, can be conducive in offsetting stress and burnout within healthcare professions (Peterson, Bergstrom, Samuelsson, Asberg & Nygren, 2008). In conjunction with the current study, informal debriefs with

colleagues who have a shared understanding of particular incidences of behaviours that challenge, could be conducive in negating work related stress and developing strategies to continue the delivery of therapeutic interventions to service users concerned. Informal debriefs may provide opportunities for health/social care professionals to receive social support from colleagues that is conducive in supporting staff in their continued engagement with care recipients who exhibit behaviours that challenge and offsetting stress. Social support has been defined as the networks that provide psychological and material resources that facilitate the successful management, offsetting or overcoming of particular stressful situations (Cohen, 2004). Thus, informal debriefs and collaboration with colleagues may provide the necessary support that is conducive in negating the work related stress that can coincide when encountering service users who exhibit behaviours that challenge (Jenkins & Elliot, 2007). This would suggest that informal debriefs with colleagues may provide sources of social support that enable health/social care professionals in their continued delivery of care to people who have previously exhibited unhelpful behavioural symptoms.

The extracts above would also suggest that informal debriefs may provide opportunities for frontline staff to gain validation or suggestions from colleagues regarding their practices when managing incidences of behaviours that challenge. It has been recognised that the process of being socially accepted by confederates can potentially elicit positive emotional states and improve performance in such tasks as public speaking (Mendes, McCoy, Major & Blascovich, 2008). In the context of the current study, it appeared that the process of being accepted or validated by colleagues, following incidences of behaviours that challenge, could be effective in negating work related stress and enabling frontline staff to continue with their professional practices.

However, further research would need to be conducted in order to ascertain if validation of professional practices, as provided by colleagues, is conducive to improving the performance of frontline staff regarding the safe prevention and management of behaviours that challenge.

1.8.3 Colleagues who have shared experiences of behaviours that challenge

Some participants suggested that having informal debriefs with peers who were actually present during and immediately following incidences may also help to reduce any negative emotional reactions as caused by encountering service users who exhibit behaviours that challenge.

“Participant 49: It just means that you can share how you feel in that particular moment. You don’t then have to go back and try to remember what it was like [as required for formal debriefing which can take place some days later]. You are feeling it at that moment so you can talk about it. Find someone to talk to at that moment and get some feedback. Once you’ve offloaded a bit, you feel a bit better and it becomes a bit more rational really. It’s trying to get over that emotional focus on what just happened”.

(Participant 49 – Community Clinical Manager)

“Participant 25: It is that emotion. You come away with your own emotion from what you’ve experienced from that incident and you really just want to let go, let it out. Informal stuff is about being able to vent, using a variety of different swear words. Then you feel better because you have done it and then you take it to supervision and that’s the kind of objective

discussion of the issue. I think the informal stuff helps to facilitate the more formal supervision.

(Participant 25 – Challenging Behaviour Nurse)

The extracts above indicated that exposure to service users who exhibit behaviours that challenge can potentially elicit unhelpful emotional states within frontline health and social care professionals. Emotional burnout can occur within formal carers who are prone to experiencing such emotions as anger as a result of encountering incidences of behaviours that challenge (Mitchell & Hastings, 2001). Positive correlations have also been observed between the number of incidences of behaviours that challenge encountered and fear of assault within healthcare professionals working in residential Learning Disability services (Mills and Rose, 2011). However, the quotes above indicated that any negative emotional reactions that occur, as a result of encountering behaviours that challenge, can potentially be nullified through engaging in informal debriefing with colleagues who were present during and immediately following incidences of concern. Thus, the reduction of negative emotional states through discussing incidences of behaviours that challenge with colleagues could serve as a protective factor against work related stress and burnout within frontline health/social care professionals. This would also indicate that immediate post incident debriefing with colleagues can be vital in ensuring that frontline staff do not experience unhelpful emotions, as caused by incidences of behaviours that challenge, for an enduring period of time and to the extent of being detrimental to the wellbeing of health/social care professionals.

1.8.4 Understanding the Triggers and Prevention of Behaviours that Challenge

Some of the participants also suggested that discussing incidences of behaviours that challenge can prevent frontline staff taking acts of aggression, as exhibited by service users, personally.

“Participant 17: We do have a strong network of a team. There is no pressure put on you that you have got to go back out there and do your job [after an incident of behaviours that challenge]. So when you have had an incident, we find it easier to debrief amongst ourselves without actually having to go to management, because the team is that strong. A certain service user has called me personal names and you come out of there and all you want to do is cry or scream. So you go and speak to your own staff team to debrief and you realise that you are not the only person that had that problem with that service user”.

(Participant 17 - Support Worker in an Autism Residential Service)

“Participant 12: We have the Psychologists, we have the Nursing team, the Doctors, OT [Occupational Therapist] and they are quite good. They help you understand why the behaviours happened, which also helps with stress because you then understand that they [service users] are not doing it [exhibiting behaviours that challenge] on purpose. It is not that they don't like you personally. It is just their illness.

(Participant 12 - Registered Mental Health Nurse)

The extracts above suggested that informal debriefs with colleagues can potentially prevent frontline staff from making inaccurate assumptions and perceiving incidences of behaviours that challenge as being personal attacks directed by service users. It was

suggested that frontline staff could inaccurately infer that incidences of behaviours that challenge are controlled and considered actions as directed by service users towards specific members of staff. Service users who are perceived to have greater control over their acts of aggression towards frontline staff can potentially elicit formal carers to withdraw from their caregiver duties (Stanley & Standen, 2000). This would suggest that care staff who hold the assumption that service users have full control over their behaviours that challenge, could be inhibited to engage therapeutically with clients who have unhelpful behavioural symptoms. However, the current study would suggest that post incident debriefs with colleagues may enable frontline staff to ascertain a more accurate understanding of the triggers for behaviours that challenge, rather than assuming the overt aggression of service users to be controlled/personal attacks.

“Participant 10: He [a service user] was getting up in the morning and being really aggressive and we were thinking “What is it? Is something wrong with him?”. It was because he didn't want to have a shower. But he didn't tell us that he didn't want a shower. An OT (Occupational Therapist) then said to me that this person [service user] doesn't like the feeling of a shower on him. So we were asking him to go into the shower and he didn't like it. So the OT said for him to have a bath. So he would have a bath and then the behaviour wasn't as bad. It was during an OT session when she was doing something with him [service user] and he said “I don't like the feel of the water that comes from the shower”

Interviewer: But for the members of staff who were trying to assist him to the shower, they might have thought his behaviour was being directed at them rather than at the water?

Participant 10: Yeah. So that all came out of having a meeting with the OT. It was just a suggestion and we tried it and it worked”.

(Participant 10 - Registered Mental Health Nurse)

“Participant 12: One of our Psychologists does a reflective practice group and it started when we had a particularly difficult young boy who came in [admitted onto the ward]. We just looked back over the whole care that we provided for him. The team said it was actually quite helpful. It is really informal and people [staff] just tend to chat about the different approaches that they were using [to prevent incidences of behaviours that challenge]. We have reflective groups for each young person [service user] where you look at their care plans and you think of different ways that you could try and help them”.

(Participant 12 - Registered Mental Health Nurse)

The above extracts have indicated that liaising with colleagues can be beneficial in gaining an understanding of the triggers for behaviours that challenge and developing strategies to prevent further exacerbation of behavioural symptoms of service users. Functional assessments of behaviours that challenge, as underpinned by Operant Conditioning Theory (Skinner, 1953), is a method that has been deployed by frontline staff within such fields of healthcare as Autism, Learning Disabilities (Matson & Williams, 2014) and Dementia (James, 2011), as a means to understand the function, or reason, as to why service users exhibit unhelpful behavioural symptoms. Functional assessments of behaviour that challenge can be useful for frontline health and social care staff in identifying the triggers and consequences for behaviours that challenge. The current study would suggest that post incident discussion with colleagues may be

beneficial in facilitating the staff to employ the principles of functional assessments in identifying triggers (assistance with personal care duties such as showering); unhelpful behaviour (aggression towards staff) and possible consequences of behaviours that challenge (staff perceiving service users' aggression as a controlled personal attack). Such collaboration with colleagues can therefore enable frontline staff to nullify triggers for behaviours that challenge, using such strategies as assisting service users to engage in their preferred method of personal care, in order to prevent further exacerbation of unhelpful behavioural symptoms. Furthermore, post incident discussion with colleagues may facilitate frontline staff in gaining a more accurate understanding of the causes of behaviours that challenge and negate the unhelpful assumptions that service users target specific carers with controlled acts of aggression. The quotes above suggested that implementing strategies to negate triggers for behaviours that challenge, as informed by discussion with colleagues, can enable frontline staff to continue their delivery of therapeutic interventions to service users concerned and offset work related stress.

1.8.5 Working with Colleagues who do not understand the causes of Behaviours that Challenge

However, some participants discussed that work related stress can occur when working alongside colleagues who do not use an investigative approach or express an interest in ascertaining an understanding as to why service users exhibit behaviours that challenge.

“Participant 53: They [some colleagues] don't see the dementia. They just see the behaviour and they think it's down to a personality trait, not the dementia. With the lack of understanding, they just see the behaviour and

they see that as who the person is. Should people be in this job, in this role if they are just looking at the behaviour? Are they in the right job role? Because I would question that. Because what kind of care are you going to give if all you look at is the behaviour and not the person and the illness?”.

(Participant 53 - Registered Mental Health Nurse)

“Participant 19: When people [colleagues] become too opinionated, they might just say “Oh well he [service user] just swears”. They [some members of staff] might just form an opinion quite quickly, which can be negative and that can make them [some colleagues] not being motivated to work with that individual [service user]. They lack understanding of why someone is swearing. That can be difficult for other people [members of staff] who are more motivated to work”.

(Participant 19 - Support Workers in Residential Autism Service)

The extracts above indicated that colleagues who are unmotivated to understand the reason as to service users exhibit behaviours that challenge can be perceived as a work related stressor for frontline staff who are motivated to ascertain the causes as to why care recipients may experience unhelpful behavioural symptoms during treatment. It has been recognised that such behaviours that challenge as swearing and repetitive vocalisations can be clinical features of such conditions as Frontotemporal Dementia (Bang, Spina & Miller, 2015) and Autism (Gabriels, Cuccaro, Hill, Ivers & Goldson, 2005) respectively. However, the quotes above suggested that some participants had experience of working with colleagues who attributed such behavioural symptoms as swearing to such stable factors as personality traits. Thus, some frontline health and

social care professionals may work within teams in which colleagues do not have an accurate understanding as to why service users exhibit behaviours that challenge, which may inhibit successful collaboration with peers and potentially elicit work related stress. This would suggest that work related stress may occur within frontline staff who work alongside colleagues who do not use an investigative or collaborative approach to ascertain the accurate causes of behaviours that challenge within health and social care settings.

1.8.6 Working with colleagues who exhibit unhelpful emotions and negativity

Some of the participants discussed the difficulties of providing health and social care when working alongside colleagues who exhibited unhelpful emotions or negativity within the workplace.

***Participant 15:** They [some colleagues] are quite negative. So that can bring the morale down as well. Certainly, it can bring me down. When you are on [shift] with certain characters who can come in the door like lovely and then something can happen with a service user and rather than just trying to muddle through it, it's like "Oh, she is doing this and I don't know why, can you go and speak to them?". Instead of just taking the initiative and trying, they give in and they will come and ask me or come and ask somebody else to deal with it.*

(Participant 15 - Support Workers Community Autism Service)

***Participant 42:** She [a Nurse Manager] was like saying that she gets heart palpitations and all that and it is so stressful that she can't do her job properly. That's the management, so imagine how that's affecting the staff.*

***Participant 41:** She is very highly strung.*

Participant 42: Yeah, she's catastrophising everything and we are kind of like "Jesus, the stress levels are everywhere". You are always a moment from a disaster, you are never a step away from something awful from happening....

Participant 41:and that is what you feel when you talk to her.

Participant 42: She kind of creates stressful working environments everywhere that she goes.

Participant 41: It is contagious".

(Participant 41 - Nurse in a Learning Disability Residential Service

**Participant 42 - Assistant Psychologist in a Learning Disability
Service)**

The quotes above indicated that colleagues who exhibit negative emotions can potentially elicit stressful working environments, which may then impact the professional practices and wellbeing of other health/social care professionals. It was also suggested that working with colleagues who did not recognise how their presentation, in terms of expressing unhelpful emotions or negativity, impacted the wellbeing of other frontline staff. Working within healthcare settings, where service users exhibit aggressive behaviours towards staff, can be stressful for both qualified and unqualified nursing professionals (Jenkins & Elliot, 2004). Therefore, it can be understood as to why colleagues may exhibit negativity or unhelpful emotional states, such as anxiety, given the difficulties that can coincide with providing health and social care to people who exhibit behaviours that challenge. However, the current study would suggest that issues can arise when the presentation of colleagues has a negative impact on the wellbeing of other frontline staff who are also providing health

and social caregiver duties. Within informal settings, it has been postulated that family members can respond to caregiver stress by expressing unhelpful emotions towards relatives, with a mental health diagnosis, through being overtly critical or hostile (Hooley & Gotlib, 2000). Family members who exhibit such unhelpful expressions of emotions have shown to potentially elicit poor treatment outcomes and exacerbate symptoms of mania/depression for relatives who have a diagnosis of Bipolar Disorder (Kim & Miklowitz, 2004). In the context of the current study, it was suggested that colleagues who exhibit unhelpful emotions and discuss the behavioural symptoms of service users in a negative manner may contribute to eliciting stressful working environments. This would suggest that working alongside colleagues, who have a tendency to express negativity within the workplace, could also have a detrimental effect on the wellbeing of frontline staff who are motivated to engage therapeutically with care recipients who exhibit behaviours that challenge.

1.8.7 Terminology used by Colleagues to Describe Service Users

Some of the participants discussed how the language used by some colleagues to describe service users who exhibit behaviours that challenge may not be conducive in ensuring the optimal delivery of health and social care services.

“Participant 53: People get labelled and they get labelled far too easily and I have seen that influence and impact on the care that they receive, especially so with sexualised behaviour. Say someone has got a delirium, they are unwell and do have that sexual disinhibition. But then that’s them labelled, even though they may not present like that for the rest of their admission. It’s hard because it’s all around communication again. You

need to relay just the right amount of information to manage the risk, but then not negatively impact on the person's [service user's] care”.

(Participant 53 – Registered Mental Health Nurse)

“Participant 44: The language can be used [by some colleagues] to demonise certain residents that are challenging. It is part of the culture as well. We are trying to change some of the language that is being used [by some members of staff to describe service users]. Sometimes they will say something that would hint at intent. That the person [service user] intended to harm another person. Using words like “He launched an attack in cool and calm and collected...”.

Participant 42: ...yes that's that was an incident report from last week...

Participant 44: ...cool calm and collected manner.

Participant 42: Like, staff narrowly escaped.

Participant 44: So that's just like saying there was psychopath in the room. That they knew exactly what they were doing and were planning it. Language is essential in this type of job.

(Participants 42 & 44 – Assistant Psychologists in a Residential Learning Disability Service)

These quotes suggested that the language used by colleagues to describe service users can potentially elicit unhelpful biases and depict working environments in which the intentions of care recipients are to cause harm towards frontline health and social care staff. Working within hospital environments that are perceived to consist of service users who regularly exhibit verbal and physical acts of aggression can have negative

consequences on the psychological and physical wellbeing of frontline healthcare staff (Spector, Coulter, Stockwell & Matz, 2007). The current study would suggest that the language used by some colleagues may also depict health and social care environments in which frontline staff are at regular risk of harm from service users who exhibit behaviours that challenge, which could elicit work related stress within the profession. It was also suggested that the terminology used by some colleagues may not be consistent with the actual presentation or behavioural symptoms of service users throughout their treatment. It has been recognised that diagnostic terms used in the field of mental health can elicit unhelpful biases and prejudices within people who do not work within health and social care professions (Martin, Pescosolido & Tuch, 2000). For example, the diagnostic term Schizophrenia can potentially elicit such unhelpful biases and prejudices as to assign people who experience psychotic symptoms as being unpredictable and aggressive (Wright, Jorm & Mackinnon, 2011). This would suggest that the use of diagnostic labels alone can be sufficient in potentially eliciting unhelpful biases and prejudices that may provide inaccurate representations of people who access health and social care services. In the context of the current study, frontline staff indicated that the language used by colleagues could potentially elicit unhelpful biases towards service users, which may inhibit the delivery of optimal health and social care. The quotes above indicated that work related stress could occur within frontline staff who perceive that the inaccurate labelling and descriptions of service users, as made by some colleagues, can be detrimental to the standards of healthcare delivered to care recipients who exhibit behaviours that challenge.

1.8.8 Resistance to the application of innovative methods to manage behaviours that challenge

Some of the participants also indicated that working alongside colleagues who are apathetic about accepting and applying innovative methods to prevent or de-escalate incidences of behaviours that challenge in a non-invasive manner can potentially elicit work related stress in staff who are willing to engage with new approaches.

“Participant 42: I think the resistance [to accepting new approaches to managing behaviours that challenge] boils down to the older staff. There is quite an obvious, sometimes less obvious, desire for all these things [non-pharmacological approaches to managing behaviours that challenge] to fail. The new staff, the new training, these new approaches, new changes... they [staff members who have worked in the profession for a longer period of time] are quite open and transparent that they want this to fail. I think that comes back to “Things weren’t so bad when we were in control was it?”. It’s like ‘This [new approach to managing behaviours that challenge] doesn’t work either, we are not as bad. Things were better when we had our way”.

Participant 45: It is extremely difficult to change hard-core minds that are fixed. No matter how many incentives, they [some colleagues] will find a reason, will put their heads together and say “We have been here longer than you” and they’ll trump you on certain things. The best training in the world can be defeated by people’s inability or unwillingness to change.

(Participant 42 - Assistant Psychologist in a Learning Disability Service

**Participant 45 – Lead Trainer in Management of Behaviours that
Challenge)**

“Participant 24: You could have the option of being difficult with people [some colleagues]. You do have the option of talking about things like safeguarding, CQC [Care Quality Commission], care management and you kind of know that’s not really going to help. So when you are in that situation [suggesting a different approach to managing behaviours that challenge], it’s quite difficult to know exactly what to do because sometimes I come away thinking “I should probably have been more assertive with them”. It’s a balance between how much you want to maintain and nurture the relationship you have with staff versus how much you want to get them to do what they should do. I probably err more towards the nurturing side. Sometimes I am frustrated because I think I should have bollocked them. Consensus isn’t that hard. Genuine consensus is hard. So getting people to genuinely believe that they need to do something is hard. It’s not hard to get people to go “Oh yeah, that’s really important, we need to do that”, when you know they don’t believe it. So genuine consensus is hard. It’s trying get that action.

(Participant 24 – Consultant Clinical Psychologist)

These views suggest that working alongside colleagues who actively avoid the consideration or use of innovative practices to manage behaviours that challenge can potentially elicit work related stress within frontline staff who are open to using new approaches in order to engage therapeutically with service users who experience unhelpful behavioural symptoms. In accordance with Social Identity Theory, the

formation of social groups can occur between people who share the same values, attitudes or beliefs towards a particular issue (Tajfel & Turner, 1979). The current study would also suggest that personal values and attitudes towards the management of behaviours that challenge can also determine the colleagues that health and social care professionals choose to be affiliated with. The highlighted quotes suggested that there are professionals who value the application of innovated approaches within caring practices and other colleagues who are not open to change their way of working when managing incidences of behaviours that challenge. This is concerning given that when particular social groups express divergent opinions on a given issue, this can potentially elicit intergroup conflict (Jackson, 2002). Within professional settings, it has also been postulated that having conflict with colleagues can potentially elicit occupational burnout (De Dreu, Dierendonck & Dijkstra, 2004). In the context of the current study, the quotes above indicated that intergroup conflict may occur between staff who assume the status quo in their practice of managing behaviours that challenge and frontline professionals who value the utilisation of new, or appropriate, approaches in negating unhelpful behavioural symptoms. Thus, frontline staff who are willing to engage in the use of innovative practices to manage behaviours that challenge may experience work related stress when their intentions of employing new ways of working are thwarted or negatively evaluated by colleagues who are not open to changing their methods of behavioural management within health and social care settings. Further, some participants articulated how the perceived negative evaluation from colleagues could inhibit the delivery of care practices, which are intended to meet the needs of service users, which could then manifest into work related stress.

“Participant 54: I do remember bathing people in the afternoon instead of the morning, that’s all I did that was different. So I had three people to

bath in a day and instead of bathing them in the morning I bathed them mid-afternoon because there was nobody else using the bathroom as opposed to the morning where everybody was using the bathroom. Now at the time, I was in my late twenties so relatively grown up, but still I am walking down through this day room with this person in a wheel chair and all the other staff are having a break and their heads are turning and looking at me, literally saying, “What is he doing now, why didn’t he do it in the morning?” Why do you feel uncomfortable? It’s because people [colleagues] comment on these things and that can inhibit you.

Interviewer: *Inhibit the way that you work with the person [care recipient]?*

Participant 54: *Yeah and I am not sure if I can take that kind of grief, and it is quite subtle.”*

(Participant 54 - Behaviour Nurse Specialist)

The process of being evaluated by others, who do not share the same values on a given issue, can elicit biological and perceived stress to the extent of potentially having detrimental consequences to wellbeing (Hausser, Kattenstroth, van Dick & Mojzisch, 2012). The views expressed by participants would suggest that working alongside colleagues who have conflicting philosophies in the management of behaviours that challenge could be perceived as sources of evaluative threat to the extent of eliciting work related stress. To explore this notion further, Chapter 5 of this thesis reports a quantitative study that aimed to ascertain the relationships between fear of being negatively evaluated by colleagues, capacity to engage with care recipients and work related stress.

1.8.9 Colleagues who avoid their duties as health/social care professionals

It was suggested that working alongside colleagues who avoid their caregiver duties can also potentially increase the level of workload for frontline health care staff who are dedicated in achieving the occupational demands that coincide with being a health/social care professional.

“Participant 53: It breeds contempt when you don’t feel supported by your team. Subconsciously or somewhere down the line, it can have a negative impact on my work with patients because if you are running around doing all of the work, you are going to be stressed. Therefore, you are not going to get that effective interaction with the patients or be able to spend as much time with them as you would do to offer them an intervention. You might be a bit more rushed. Then you’re a little bit hacked off or irritable. You’re not being able to have that effective communication because your tone of voice or facial expression with that patient isn’t what it would be if you actually felt supported with the work load”.

(Participant 53 – Registered Mental Health Nurse)

“Participant 23: Where you tend to get problems is when you've got people [colleagues] who don't pull their weight or people who run a mile at the first sight of trouble and start to panic. You get annoyed with them obviously. If you've got a 12 hour shift and a couple of incidents in a day, or difficult situations, and you know you are the one that's going to be dealing with it all, then that can really annoy you. There's not a single person that I work with who I don't get on with. I like them all. We've got a fab team. But that being said, you can still look at the rota and think “Oh

god, I am going to be doing everything today. When it comes down to it, I am going to be doing everything". So before you have even got to work, you are thinking "This is going to be 12 hours of sheer hell".

(Participant 23 - Support Worker in Residential Autism Service)

The extracts above suggested that working alongside colleagues who do not fulfil their duties or provide any contribution to the safe management of behaviours that challenge, could place an increase in occupational demands upon frontline staff who are diligent in achieving their duties as health/social care professionals. There have been many studies which have indicated that the support of colleagues may serve as a protective factor against work related stress within health/social care professions, such as community forensic mental health services (Coffey & Coleman, 2001) and nursing (Bartram, Joiner & Stanton, 2004). However, there has been little attention given to how the avoidant behaviours of colleagues may elicit work related stress levels within the frontline health and social staff. The avoidant behaviours of colleagues can be explained by the phenomenon of Social Loafing, which suggests that individual members of staff reduce their effort when working as part of a team as opposed to when working independently on a given task (George, 1992). It has been recognised that the colleagues who exhibit the tendencies associated with social loafing can cause members of staff, who are motivated to achieve organisational tasks, to increase their work related effort in order to counteract the more apathetic team members (Liden, Wayne, Jaworski & Bennett, 2004). With regards to the current study, the quotes above indicated that the avoidance of some colleagues to engage in caregiver duties can elicit perceptions of injustice in frontline staff who are required to increase their workload to ensure that the health and social care needs of service users are met. Occupational burnout and physical ill health may occur within employees who

experience the sense of injustice that can coincide with receiving the same or fewer rewards than those colleagues who provide less professional input in achieving organisational goals (Head, et al., 2007). In the context of the current study, colleagues who avoid the fulfilment of caregiver duties can potentially elicit work related stress within frontline staff who are required to compensate and increase their occupational input in order to ensure the continued provision of health and social care. The quotes above also suggest that such increases in occupational burden, as elicited by colleagues who avoid caregiver duties, may also impact the way in which frontline staff interact with service users. It has been postulated that anger can manifest as result of experiencing an injustice (Diguseppe & Tafrate, 2001). The quotes above indicated that the emotional response that frontline staff can experience when required to compensate for the apathy of colleagues who avoid caregiver duties, may have a detrimental effect on the capacity to engage therapeutically with service users who exhibit behaviours that challenge. Thus, colleagues who inhibit the successful delivery of therapeutic interventions through exhibiting the characteristics of social loafing and placing increased burden upon the more motivated members of staff, could potentially elicit work related stress within health and social care professions.

1.8.10 Unsupportive colleagues and workplace bullying

It was also suggested that working with colleagues who do not show support towards frontline staff who have been involved in incidences of behaviours that challenge can also potentially elicit or perpetuate work related stress within health and social care professionals.

“Participant 23: I could be sent in on a morning to get her [a service user] up and do her personal care and then again on a night-time where she

might have wanted somebody else to go in and do it on a night-time. She didn't want to see me again. That was one of her favourite things, "I don't want to see your bloody face again" she used to say to me, and I used to think "Yeah and I probably feel the same way about you as well to be honest at the minute". But if it is constant and its day in and day out, you can understand how you can get stressed. It can cause incidences. She would just lash out and hit and it was always me who got it because I was stuck with her day after day. I think that at the time, we had certain staff members who thought it was funny when she put me over the bonnet of a car. My hair was just was coming out in clumps, she had hold of me that much. Some certain members of staff just laughed and thought it was funny. People who made light of it, they don't work there anymore as I did actually open my mouth and say "Right that's it, enough is enough. I am not doing it anymore. I am not working with that morning, noon and night".

(Participant 23 - Support Worker in Residential Autism Service)

"Participant 52: I struggled. The atmosphere in that place didn't help because if you said "I'm struggling with something", then you were perceived as weak and not good enough to be here. There were a number of staff who were just causalities along the way because of that. If we had actually been supported, then we would have been OK. If you feel that you are speaking out and nobody is listening to you, then you feel you have no choice other than to say "Right, I am going onto the sick because I am not getting anywhere". It's not what you want to do, but sometimes you feel stuck".

(Participant 52 – Support Worker in a Community Service)

The quotes above illustrate the difficulties of working alongside colleagues who are unsupportive following incidences of behaviours that challenge. It was suggested that work related stress may occur for frontline staff who have been involved in incidences of behaviours that challenge and colleagues have actually found that to be humorous, which could be constituted as being an example of work place bullying. Intentions to leave such professions as nursing can be caused by the stress that can coincide with work place bullying (Lee, Lee & Bernstein, 2013). Such factors as assuming credit for the work of others, the refusal to share practice related information and ostracising particular members of staff have been recognised as examples of bullying that can occur in the profession of nursing (Felblinger, 2008). The current study would also indicate that colleagues who undermine the difficulties that some frontline staff experience when encountering incidences of behaviours that challenge can be perceived as workplace bullying and may elicit work related stress to the extent of requiring to take sick leave. Thus, working alongside colleagues who do not empathise with the difficulties of encountering incidences of behaviours that challenge could disrupt the capacity for health and social care professionals to engage in their occupation. The quotes above also indicated that work related stress and the inability to work therapeutically with service users could be further exacerbated when frontline staff have voiced their concerns but no action has been taken by senior members of the team as a means to address the expressed grievances. Some participants expressed how the process of receiving inadequate levels of support from senior members of a team could have negative consequences on the professional practices of frontline health and social care professionals.

“Participant 15: Not in my experience have I been pulled in and has the manager said “Oh I have noticed this, so how are you feeling? Oh, this happened to you, how do you feel about that? Are you alright?”. Like we had an incident where I was assaulted and there was some staff who was on shift who said to me “Oh, are you alright?”. But I didn’t get that from the manager and I think it’s quite important to look after your staff team”.

(Participant 15 – Support Worker in an Inpatient Psychiatric Service)

Participant 17: It makes me angry because you think to yourself “Why don’t you [senior members of staff] come down to our level and deal with the situation yourself instead of just sitting in your office. I know you get into offices because you have worked through the system but come in and have a look and see. We had one service user [with Pathological Demands Avoidance] and none of our managers had any experience of PDA [Pathological Demands Avoidance] and they expected us to work with that service user. They [senior members of staff] had nothing. They came to us and asked us “Has anyone had any experience [of working with someone who has Pathological Demands Avoidance], can you tell us what to do?”.

(Participants 17 - Support Workers Community Autism Service)

The above quotes suggested that work related stress can occur in frontline staff who work within teams that consist of senior members who do not check the wellbeing of employees following incidences of behaviours that challenge and lack the expertise to provide meaningful support in the delivery of therapeutic interventions to service users. The way in which the leadership styles of senior staff members affects the

performance and wellbeing of the more junior employees within the workplace has received some notable attention within existing literature. For example, Transformational Leaders who support staff through demonstration of expertise and consideration of employee needs (Burns, 1978) have been shown to improve performance and offset frustration in junior employees within white collar occupations (McCull-Kennedy & Anderson, 2002). It has been shown that senior members of staff who provide psychological support and meaningful input on how to achieve work related tasks can also be effective in offsetting work related stress and ensuring organisational commitment within more junior employees (Dale & Fox, 2008). This would suggest that the leadership style of senior members of staff can have an impact on the wellbeing and work related performance of more junior employees. In relation to the current study, the quotes above indicated that senior members of staff who are negligent in their support of frontline staff who are involved in incidences of behaviours that challenge could be perceived as contributing to work related stress within health and social care professions. The quotes above would also suggest that working with senior colleagues who do not have expertise on the diagnoses of service users may also inhibit the capacity for frontline staff to deliver therapeutic interventions and prevent/manage incidences of behaviours that challenge in an effective manner.

1.8.11 Summary of how colleagues can facilitate or inhibit therapeutic work with service users and influence the work related stress levels experienced by health and social care professionals

This section has provided illustrations, using participants' articulated experiences, as to how colleagues can potentially influence the levels of work related stress

experienced by frontline health and social care professionals who provide care for people who exhibit behaviours that challenge.

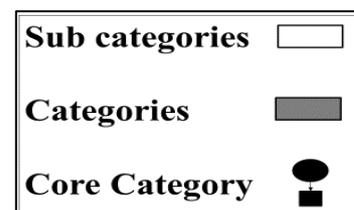
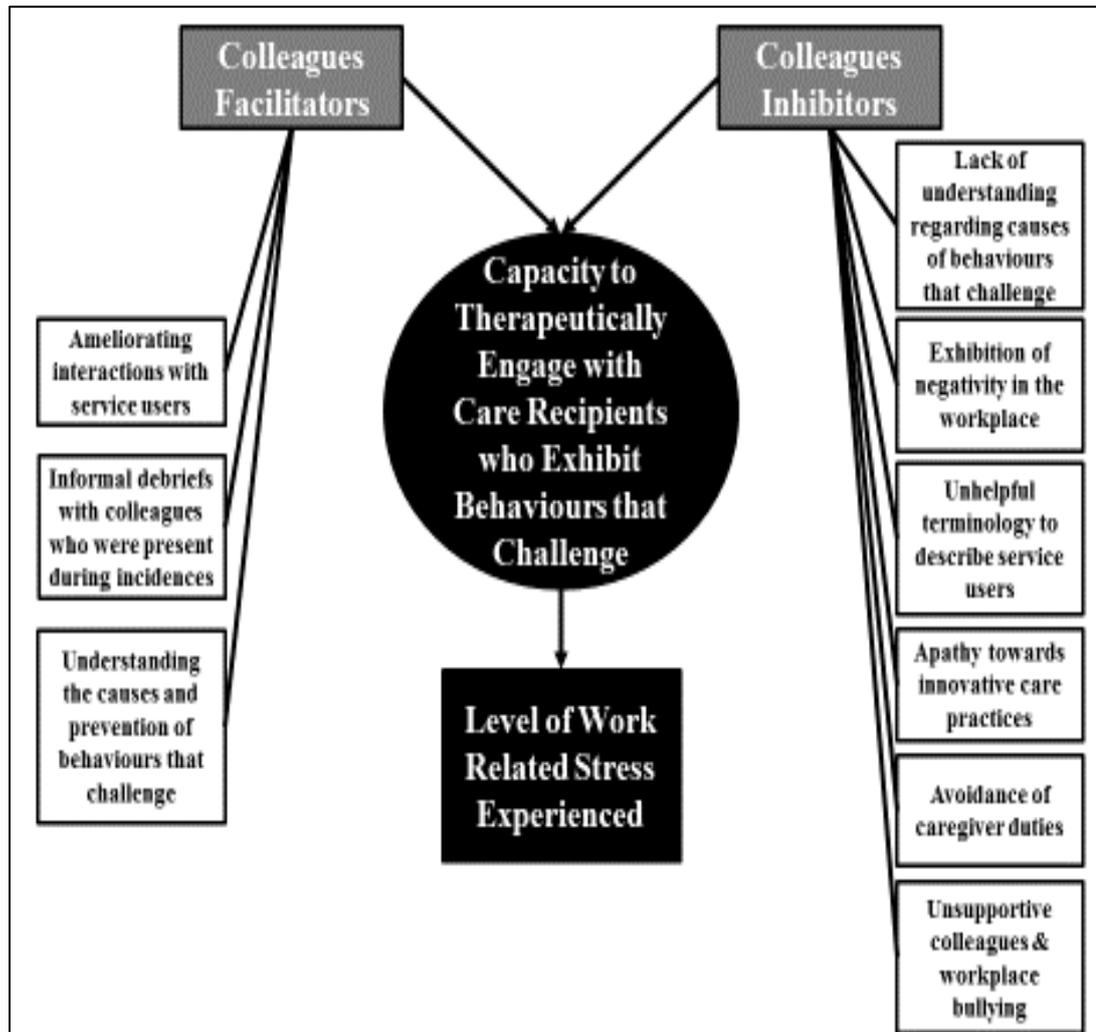


Figure 1.9. Illustration of how workplace colleagues can influence the capacity for frontline staff to therapeutically engage with service users who exhibit behaviours that challenge and the levels of work related stress within health/social care professions.

The views of participants suggested that there are various ways as to how colleagues could offset work related stress by assisting frontline staff to engage therapeutically with service users:

- The assistance of frontline staff can be beneficial in reducing the work related stress that can occur when anticipating the challenge of interacting or entering into discussions with service users who have a known history of exhibiting behaviours that challenge.
- Experienced colleagues who validate or provide suggestions on how to improve practices to manage incidences of behaviours that challenge can be conducive in reducing work related stress following challenging incidences with service users.
- Collaboration with colleagues can facilitate frontline staff to use an investigative approach as a means to gain a more accurate understanding of the triggers for service users to exhibit behaviours that challenge.
- Collaborative working appeared to be conducive in facilitating frontline staff to consider that other biopsychosocial factors can cause service users to exhibit behaviours that challenge during treatment as a means to identify triggers more accurately.
- Gaining an accurate understanding of triggers for unhelpful behavioural symptoms, rather than assuming behaviours that challenge to be personal attacks towards members of staff, enabled the implementation of interventions to prevent subsequent incidences from occurring.
- Identification of triggers, through the collaboration with colleagues, could be beneficial in preventing incidences of behaviours that challenge, enabling

frontline staff to continue their therapeutic engagement with service users concerned and offsetting work related stress.

However, some participants also articulated that some colleagues could also cause work related stress when their actions actually inhibited the successful delivery of therapeutic interventions to service users who exhibit behaviours that challenge:

- Working alongside colleagues who assign the causes of behaviours that challenge as being attributable to such stable factors as the personality traits of service users, could elicit work related stress within frontline staff who valued to consideration of other biopsychosocial factors to explain the behavioural symptoms of service users.
- Colleagues who expressed negativity within the workplace and towards service users could potentially elicit stressful working environments within health and social care settings.
- Some colleagues may use language to portray service users in a way that could be inconsistent with the actual symptomatology of care recipients. Such inaccurate use of language, terminology and depiction of service users had the potential to elicit unhelpful biases that were not conducive in facilitating the therapeutic work of frontline staff who disagreed with the incorrect use of diagnostic terms or description of care recipients.
- Colleagues who are apathetic or obstructive in modifying their approach to managing incidences of behaviours that challenge could also potentially inhibit the delivery of behavioural management strategies that were appropriate in negating triggers. This was viewed as a work related stressor for frontline professionals who valued the consideration and application of innovative

training programmes that advocate the use of non-invasive methods to safely prevent or de-escalate incidences of behaviours that challenge.

- The perception that health/social care professionals are being negatively evaluated by colleagues can inhibit capacity to therapeutically engage with care recipients who exhibit behaviours that challenge and elicit/perpetuate work related stress. (This observation was investigated, using appropriate quantitative methodologies, and is reported within Chapter 5 of this thesis.
- Colleagues who avoid fulfilling their duties as health and social care professionals can potentially increase occupational demands and contribute to work related stress within the profession. It was suggested that the frustration or anger, as caused by the injustice of compensating for apathy of some colleagues to engage in their professional duties, could have negative consequences of the capacity for frontline staff to engage therapeutically with service users who exhibit behaviours that challenge.
- Colleagues who suggest that incidences of behaviours that challenge, involving the assault of staff, to be humorous could be construed as acts of workplace bullying. Such workplace bullying could cause frontline staff, who had been involved in incidences of behaviours that challenge, to take sick leave away from their occupation.
- Senior members of staff who lack relevant expertise and were negligent in their provision of post incident support, could also potentially elicit work related stress through not having adequate support to effectively engage with service users who exhibit behaviours that challenge.

The category of Colleagues has illustrated how the attitudes towards care practices, work ethic, quality of assistance and presence of peers can potentially impact frontline

staff in their capacity to work therapeutically with service users who exhibit behaviours that challenge and thus levels of work related stress in the profession. Chapter 5 further explores the nuanced stressor, as discussed in this section, of how the fear of being negatively evaluated by colleagues in the work place could influence perceived capacity to engage with care recipients and levels of work related stress.

1.9 The Facilitating and Inhibiting effects of Staff Interactions with Care Recipients and the Impact upon Work Related Stress

The category of ‘Care Recipients’ was defined by participants’ experiences of how interactions with people who exhibit behaviours that challenge could affect the capacity for frontline health/social care professionals deliver therapeutic interventions and influence levels of work related stress.

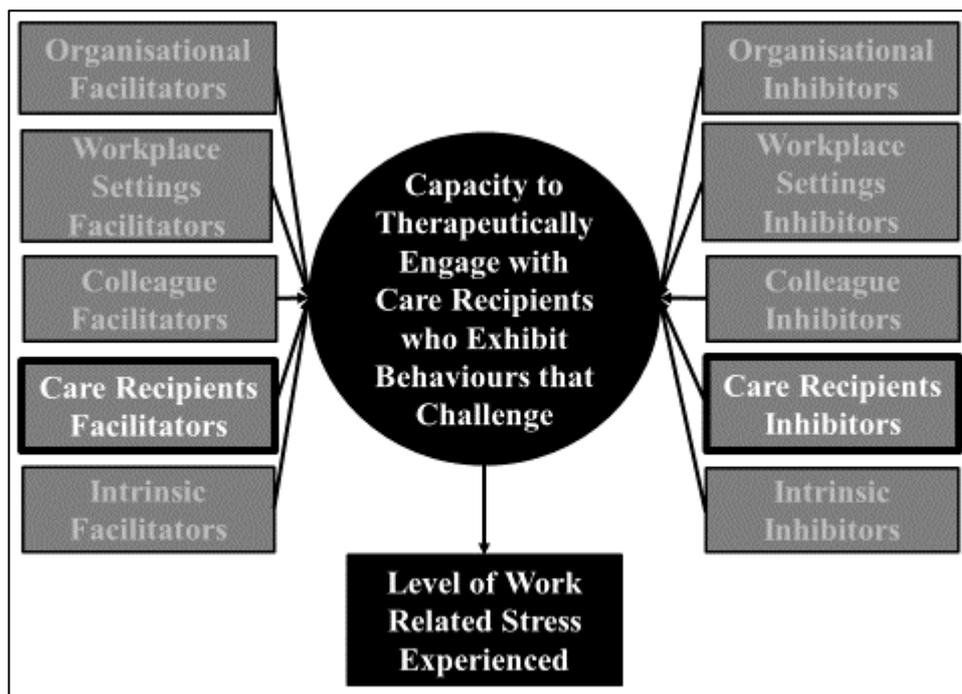


Figure 1.10. This section discusses participants experiences of how care recipients can either inhibit or facilitate health/social care professionals in their delivery of caring interventions for people who exhibit behaviours that challenge.

1.9.1 Encountering Service Users who Exhibit Violence and Aggression

Firstly, participants stated how encountering care recipients who exhibit overt acts of aggression can inhibit frontline health/social care staff in their professional practice.

“Participant 21: When they [service users] lash out, they bite, they kick and then your adrenaline runs. Then there's verbal and that is just as bad

because it hurts and it can be very personal. Sometimes, it doesn't bother me but if you are having a bad day to start off with, then it can knock you right down and it affects you”.

(Participant 21 - Support Worker Residential Autism Service)

“Participant 4: If it was a challenging behaviour where you felt physically threatened, you might feel fear. We have had a situation recently where somebody [a service user] who was very poorly and was being volatile. At the moment, I think that everybody [members of staff] feels slightly nervous around this person now and that is not a good way to feel obviously. We feel quite anxious and nervous”.

(Participant 4 – Senior Support Worker Community Mental Health

Service for Working Age Adults)

The quotes above suggested that providing care for care recipients who exhibit verbal and physical aggression can elicit unhelpful emotional states such as anxiety and fear. Positive correlations between levels of anxiety/fear and emotional exhaustion have previously been observed within carers who have been exposed to regular incidences of aggression in Learning Disability residential services (Rose, Horne, Rose & Hastings, 2004). This is concerning given that the emotional states of anxiety and fear may impact the professional practices of frontline staff who are required to provide health and social care for service users who exhibit overt acts of aggression. Within the field of policing, it has been reported that frontline officers avoid engaging in occupational tasks as a means of coping with the anxiety caused by encountering incidences of violence in community settings (Pasillas, Follette & Perumean-Chaney, 2006). The emotional state of fear can also elicit avoidant behaviours from stimuli that

may constitute as being potential threats to personal wellbeing (Mogg, Bradley, Miles & Dixon, 2004). The quotes above have suggested that fear and anxiety can coincide with apprehension when required to engage with service users who have exhibited aggressive behaviours during their treatments.

1.9.2 Exposure to bodily fluids

Some participants also articulated a fear of providing caregiver duties to service users who purposefully expel bodily fluids, and how such behaviours can elicit work related stress.

“Participant 22: Where I work, the worst thing is spitting.

Participant 20: There is a lot of spitting where I work as well.

Participant 19: I can't cope with that.

Participant 21: My stress levels are up on the ceiling if people [service users] are constantly spitting at me. I don't cope with that at all.

Participant 19: When they [service users] swear, we do stop them, we do say that it is not appropriate. So that doesn't bother me. The smearing and the spitting [though], it's disgusting.

Participant 22: What I think about, going over it all in my mind, is that the stress comes out when you are thinking “How can you avoid getting attacked?”. You stress about getting an infection because there is a lot of soiling. So that that's a stress factor”.

**(Participants 19, 20, 21 and 22 - Support Workers Residential
Autism Service)**

“Participant 41: Working with somebody [a service user] who smears faeces, it is one of the worst things that a person could do. It’s the greatest form of protest”.

The quotes above suggested that frontline staff can experience a fear of infection or contamination when providing care for care recipients who expel bodily fluids, through such acts as spitting and smearing, which can be perceived as a work related stressor. There is a dearth of research that has considered how the challenge of providing care for people who present as expelling bodily fluids on purpose, through spitting or smearing, can influence the work related stress levels experienced by health/social care staff. Organisations that consist of inadequate hygiene protocol can lead to mental healthcare professionals, who work within inpatient settings, being at risk of acquiring infections through exposure to bodily fluids (Ott & French, 2009). The current study has also suggested that care recipients who expel bodily fluids may also present as a risk for some health/social care professionals in terms of acquiring an infection. Thus, health/social care staff who encounter behaviours that challenge, which consist of the expulsion of bodily fluids, could be at risk of being infected with bacteria that can cause such ailments as Influenza, Norovirus and MRSA (Kramer, Schwebke & Kampf, 2006). The quotes above have illustrated how the process of providing care for service users who purposefully expel bodily fluids can elicit fear of infection and present as a risk to the physical wellbeing of frontline health/social care staff, which may impair the capacity for frontline staff to engage with care recipients concerned.

The quotes above suggested that such acts as spitting and smearing, as exhibited by service users, can also elicit disgust within frontline health/social care staff. The construct of disgust can manifest and cause repulsion from stimuli that presents as a

being a risk of causing infection or contamination (Rozin & Fallon, 1987). People who are sensitive to experiencing disgust can be hyper-vigilant towards and more likely to avoid stimuli perceived as being risk of causing infection or contamination (Deacon & Olatunji, 2007). This would suggest that frontline health/care staff who are sensitive to experiencing disgust when being exposed to bodily fluids, may actively avoid engaging with service users who exhibit behaviours that challenge such as spitting and smearing to avoid the risk of contamination.

1.9.3 Repetitive vocalisations

Repetitive vocalisations, as exhibited by service users, was also identified as a behaviour that could inhibit frontline staff in their delivery of therapeutic interventions and elicit work related stress.

“Participant 33: We do have one service user who is very repetitive and he’ll go “Do you know what? Do you know what?, Do you know what?” and the staff don’t acknowledge that all of the time because once you say “Oh, what Billy?” he has got you. Once you have given that response, it’s difficult to get out of that. The more you engage with him, the more your anxiety levels go up, because once you respond “Oh, what Billy”, that is it “Do you know what?, Do you know what?, Do you know what?”.

Participant 31: I have been in there and he was the most difficult one for me to deal with. I had never dealt with him before and I came back to you and said “I struggled with him the most”. That was the most difficult behaviour”.

(Participant 31 and 33 - Team Leads for a Community Autism Service)

***Participant 22:** It can be tiring if you are at dealing with repetitive conversations [with service users who exhibit repetitive vocalisations] over and over again and you come back in the next day to start the same [conversation] over and over again.*

***Participant 20:** Sometimes you've got to take a step back because you can get so immersed. You have already told them [service users who exhibit repetitive vocalisations] the answer and that they should know the answer. On a good day, when you are able to take a step back and think “Well, if it is irritating me this much, then what is going on in their minds? They must be really irritated by having these thoughts again and again”. But on a bad day, it is really hard not to snap and say “Well, you already know what you are doing today, I have already told you”. If you have been the focal point for that question again and again and again over a 12 hour period, that can get your stress levels up a bit”.*

**(Participants 19, 20, 21 and 22 - Support Workers Residential
Autism Service)**

The quotes above illustrated the difficulties of providing health and social care for care recipients who engage in repetitive vocalisations throughout their assessment and treatment. It was suggested that care recipients who exhibit repetitive vocalisations can elicit fatigue within frontline health and social care staff. Encountering repetitive vocalisations can be a common occupational demand for staff who work within such settings as Nursing Homes, Residential centres (Gruber-Baldini, Boustani, Sloane & Zimmerman, 2004) and Autism services (Cullen, et al., 2005). This is concerning, given that the above quotes would suggest that encountering repetitive vocalisations

on a regular basis can be tiring and contribute to the manifestation of work related stress. There is currently a lack of research investigating how repetitive vocalisations, specifically, can influence the professional practices of and levels of work related stress within frontline staff. The current study has indicated that repetitive vocalisations is a specific type of behavioural conduct that requires further empirical investigation in the context of work related stress and the therapeutic practices of health and social care professionals.

1.9.4 Deliberate self-harming behaviours

Providing care for people who deliberately harm themselves was also identified by participants as being stressful.

“Participant 14: I think violence and aggression is always hard because you are trying to keep everybody in that situation safe. But I think self-harming is also difficult to deal with. We've got a young lady who self-harms. She ties ligatures; she tries to cut herself, tries to choke herself. I find those kind of things difficult as well. When somebody is trying to harm themselves, I think that's quite anxiety provoking”.

(Participant 14: Staff Nurse Mental Health Inpatient Service)

“Participant 6: I have worked with the lad [service user] for a year and a half now, he's got borderline personality disorder. He is a serious self-harmer. When he says he is going to self-harm, it's bad. He hits his hand with a hammer. He's gone through tendons and he's got limited movement. I picked him up from the local mental health hospital and I built up quite a good rapport with him. The hope was to keep him out of hospital and try and reduce the self-harming by putting me in [to provide care for the

service user] for four hours a week. So that's what I've been doing with him. About two months ago, I was chatting with his care co-ordinator and we were possibly going to be reducing his support. Then he had quite a few hospital admissions as he tipped acid on his arm which obviously, as you can imagine, is quite serious. So he's had to have an operation and skin grafts. Now he does like to shock people and he likes to get the attention for it. I had been working with him for a year and a half, I was in place and getting paid to try and reduce the risk of him going into hospital, but actually it hadn't worked. Things started to kick off again, so it wasn't working".

(Participant 6 - Support Worker within a Community Mental Health Service)

Deliberate self-harming behaviours can serve many different functions for people who have experienced psychological trauma such as to reduce unhelpful emotional states, divert attention from intrusive thoughts and relieve tension (Gratz, 2003). The quotes above indicated that care recipients may also self-harm at the stage of treatment where frontline staff plan to reduce or cease their input in the delivery of health or social care. Self-harming behaviours can occur when people are experiencing psychological distress and are sensitive to the notion of being socially rejected (Mangnall & Yurkovich, 2008). People accessing mental health services who have deliberately self-harmed have reported to experience higher levels of social isolation than care recipients who have not engaged in self-harming behaviours (Castille, et al., 2007). In accordance with the quotes above, some frontline staff may perceive that care recipients deliberately self-harm as a strategy to maintain contact with and input from health/social care professionals as a means to prevent social isolation or reduce

feelings of being rejected. However, it has been argued that self-harming behaviours has been misconceived as method to gain attention from others (Gratz, 2003). It has also been posited that inadequate training within specialisms, such as Psychiatry, can underpin misconceptions and poor understanding as to why care recipients engage in self-harming behaviours (Jeffery & Warm, 2002). Thus, ascertaining whether deliberate self-harming behaviours can serve as a function to maintain contact with health and social care professionals/avoid discharge from services, warrants further investigation. Nonetheless, work related stress may occur within frontline staff when their plans to reduce or cease professional input can coincide with the exacerbation of self-harming behaviours within care recipients who are experiencing psychological distress and are sensitive to the notion of being rejected. Thus, frontline staff may experience work related stress when they are unable to support care recipients, who have engaged in self-harming behaviours, through a successful reduction of or discharge from health and social care services.

Along with the difficulties of overseeing successful discharges from services, the quotes above have also illustrated how frontline staff can experience such emotional states as anxiety when witnessing the effects of self-harming behaviours on the wellbeing of care recipients. There is a dearth of research regarding how the process of witnessing incidences or attempts of self-harming behaviours can influence work related stress and the professional practices of frontline health/social care staff. However, frontline staff can experience negative attitudes towards care recipients who deliberately self-harm when experiencing low levels of efficacy and a high level of uncertainty when assessing/treating patients who have repeatedly exhibited this behaviour that challenges (McAllister, Creedy & Moyle, 2002). Thus, it could be that low efficacy and uncertainties on how to successfully treat care recipients who engage

in self-harming behaviours may underpin the reported stress that can coincide with delivering health/social interventions to care recipients who have deliberately harmed themselves. It is suggested that further empirical research is conducted to ascertain how the deliberate self-harming behaviours specifically impacts frontline health/social care professionals in their capacity to deliver therapeutic interventions and levels of work related stress.

1.9.5 Service users who become attached to specific members of staff

Some of the participants articulated that work related stress can occur when providing care for service users who become inappropriately attached to specific members of staff.

Participant 14: Quite often in young people [service users], sometimes there is a lot of attachment issues. So if you support a young person, you have got to be careful with attachment issues. That can be quite difficult. For example, I had a young person and it became quite difficult because they wanted me there all of the time. When I wasn't there, then incidences would happen to try and get me there. That was quite stressful for me as well because I wanted to work with this patient, but I knew I couldn't because it got to the point where they wouldn't engage with other staff members just to see if I would come over and that is not good.

(Participant 14: Staff Nurse Mental Health Inpatient Service)

Participant 6: I think she [the service user] was a little bit let down because I had to end the support work [with her] because I felt that she was doing fine. But then she kept trying to find things to keep me. But I had people on a waiting list who seriously needed support. We have four

places for us to support somebody with a housing need. So I dealt with her housing, I'd even done a lot extra for her. It was only meant to be for a couple of months while she was getting back onto her feet. [But] She [service user] still said she is going to phone me next Monday”.

(Participant 6 - Support Worker within a Community Mental Health Service)

The quotes above suggested that care recipients may exhibit behaviours that challenge as a strategy to attain proximity with specific members of frontline health and social care professionals, which can contribute to the manifestation of work related stress. Bowlby's Attachment Theory (1951) posited that infants seek proximity with trusted adult caregivers as a means to ensure wellbeing and survival. Younger people who have experienced trauma through childhood can also exhibit attention-seeking behaviours as a means to gain close proximity to trusted caregivers in order to reduce perceived stress and anxiety (Schoore, 2001). It has been posited that professionals who are able to respond therapeutically to the attachment or attention seeking behaviours of people who have a learning disability can be conducive in ensuring the development and maintenance of good therapeutic relationships between carer and care recipient (Schuengel, Kef, Damen & Worm, 2010). The process of attaining proximity with professional carers, who are trusted, has also shown to alleviate unhelpful behavioural symptoms in people who have a Learning Disability (De Schipper & Schuengel, 2010). This would suggest that when health/social care professionals are able to meet care recipients' needs that consist of ascertaining proximity or input from a trusted carer, this may be conducive in preventing incidences of behaviours that challenge. However, the quotes above have illustrated that work related stress may occur within frontline staff when they are unable to respond therapeutically to care recipients who are

actively seeking proximity or continued care, due to such organisational demands as waiting lists, which can then lead to incidences of behaviours that challenge. Thus, the process of being unable to respond therapeutically to care recipients who seek attention or professional input for specific members of staff may elicit perceptions of failing to provide caregiver duties and therefore elicit work related stress.

1.9.6 Service users who do not engage with therapeutic interventions

Contrary to service users who actively seek ways of interacting with health/social care professionals, some participants articulated their difficulties of providing caregiver duties for care recipients who do not engage with therapeutic interventions.

“Participant 14: There are some patients that won’t engage. You know if they don’t engage, that it could lead to an incident. You are trying to do everything to prevent it and trying to get them to engage with you a bit, but sometimes it just doesn’t happen. It is frustrating and when you know that an incident is probably going to happen. It is quite stressful as you are just waiting for it to happen, even though you are really trying to prevent it from happening”.

(Participant 14: Staff Nurse Mental Health Inpatient Service)

“Participant 8: You can get a lack of motivation [from service users] that can be due to medication or their illness. I was working with a service user to help them work out their finances. I made a lot of effort and it all came to nothing and that can be challenging. (P8, WAD)

Participant 4: If you are supporting somebody longer term, just working on behaviour change, you can get trapped into quite negative cycles [with service users]. You are giving people [service users] strategies that they

can use and then they don't use them. You're giving people things to do and strategies to use and then you meet with them the next week and you are asking "Have you done what we set last week?" and then they say "No I have not"...

Participant 7: *...and they [service users] say "I have tried it for two weeks and it hasn't worked".*

Participant 4: *Keeping people [service users] constantly motivated is quite challenging".*

**(Participant 4 – Senior Support Worker within a Community
Mental Health Service**

**Participants 7 & 8 - Support Workers within a Community Mental
Health Service)**

The quotes above suggested that frontline staff can experience difficulties when required to motivate service users who are ambivalent about engaging with health and social care professionals. Patients who are unmotivated to engage with therapeutic interventions is a phenomenon that has been observed across many specialisms within healthcare such as Schizophrenia (Rector, Beck & Stolar, 2006), Postnatal Depression (Bilszta, Ericksen, Buist & Milgrom, 2010) and Anorexia Nervosa (Sjogren, 2017). Avoidance of pain and low mood have been identified as being factors that can elicit low motivation to engage in rehabilitation interventions that consist of physical and occupational therapies (Lequerica, Donnell & Tate, 2009). Psychotic symptoms, such as visual or auditory hallucinations, have also been posited as causing patients to present as being unmotivated to engage with professional carers within Mental Health services (Koekkoek, van Meijel & Hutschemaekers, 2006). However, the quotes

above have indicated that health/social care professionals may perceive that their failure to engage with care recipients, who are ambivalent to accepting therapeutic input, could cause incidences of behaviours that challenge.

The extracts above have also suggested that the some frontline staff may perceive that the side effects of medication could compound the difficulties in engaging with care recipients who present as being ambivalent towards the acceptance of therapeutic input. Selective Serotonin Reuptake Inhibitors, used to treat depressive disorders (Barnhart, Makela & Latocha, 2004), and antipsychotic medications (Moncrieff, Cohen & Mason, 2009) can elicit side effects such as reduced motivation and loss of interest in activities that were previously considered as being meaningful. This would suggest that frontline staff, who provide care for care recipients who are prescribed medications that can cause a decrease in motivation, could experience difficulties in successfully delivering non-pharmacological interventions such as talking therapies. The current study would suggest that even with the knowledge that some medications can cause reduced motivation, the process of providing care for service users who are ambivalent about engaging with frontline carers can still elicit work related stress within health and social care professions.

It was also suggested that work related stress may occur within staff when service users do not complete tasks, as set by frontline health/social care professionals, which aim to facilitate care recipients to achieve the aims of therapeutic interventions. The success of some interventions, such as Cognitive Behavioural Therapy, relies on the care recipient to engage with the therapist and complete homework tasks in between sessions (Thase & Callan, 2006). Higher levels of engagement in homework tasks, as set by a therapist, has shown to enhance the therapeutic experience of engaging in Cognitive Behavioural Therapy and can be more beneficial in reducing the symptoms

of depression (Neimeyer, Kazantzis, Kassler, Baker & Fletcher, 2008). However, the quotes above have illustrated the difficulties that frontline staff can experience when providing care for service users who do not actively engage with health/social care professionals and fail to utilise the strategies as discussed during appointments. This is concerning given that health/social care professionals can encounter service users who present as being ambivalent through accessing health/social care services in order to receive therapeutic input, but are also unwilling to engage at a level where interventions can become effective (Hall, Gibbie & Lubman, 2012). The current study suggested that providing care for such ambivalent service users can inhibit frontline staff from observing positive outcomes from their therapeutic practices in terms of facilitating the recovery of care recipients, which could be perceived as a work related stressor. Thus, the process of providing caregiver duties to service users who access health and social care services, but are actually ambivalent towards engaging at the level required in order to elicit therapeutic change, can elicit work related stress within frontline staff.

1.9.7 Enhancing knowledge through engaging with service users

Some participants discussed how their direct interactions with service users could actually be beneficial in acquiring work related knowledge which could serve as a protective factor against occupational stressors.

“Participant 4: I sometimes think back to when I first came to work here and I learnt a lot about the clinical side of mental health and diagnoses. Actually, when I think about it now, it just makes me shudder because the people who I have learnt the most from and learnt the most useful information is from the actual people [service users] who come here. Just

being sat down and listening to people and listening to their stories and actually figuring out what to do based on what people say. Some people do need very specific support and very specific care and it help to really understand that person's background and some of the things that they are struggling with”.

**(Participant 4 – Senior Support Worker within a Community
Mental Health Service)**

“Participant 53: If I know that person [service user] as much as I can from a nursing point of view or a challenging behaviour point of view, then I am going to be able to do my job better with regards to being able to implement interventions and then take them out to the community and provide a successful discharge. It helps me to discuss with the staff on discharge, in different care settings, how they can tweak their approaches to meet that person’s needs”.

(Participant 53 - Registered Mental Health Nurse)

The quotes above have illustrated how the direct interactions with service users can enable frontline health and social care staff to effectively implement therapeutic interventions. In the field of Psychotherapy, Carl Rogers (1961) posited that service users have the greatest insight to their experience and should inform the way in which therapists implement therapeutic interventions. As discussed in section 1.9.7, the work of Carl Rogers informed the development of Person Centred Care which is a philosophy that advocates the consideration of service users’ values and idiosyncratic needs in order to ensure that interventions are delivered appropriately for each individual care recipient (Beach, Saha and Cooper, 2006). The current study has

illustrated that some participants acknowledge the importance of listening to and identifying the needs of service users in order to enable frontline health/social care professionals to deliver therapeutic interventions in an effective manner. The quotes above suggest that the process of acquiring and applying knowledge that is specific to the needs of each individual service user can empower frontline staff to effectively implement therapeutic interventions; a process that can be conducive in offsetting work related stress.

Empowering and enabling frontline staff to enhance their work related knowledge through allowing access to relevant information and resources has shown to be a potential protective factor against occupational stress within frontline healthcare staff who work in older people's residential settings (Li, Chen & Kuo, 2008). Training interventions, that have been effective in improving efficacy and knowledge in the management of behaviours that challenge, could also elicit acute beneficial effects in negating burnout within professional carers of people with dementia (Mackenzie & Peragine, 2003). This would suggest that access to information, increasing work related knowledge, and improving efficacy in the management of behaviours that challenge, could all serve as protective factors against work related stress. The current study has indicated that the process of directly interacting with service users can also provide opportunities for frontline health/social care professionals to acquire information, knowledge and the skills required to effectively engage therapeutically with care recipients and manage/prevent behaviours that challenge. This provides an illustration as to how the process of engaging therapeutically with service users can be integral in informing frontline staff on how to achieve their successful delivery of professional practices and offsetting work related stress.

1.9.8 Summary of how interactions with care recipients can elicit or offset work related stress

The category of Care Recipients has illustrated some of the ways in which direct interactions with people who exhibit behaviours that challenge can either inhibit or facilitate frontline staff in their delivery of therapeutic interventions, which can then determine levels of work related stress experienced.

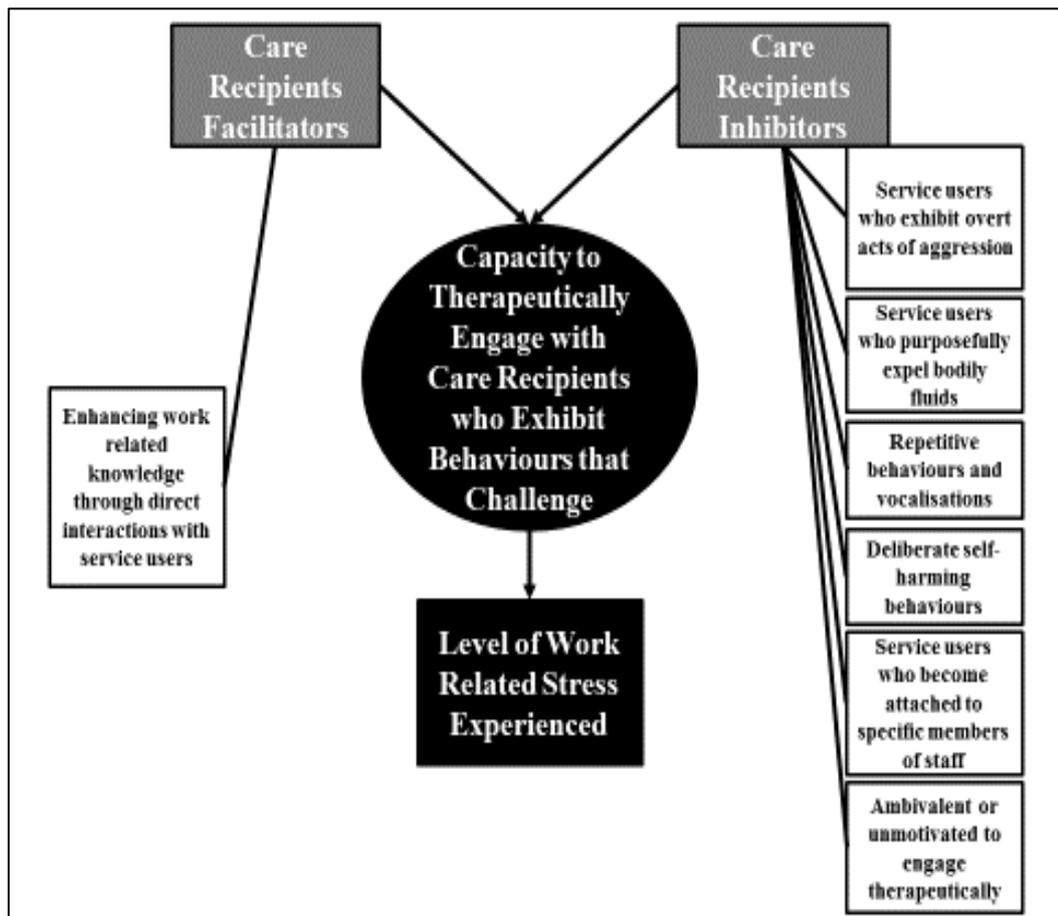


Figure 1.11. Illustration of how direct interactions with service users can influence the capacity for frontline staff to therapeutically engage with care recipients who exhibit

behaviours that challenge and the levels of work related stress within health/social care professions.

Some of the participants stated that the behavioural conduct of care recipients could impact the professional practices of and work related stress within frontline health/social care staff in the following ways:

- Encountering service users who exhibit overt acts of aggression can elicit unhelpful emotional states such as anxiety and fear.
- Service users who purposefully expel bodily fluids through such acts as spitting and smearing can elicit fears of infection and contamination within frontline health/social care staff. Some participants stated they can experience disgust towards behaviours that challenge that consist of spitting and smearing, which can potentially inhibit health/social care professionals to work therapeutically with service users concerned.
- Regular exposure to repetitive behaviours, as exhibited by service users, can potentially elicit carer fatigue within frontline health/social care professionals.
- Frontline health/social care professionals can experience anxiety when providing caregiver duties for service users who deliberately self-harm. The anxiety of encountering service users who deliberately self-harm could be underpinned by a lack of understanding on the causes of and uncertainties on how to successfully reduce/prevent this behaviour that challenges.
- Work related stress can occur within frontline staff when providing caregiver duties to service users who self-harm at the stage of treatment that prevents a successful discharge from health or social care services.

- Service users who exhibit behaviours that challenge as a means to gain the attention and professional input from specific members of staff.
- Service users who attempt to maintain contact with specific members of staff after being discharged from health or social care services.

With regards to previous research (Skirrow & Hatton, 2007) that has investigated stress with professional carers, the term behaviours that challenge has been used to encapsulate a conglomerate of behaviours that could be perceived as being stressors within health and social care professions. Existing literature has drawn attention to how aggressive behaviours (Pulsford & Duxbury, 2006), as exhibited by service users, can elicit work related stress within health and social care professionals. However, there is a lack of research on how specific behaviours, such as spitting or deliberate self-harm, can influence the work related stress levels of health/social care professionals and their capacity to deliver therapeutic interventions. It is suggested that further research classifies specific behaviours that challenge, some of which have been discussed within this category, to gain a more accurate understanding of how the behavioural conduct of service users affects work related stress experienced by health and social care professionals.

This section has also illustrated how the process of directly interacting with care recipients can allow opportunities for frontline staff to acquire knowledge and expertise, which can be conducive to enabling the effective delivery of therapeutic interventions and offsetting work related stress.

1.10 The Intrinsic Factors of Frontline Health & Social Care Professionals Staff and their impact on Interactions with Service Users and Work Related Stress

The final category to be reported within this Grounded Theory study concerns how the intrinsic qualities of frontline health/social care professionals could either inhibit or facilitate their delivery of therapeutic interventions to care recipients who exhibit behaviours that challenge and influence levels of work related stress.

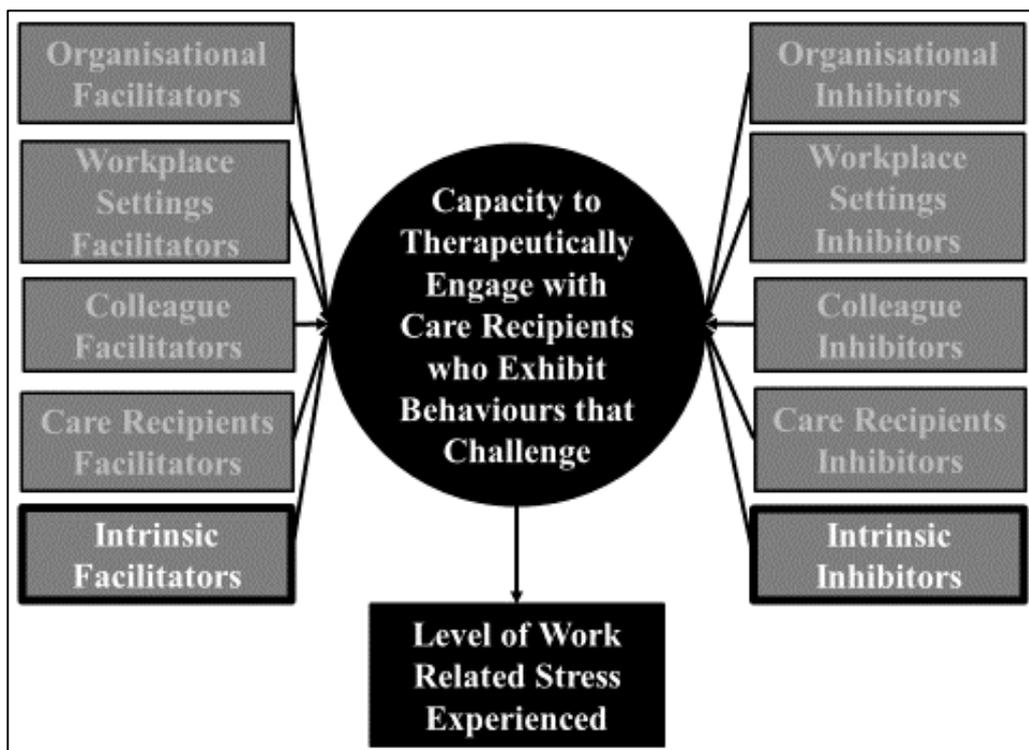


Figure 1.12. This section reports participants experiences of how the intrinsic qualities of health/social care professionals could influence their capacity to engage with care recipients who exhibit behaviours that challenge and levels of work related stress.

1.10.1 Inexperienced health and social care professionals

Some of the participants articulated that being inexperienced can potentially contribute to the manifestation of work related stress when providing health or social care to care recipients who exhibit behaviours that challenge.

“Participant 1: I came as a volunteer about 20 years ago now and I think, probably, it was a challenge because I didn't know much about mental health. I think it was the unknown of going into a totally new environment that were challenging environments. I didn't know what I was supposed to do, could I say the wrong thing that could set somebody [a service user] off on a bad episode? But I knew I had to learn quickly”.

(Participant 6 – Support Worker Lead within a Community Mental Health Service)

“Participant 19: My first two weeks [in starting the role] I went home and cried myself to sleep every night. I had application forms in at every shop at the local shopping centre after I had that incident [of behaviour that challenges] because it was causing me stress”.

(Participant 19 - Support Workers in Residential Autism Service)

The views above suggested that the challenge of providing care for people who exhibit behaviours that challenge, whilst being an inexperienced practitioner, can potentially cause frontline staff to experience work related stress, thoughts of having inadequate levels of knowledge and consider leaving the profession. It has been recognised that the initial weeks of commencing professions, such as Nursing, can coincide with work related stress and intentions to leave the profession (Chiang & Chang, 2012). The quotes above would suggest that exposure to incidences of behaviours that challenge is one work related factor that could contribute to frontline staff in their considerations of leaving caring professions when new to the role. The process of being an inexperienced health/social care professional can also coincide with having inadequate levels of knowledge on how to successfully engage with service users who exhibit

behaviours that challenge. This is consistent with previous research, which has observed that student nurses can be prone to experiencing stress when perceiving that they have inadequate levels of knowledge and expertise to successfully deliver nursing care to patients (Sheu, Lin & Hwang, 2002). However, the process of gaining experience could serve as a protective factor in offsetting the work related stress of providing care for people who exhibit behaviours that challenge.

“Participant 12: I have been here just over a year and a half now. When I was doing my preceptorship, for the first six or seven months when I started here, you do feel like “Am I doing the right thing? Am I any good at my job?”. But I think watching other people and learning how they manage situations, you just build up that experience. I think the stress elements of it and the anxiety of not feeling like you're very good at your job goes as your experience grows. Now I feel that actually, I can manage situations safely and to the best of my ability”.

(Participant 12 - Registered Mental Health Nurse)

The quote above suggests that gaining work related experience can be integral to the acquirement of the expertise and knowledge that is required to become an effective practitioner in the field of nursing (Herbig, Bussing & Ewert, 2001). This would suggest that the levels of experience, knowledge and expertise, in the effective management of behaviours that challenge, could influence the extent to which health/social care professionals experience work related stress when engaging with service users who have unhelpful behavioural symptoms. The quotes above have indicated that health/social care professionals can embark on their careers with little knowledge on how to effectively engage with service users who exhibit behaviours

that challenge. Sections 1.8.2 and 1.9.7 have illustrated how colleagues and direct work with care recipients can serve as useful sources for frontline health/social care professionals to acquire knowledge on how to therapeutically engage with people who exhibit behaviours that challenge. Thus, in order to ensure the retention of inexperienced health/social care professionals, new members of frontline staff may need to have opportunities to engage with occupational resources that facilitate the acquisition of skills required to safely prevent or de-escalate incidences of behaviours that challenge.

1.10.2 Perceiving that care recipients are in control of their behaviours that challenge

Some of the participants indicated that health/social care professionals who perceive that service users are fully in control of their conduct, when exhibiting behaviours that challenge, could be prone to experiencing work related stress.

“Participant 20: For about three weeks, I didn't know how I got back to work every single day. I didn't want to go back to work when I first started [working in the profession]. The fact that on my first day someone vomited on my shoe, I took that really, really personally. On that first day it felt like “Oh, here is the new girl and they [service user] have been sick on my shoe”. That was the first of many, many behaviours that I had that were very challenging behaviours.

(Participant 20 - Support Worker in Residential Autism Service)

“Participant 31: In my experience, what I found the most difficult were those subtle, repetitive behaviours [as exhibited by service users]. They seemed personal or that they targeted me. If they [service users] know that

it annoys somebody, they do it quite deliberately. That's what I think people [members of staff] find the most challenging. Those little things that are there all of the time, that are a bit repetitive. You are walking past [a service user] and there is a little cough or a little word in your ear. I think that's what people find challenging because they feel that that person [service user] has got some level of control over that behaviour and they are actually doing it deliberately or they are doing it for a response or a reaction, which is probably the case 90 percent of the time. That's what's hard to deal with".

(Participant 31 - Team Lead for a Community Autism Service)

Section 1.8.5 has illustrated that the process of working alongside colleagues who assume that service users are in control of their behavioural symptoms and do not attempt to gain an accurate understanding of the causes for behaviours that challenge, can be a work related stressor for some health/social care professionals. The quotes above have suggested that health/social care professionals, who assume that service users are in control of their unhelpful behavioural symptoms, could be vulnerable to work related stress. The views above have provided examples where health/social care professionals have assumed that the function for behaviours that challenge, such as the expulsion of bodily fluids and repetitive vocalisations, was to gain an unhelpful reaction from frontline staff. Within informal care settings, it has been recognised that carers can become hostile, or less inclined to express caregiver tendencies, when perceiving that recipients of care are fully in control of their conduct when exhibiting behaviours that challenge (Bolton, et al., 2003). This would suggest that the capacity to engage with care recipients could be inhibited when health/social care professionals perceive that behaviours that challenge are exhibited on purpose and with the intent of

harming staff. Sections 1.6.11 and 1.8.2 have illustrated how the process of engaging in formal and informal post incident debriefs, respectively, can potentially facilitate health/social care professionals to consider how biological, social and psychological factors can contribute to the unhelpful behavioural symptoms of service users. Thus, health/social care professionals who are prone to perceiving that care recipients are fully in control when exhibiting behaviours that challenge, may benefit from post incident debriefs and liaising with colleagues in order to gain more accurate attributions for behavioural symptoms.

1.10.3 Repetitive Negative Thinking

Some of the articulated experiences of participants suggested that health/social care professionals, who are prone to have repetitive negative thoughts, may be vulnerable to the onset of work related stress.

“Participant 4: I’m just thinking of a couple of times where I’ve had a bad day and I’ve been meant to go out that night. I have had plans and I have cancelled them because I just thought I will be an absolute misery, which isn’t great because you retreat into your cave for a bit. Sometimes it’s all very well to say “Oh well just stop thinking about those things”, but it is really hard. It is really hard when you care about the people [service users] that you work with. It is really hard to switch off from that sometimes. It is horrendous. I go home and dwell on it. You question your input and you say “I should have helped that person more, I should have done it, I should have done that differently”. You go over it and it can make you feel quite helpless”.

**(Participant 4 – Senior Support Worker within a Community
Mental Health Service**

“Participant 54: The anticipation can cause a kind of dread, sick feeling. I have had all of those before going to work. Not able to eat your breakfast and then thinking “I have to force it down” because I am going to need the energy and hit the ground running at 8 o clock. I have worked in hectic environments and you just feel that dread and also question the lack of effectiveness of what you are doing. It stops me working properly with the service user you know, it’s not a protective factor, it’s a stressor. It’s basically that feeling of “I’m not doing well”. I was a shift leader and also thought “Am I also doing the right thing for my colleagues?” which is very unpleasant because I am not leading the shifts as I would like to. I’ll be honest with you, I prayed that I would be able to do the right thing for my colleagues. I’m stressed that I can’t do the direct work with the client who I’m going to be with for the next three hours. I’m stressed that I am not leading the shift as well as I can. I pray that it will work out for everybody else.

(Participant 54 - Behaviour Nurse Specialist)

The quotes above have suggested that the process of thinking about difficult interactions with care recipients, in which the delivery of therapeutic interventions have been perceived as being ineffective, can underpin the manifestation of work related stress. It has been illustrated how the processes of being involved in incidences of behaviours that challenge (section 1.7.6) and not being provided a post incident debrief (section 1.6.10) can potentially cause staff to ruminate of their difficult

interactions with care recipients concerned. Rumination is a term used to describe repetitive negative thought processes on incidences that have occurred in the past (Nolen-Hoeksema, 1991). However, the quotes above have indicated that rumination on previous incidences of behaviours that challenge can also coincide with unhelpful thoughts on future appointments with care recipients concerned. Section 1.7.6 has already illustrated how the process of worrying about future interactions with service users can cause health/social professionals to experience work related stress and impair their capacity to therapeutically engage with care recipients. Worry has been defined as the repetitive thinking and fixation on the potential for future negative events to occur (Roemer & Borkovec, 1993). Positive correlations have been observed between levels of worry, as underpinned by repetitive negative thinking, and severity of anxiety and depressive symptoms (Segerstrom, Tsao, Alden & Craske, 2000). The quotes above provide further demonstration that health/social care professionals who have a tendency to engage in repetitive negative thinking, through ruminating on past incidences or worrying about future interactions with care recipients who have exhibited behaviours that challenge, could be prone to work related stress.

The data set of the current study suggested that the propensity to ruminate on previous incidences of behaviours that challenge or worry about future interactions with service users who have exhibited unhelpful behavioural symptoms, could be influential in the level of work related stress experienced by health/social care professionals (Topper, Emmelkamp & Ehring, 2010). However, psychological therapies that target the reduction repetitive negative thinking have shown to be effective in nullifying the symptoms of anxiety and depression (Kertz, Koran, Stevens & Bjorgvinsson, 2015). It could be that interventions that reduce rumination on previous incidences of behaviours that challenge and the worry of future interactions with service users who

have unhelpful behavioural symptoms may also be beneficial in offsetting stress within health/social care professionals who are prone to repetitive negative thinking. Chapter 3 of this thesis reports a study that aimed to ascertain if the perceived capacity to engage with care recipients could serve as a mechanism for change in reducing propensity to have repetitive negative thoughts and work related stress within mental healthcare staff who encounter behaviours that challenge.

1.10.4 Openness and honesty in the disclosure of limitations

Some of the participants suggested that the ability to reflect on their input, during incidences of behaviours that challenge, and be open about the areas in which they need to improve as practitioners, could be beneficial in offsetting work related stress.

“Participant 25: It’s having that self-awareness of what you need to manage in those situations [of behaviours that challenge] and support you. You do need to ask for that support and go for and be willing to be open about it. Not everyone has that self-awareness of being honest about what they need to develop or what they are comfortable with. I think it’s a big thing to say “No, in actual fact I am not good at that and I need to do something about it”. I think you have to be very open about yourself in that way”.

(Participant 25 – Challenging Behaviour Nurse)

“Participant 54: I think about that in terms of basic record keeping. If you have made a mistake, get it down now [in writing]. Something went wrong that you were part of, even if you didn’t make a mistake and you were just part of that process, get it down there [in writing]. The debrief won’t necessarily do that mind. The debrief might just be about the emotions and

that's that. You have had a hairy time that wasn't very nice and everything that could go wrong, did go wrong. It's more a case of recovering your attitude, whatever positive attitude you had during the last incident [of behaviour that challenges], and don't panic through the debrief. You will recover. The next [incident of behaviours that challenge], it might also, again, go wrong. You need to be honest about how to improve".

(Participant 54 - Behaviour Nurse Specialist)

The process of reflection can consist of appraising personal input on a given task, identifying areas for improvement and implementing the required changes in order to enhance professional practice (Valli, 1997). Within healthcare professions, it has been purported that the ability to reflect on personal practices can be fundamental to the process of learning, acquiring knowledge and becoming a more effective practitioner (Sobral, 2000). The views expressed above indicated that having the ability to reflect on personal practice can enable health/social care professionals to become aware of their own limitations in the safe prevention and management of behaviours that challenge, which can then be disclosed to others.

The quotes above also suggested that some health/social care professionals may use their disclosure of limitations, through discussion with colleagues or reflective writing, as a means to reduce work related stress and develop strategies to improve as practitioners in the safe management of behaviours that challenge. The process of discussing or writing about issues, that are perceived as being stressful, has shown to potentially alleviate psychological distress (Lyubomirsky, Sousa & Dickerhoof, 2006). Section 1.8.3 has also illustrated how venting to colleagues, within informal debriefs, can facilitate emotional disclosure of the difficulties that coincide with incidences of

behaviours that challenge. In conjunction with the quotes above, having opportunities to engage in either formal or informal post incident debriefs could provide the outlets required for health/social care professionals to be open/honest about areas for improvement as practitioners when de-escalating incidences of behaviours that challenge. Thus, health/social care professionals who are open and honest about their limitations in managing behaviours that challenge, may use discussion with colleagues or reflective writing as an effective coping strategy to reduce work related stress and improve professional practices.

1.10.5 Using humour

Having a good sense of humour was also deemed as being a quality that could help in offsetting the work related stress that can occur when providing care for people who exhibit behaviours that challenge.

“Participant 14: I think a lot of the patients, their relationships develops with staff through humour, or I know that some of them do with me. That's just from experience because if you've got a good sense of humour, it just takes the edge of things doesn't it? It makes people feel better”.

(Participant 14 - Staff Nurse Mental Health Inpatient Service)

“Participant 32: You have got to have a sense of humour, because after something has happened, you sort of need to be upbeat. Don't make a joke about it but just sort of brush it off. You need that, you can't just sit and cry, otherwise you wouldn't be able to get on with your day. Like at first, I found it hard having an incident and then acting normal. I found it hard at first, just trying to act like it hadn't happened and just getting on with

the day and working with the individual. But you just sort of learn to just understand it's the nature of the beast.

***Participant 36:** It's not making a joke of what happened, it's just making it a bit lighter and I think we've got that opportunity on our site, which you may not get when lone working”.*

(Participant 32 and 36 – Support Workers for a Community Autism Service)

The views above suggested that the appropriate use of humour could be beneficial for frontline staff in developing professional relationships with care recipients who have unhelpful behavioural symptoms and also reducing work related stress after being involved in incidences of behaviours that challenge. However, the extent to which humour can be an effective, or appropriate, coping strategy to alleviate work related stress within health/social care settings warrants some attention. The impact of humour can be dependent on a number factors, such as the communication skills of the person intending to be humorous and how the audience interprets acts of humour (Robinson, 1993). Humour can serve a number of functions such as self-enhancement, self-deprecation, to establish relationships and to express aggression towards others (Martin, Puhlik-Doris, Larsen, Gray & Weir, 2003). It has been recognised that the expression of humour, which is intended to be good-natured and non-aggressive, can be more effective in eliciting positive emotional states as opposed to other forms of humour where the function is to direct hostility towards others (Samson & Gross, 2012). Thus, humour that is perceived as being good natured/non-aggressive by both the communicator (health/care professional) and audience (colleagues or care recipients) may be conducive in upregulating positive emotional states and reducing the work related stress of managing incidences of behaviours that challenge. However,

given that there are situations in the field of Nursing in which the use of humour can be inappropriate and unprofessional (Jones & Tanay, 2016), the type of humour and the setting in which it is expressed requires some consideration by health/social care professionals.

Social work students have reported that the use of humour, within a social context, can be beneficial in alleviating perceived levels of stress (Moran & Hughes, 2006). In conjunction with the quotes above, this would suggest that health/social care professionals could use humour as a coping strategy to reduce stress after encountering behaviours that challenge when in the presence of colleagues and within informal debriefing scenarios. The use of humour can also be beneficial in reducing negative appraisals of perceived stressors and encouraging a more helpful reappraisal of stressful situations, which can be effective in buffering stress (Abel, 2002). Thus, some health/social care professionals may use humour as a means to appraise, or evaluate incidences of behaviours that challenge in a more positive manner, which may help to reduce the work related stress that can occur when encountering care recipients who exhibit unhelpful behavioural symptoms.

The quotes above also indicated that using humour can facilitate the development of professional relationships with care recipient who exhibit behaviours that challenge. Within the profession of teaching, teachers who use humour as means to develop/maintain professional relationships with students can experience lower levels of emotional exhaustion and greater personal accomplishment in their occupation (Ho, 2015). This would suggest that health/social care professionals, who have the capacity to express humour with the intention of developing relationships with others, may be able to use this quality as a means to engage therapeutically engage with care recipients who respond positively to such styles of humour.

1.10.6 Summary of qualities intrinsic to health/social care professionals and the capacity to engage with care recipients who exhibit behaviours that challenge

This category has provided illustrations of how the qualities intrinsic to health/social care professionals can serve to either facilitate or inhibit the capacity to engage with care recipients who exhibit behaviours.

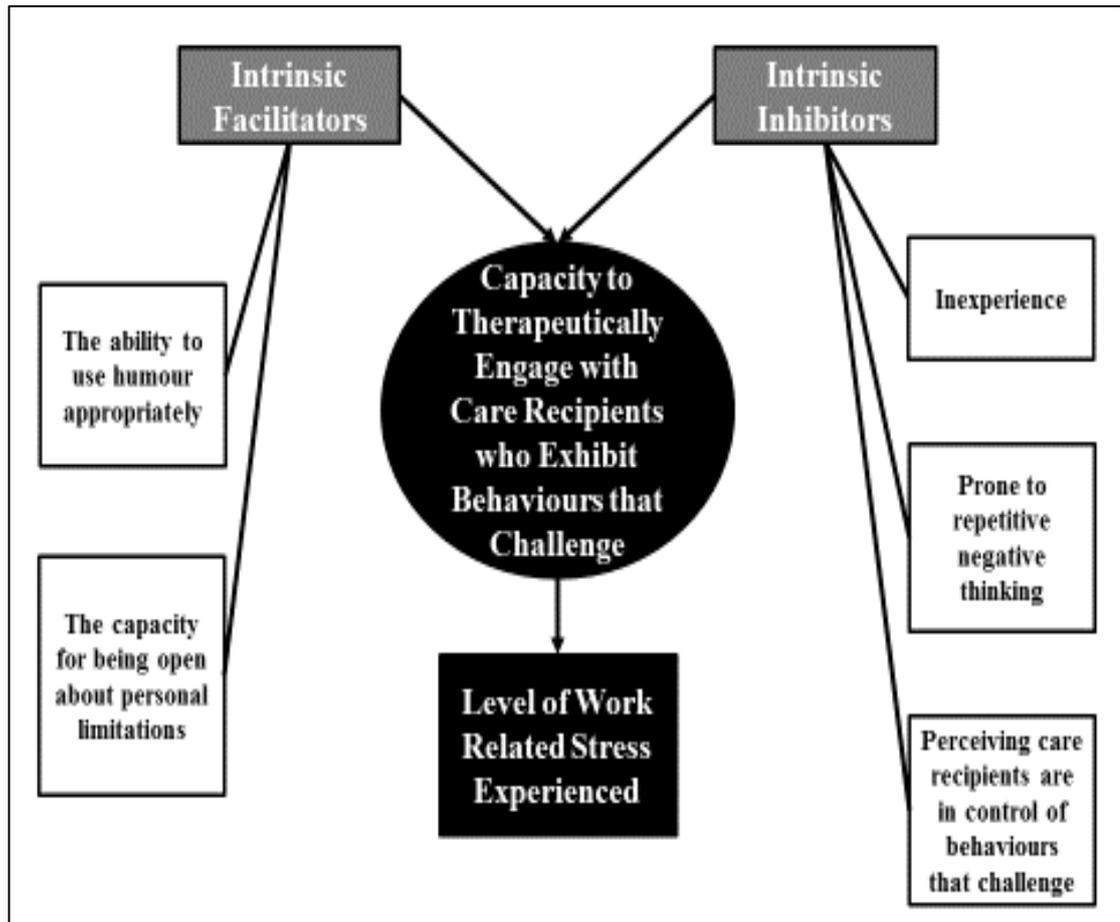


Figure 1.13. Examples of the qualities intrinsic to health/social care professionals that can influence the capacity to therapeutically engage with care recipients who exhibit behaviours that challenge and levels of work related stress.

The articulated experiences of participants suggested that health/social care professionals who are open about disclosing personal limitations, having patience when establish trusting relationships with service users and the ability to use humour

appropriately could apply such characteristics to reduce work related stress. However, characteristics such as being inexperienced, prone to repetitive negative thinking and perceiving that care recipients are in control of their conduct when exhibiting behaviours that challenge, can make health/social care professionals vulnerable to stress. It is therefore an essential requirement for health/social care professionals to access sources of support that suppress characteristics that can contribute to stress and encourage the intrinsic qualities that are helpful in facilitating staff to successfully engage with care recipients who have unhelpful behavioural symptoms.

1.11 Strengths and Limitations of the Grounded Theory study

One of the remits for this study was to recruit participants who had experience of providing health and social care to people who exhibit behaviours that challenge as a means to explore the causes of and protective factors against work related stress within this profession. It must be acknowledged that all of the participants who took part in the study were employed and engaged in a health/social care professional profession at the time of data collection. In 2017, 38% of 468,712 NHS staff reported to have experienced ill health due to work related stress (National NHS Staff Survey, 2017). It could be argued that the current study should have sought the articulated experiences of health/social care professionals who were not engaged in their profession, due to work related stress, at the time of data collection. This may have been beneficial in ascertaining ‘in the moment’ perspectives as to what aspects of the occupation cause work related stress to the extent of requiring to take sick leave from work. However, there would be ethical issues recruiting participants who were on a leave of absence due to work related stress, given that reflecting on traumatic incidences without having the opportunity to reappraise the events in a helpful manner, can potentially elicit re-traumatisation and have negative consequences on wellbeing (Littrell, 2009). Table

1.2 indicates that the participant group recruited for this current study were experiencing levels of perceived stress that were higher to that of the norms for the Perceived Stress Scale (Cohen, Karmarck & Mermelstein, 1983). All of the participants who took part in the study also stipulated that they had first-hand experience of providing health or social care to people who exhibit behaviours that challenge. Existing literature, along with the articulated experiences illustrated in Part A of this thesis, clearly suggests that the occupational task of encountering incidences of behaviours that challenge can be stressful. Thus, it is reasonable to suggest that the participants who took part in this study had relevant experiences in order to give valid insights to the causes of and protective factors against work related stress along with the provision of health/social care to people who exhibit behaviours that challenge.

1.11.1 Summary of the Grounded Theory Study

The aim for the initial study of this thesis was to develop a theoretical framework, using Grounded Theory methodology, as a means to provide an explanation for the causes of and protective factors against work related stress for professionals who provide health and social care to people who exhibit behaviours that challenge. The first part of this thesis has demonstrated how the articulated experiences of health/social care professionals, who manage behaviours that challenge, has informed the development of Therapeutic Engagement Stress Theory (TEST).

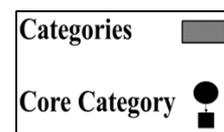
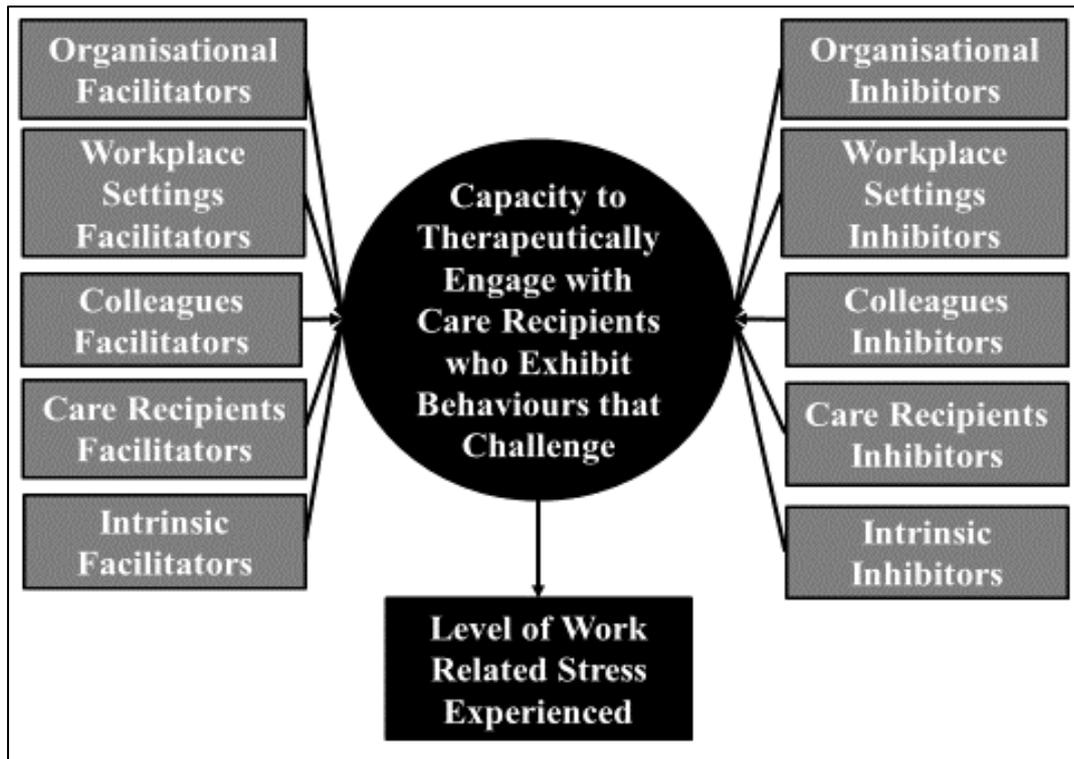


Figure 1.14. Therapeutic Engagement Stress Theory

The core category within TEST posits that the extent to which health/social care professionals are able therapeutically engage with care recipients, who exhibit behaviours that challenge, can determine the levels of work related stress experienced. TEST also illustrates that an interplay of work related factors can be conducive to either inhibiting or facilitating frontline staff in their delivery of therapeutic interventions to service users, which then influences stress levels experienced by frontline staff. The TEST model indicates the causes for and protective factors against stress can be bespoke to each individual health/social care professional. For instance, some members of staff may experience stress due to inadequate support from an employing organisation, which could be buffered by collaborative working with

colleagues. Other members of staff may be prone to ruminative thinking on incidences of behaviours that challenge, which can be resolved by an effective post incident debrief. This demonstrates that the TEST model could be used as a method of formulation to conceptualise the causes of and protective factors against stress for each individual health/social care professional who is required to provide care for people who exhibit behaviours that challenge. Glaser and Strauss (1967) indicated that good theories are the ones that are useful in explaining, providing solutions to problems and understood by the people attached to a particular social phenomenon. It is therefore imperative to develop and ascertain methods on how TEST can be operationalised to assist health/social care professionals, who present as having difficulties in engaging with service users who exhibit behaviours that challenge, in implementing strategies to negate work related stress. Thus, developing a battery of measures that tap into each category within TEST may be useful in demonstrating how its application in health/social care services could assist with the identification of work related factors that inhibit or facilitate the delivery of caring interventions to service users and its impact on work related stress within frontline staff.

PART B

Chapter 2: Investigation of Therapeutic Engagement Stress Theory using Quantitative Methods.

As stipulated in Part A, this research programme employed an exploratory sequential mixed methods design. Part B of this thesis will go on to further develop the Therapeutic Engagement Stress Theory (TEST) by using quantitative methods to determine if the model can provide valid explanations for the causes of and protective factors against stress within health/social care professionals who manage behaviours that challenge. Exploratory sequential mixed methods research designs consist of conducting an initial qualitative study which can inform the development of an initial theory which can then be tested using appropriate quantitative methodologies (Hanson, Cresswell, Plano Clark, Petska & Creswell, 2005). It has been purported that applying quantitative methods to test theories, as developed using Grounded Theory methodology, can add further rigour to theory development (Shah & Corley, 2006). Within exploratory sequential mixed methods research programmes, the measures used in the quantitative studies should be clearly informed by the results of a qualitative study (Cresswell, 2015). Thus, in order to add further rigour to the development of the TEST model, it was necessary to identify measures that were appropriate in quantifying each category and core category within the framework.

2.1 Quantifying the Core Category

The core category within theoretical frameworks, which have been developed using Grounded Theory methodology, often serve to integrate a number of key categories, or variables, to illustrate a central problem that is relevant in explaining a particular

social phenomenon (Glaser & Strauss, 1967). In the context of the current study, the core category reflects how multiple work related factors can influence the capacity of health/social care professionals to therapeutically engage with people who exhibit behaviours that challenge, which then determines the levels of work related stress experienced.



Figure 2.1. Core category within Therapeutic Engagement Stress Theory

In order to commence with the quantitative phase of theory development, in accordance with exploratory mixed methods research designs, there was a need to identify measures that could appropriately quantify the core category of TEST (Cresswell, 2015).

The Student-Teacher Relationship Scale (STRS; Pianta, 2001) was identified as a measure that would be appropriate in quantifying the perceived capacity for health/social care professionals to engage therapeutically with care recipients who exhibit behaviours that challenge. The STRS was initially developed to quantify the

appraisals, beliefs and feelings that teachers have regarding their interactions and quality of professional relationship with students. The STRS also consists of three lower order factors that may contribute to the perceived quality of relationships that teachers believe to exist with their students, namely *conflict*, *closeness* and *dependency*. The construct of *Conflict* taps into the extent to which teachers perceive their interactions with students to be turbulent, which may present as inhibiting student-teacher relationships and the successful delivery of educational programs. The construct of *Conflict* is particularly relevant to TEST as sections 1.9.1, 1.9.2 and 1.9.3 have indicated that difficult interactions between the health/social care professional and care recipient can impinge on the successful delivery of therapeutic interventions. The construct of *Closeness* represents the extent to which teachers perceive having a warm professional relationship and good communication with students. It has been recognised that the quality of professional/caring relationships between healthcare practitioners and care recipients can be an integral component to the successful delivery of therapeutic interventions within mental healthcare settings (Krupnick & Pilkonis, 1996). Thus, level of *professional closeness* is also relevant to the TEST as the perceived extent to which health/social care professionals are able to develop caring relationships with patients who exhibit behaviours that challenge, could influence overall therapeutic engagement and levels of work related stress. Finally, the factor of *Dependency*, measures the extent to which teachers perceive that a student exhibits possessive behaviours towards members of teaching staff. The levels of dependency that care recipients exhibit towards health/social care professionals is also relevant to the core category of TEST as possessive behaviours, such as seeking close proximity and constant reassurances from care recipients, can be a behaviour that professional carers find challenging (Deb, Thomas & Bright, 2001). Section 1.9.5 also

illustrated how care recipients, who may become inappropriately attached to health/social care professionals, may inhibit the successful delivery of therapeutic interventions, which can then elicit work related stress within frontline staff.

Thus, the Student-Teacher Relationship Scale (STRS; Pianta, 2001) was modified and used to measure the extent to which participants perceived that they were able to therapeutically engage with a service user who had exhibited behaviours that challenge within the previous month (See appendix B for modified version of the STRS). The author of the STRS provided written confirmation that this measure could be modified for the purpose of the current research programme. The modification of the STRS consisted of beginning the questionnaire with the following instruction, 'Please think about a service user who has exhibited a behaviour that you found to be challenging within the past month. Now think about the degree to which each of the following statements currently applies to this service user'. Item 2 of the STRS originally read as 'This child and I always seem to be struggling with each other'. For the modified version of the STRS, item 2 read as 'This service user and I always seem to be struggling with each other'. Such modifications were made to all 28 items on the STRS. Participants were required to respond on a 5 point Likert scale ranging from 1 = definitely does not apply to 5 = definitely applies. The factor structure of the original STRS, as developed by Pianta (2001), was applied when conducting analyses on the responses provided on the modified version of the STRS. All 28 items, loading onto a single factor, has a reported Cronbach's alpha of 0.89. Total scores, ranging from 28 – 140, represented the extent to which participants perceive that they are able to engage therapeutically with service users who exhibit behaviours that challenge. Higher scores on the overall scale represented having a greater perceived capacity to therapeutically engage with service users who exhibit behaviours that challenge. The

lower order factors measured 1) perceived levels of *conflict* (Cronbach's alpha = .92), 2) *professional closeness* (Cronbach's alpha = .86) and 3) *dependency* (Cronbach's alpha = .64). To note that the STRS has not been used previously to investigate the perceived capacity of health or social care professionals to engage therapeutically with care recipients who exhibit behaviours that challenge. However, the constructs of *conflict*, *professional closeness* and *dependency* were deemed as relevant when investigating how perceived capacity to engage therapeutically with people who exhibit behaviours that challenge could determine levels of work related stress. Thus, the modified version of the STRS will be referred to subsequently in this thesis as the Therapeutic Engagement Scale (TES).

There was also need to administer a measure that could quantify notions of perceived work related stress in relation to the core category within the TEST model. The Perceived Stress Scale (PSS; Cohen, Kamarck & Mermelstein, 1983) (Appendix C) was developed as a self-reported measure to tap into levels of subjective stress as experienced over a preceding month and has been described in section 1.4.3. Thus, the TES and PSS were administered in the subsequent quantitative studies of this thesis in order to assess the extent to which the perceived capacity to engage with patients who exhibit behaviours that challenge can determine levels of work related stress.

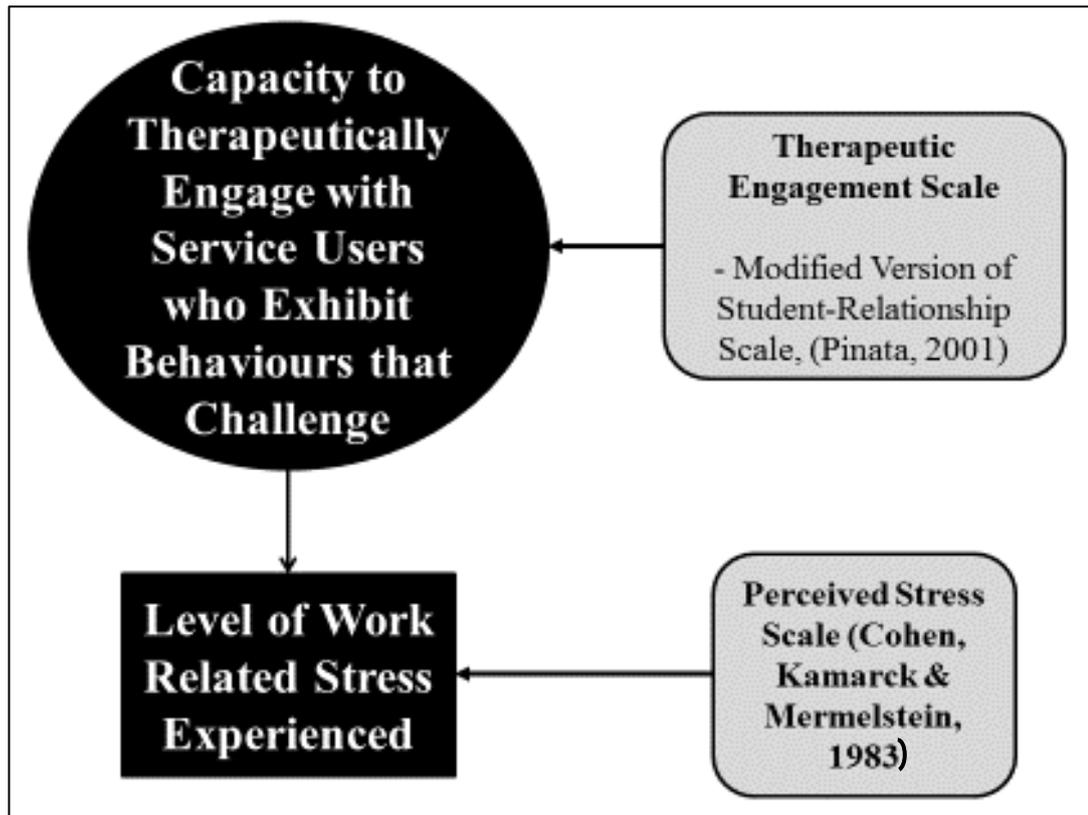


Figure 2.2. Quantitative measures used to tap into the core category of Therapeutic Engagement Stress Theory.

2.2 Overview of quantitative studies to explore the TEST model

The subsequent sections in this thesis will consist of reporting quantitative studies that aimed to investigate the way in which organisational factors, work places environments, colleagues, interactions with care recipients, and qualities intrinsic to health/social care professionals influenced the core category within the TEST model. Exposure to behaviours that challenge has been identified as an occupational stressor within mental healthcare (Jenkins & Elliot, 2004) and dementia care settings (Edvardsson, Sandman, Nay & Karlsson, 2008). Thus, mental healthcare professionals and frontline carers of people with dementia, who had experience of managing incidences of behaviours that challenge, were recruited to take part in the studies as reported in the subsequent chapters of this thesis.

The studies concerning mental healthcare professionals are reported in chapters 3 and 4. These studies investigated how work place environments, perceived quality of interactions with care recipients and intrinsic factors could influence mental healthcare professionals in the capacity to engage with patients who exhibit behaviours that challenge and levels of work related stress. Chapters 5 and 6 report studies that investigated how organisational factors and colleagues can impact the capacity for Professional Carers to therapeutically engage with residents who have dementia.

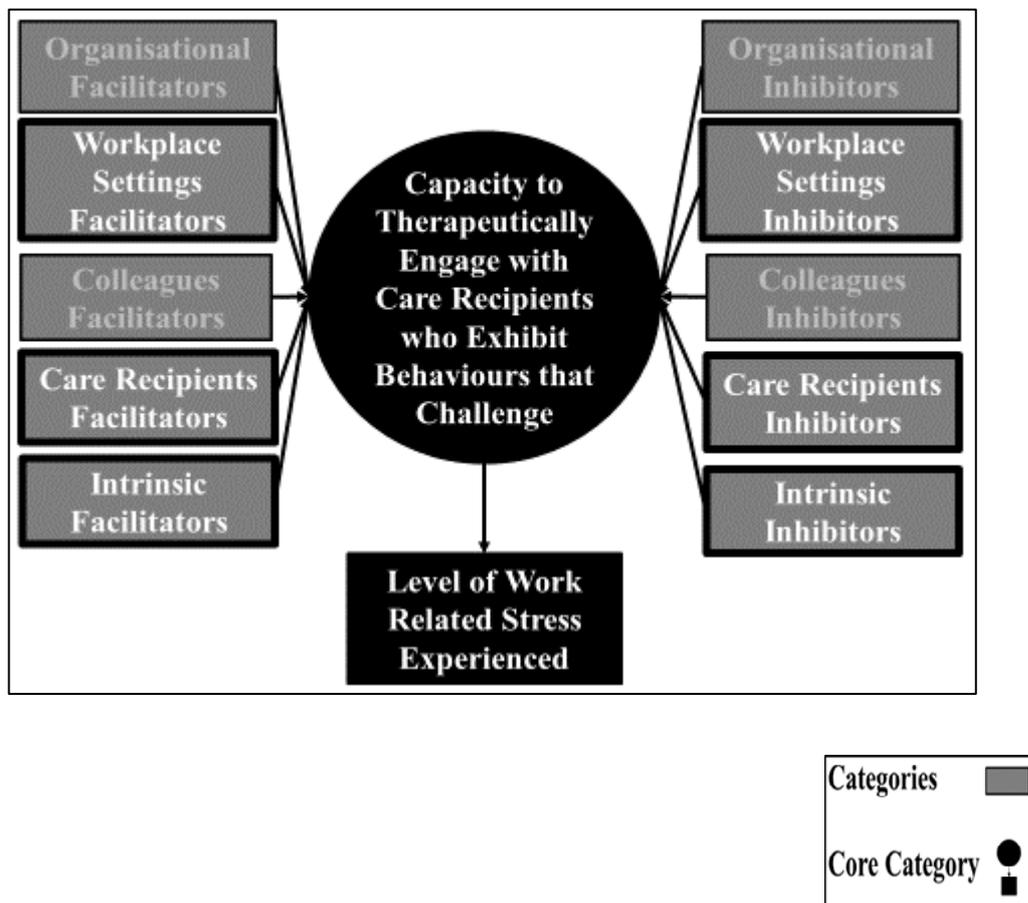


Figure 2.3. The categories concerning workplace settings, care recipients and intrinsic factors were investigated within a population of mental healthcare professionals who manage behaviours that challenge.

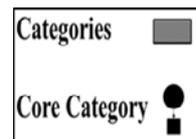
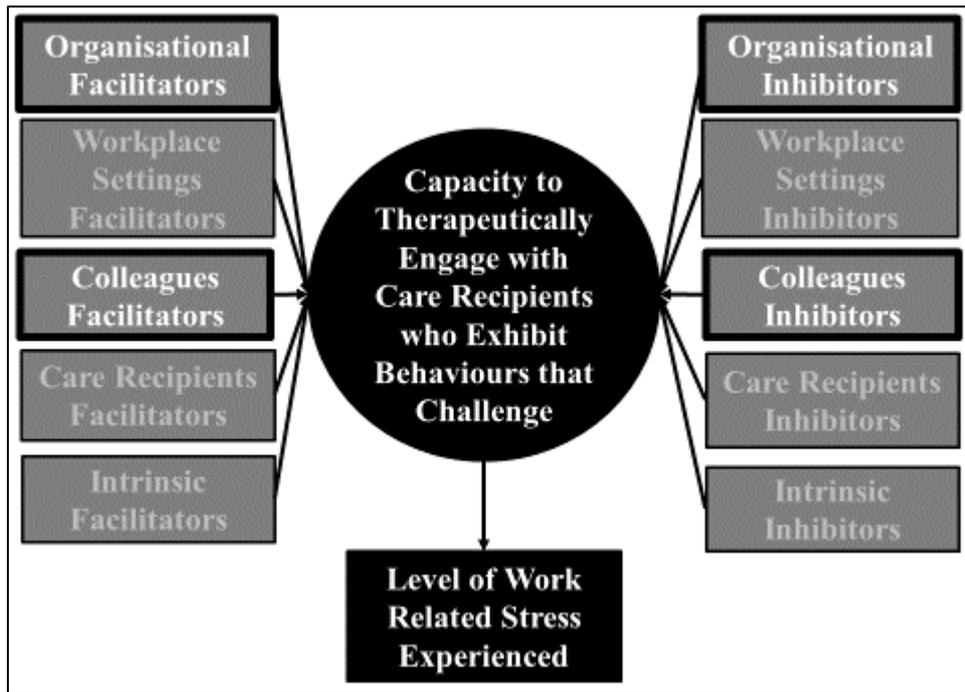


Figure 2.4. The categories concerning organisational factors and colleagues, regarding their impact upon the core category in the TEST model, were investigated within a population of professional carers of people who have dementia who manage behaviours that challenge.

Chapter 3: The Influence of Repetitive Negative Thoughts, and Perceived Conflict towards Care Recipients, on the Capacity to Therapeutically Engage with Patients who Exhibit Behaviours that Challenge and Work Related Stress.

This chapter reports the findings of a study that investigated how the propensity to have negative thoughts may impact mental healthcare professionals in their capacity to therapeutically engage with patients who exhibit behaviours that challenge and work related stress. It was also an aim to ascertain how perceived conflict with patients who exhibit behaviours that challenge may inhibit mental healthcare professionals with their engagement with patients, thus influencing levels of work related stress. Mental healthcare professionals (N = 85) completed the Therapeutic Engagement Scale, The Perceived Stress Scale and Perseverative Thinking Questionnaire. Bivariate correlations indicated that greater propensity to have repetitive negative thoughts was related to higher levels of perceived stress and lower capacity to therapeutically engage with patients who exhibit behaviours that challenge. Higher levels of perceived conflict with patients who exhibit behaviours that challenge were also related with greater propensity to have repetitive negative thoughts and higher work related stress. Mediation analysis revealed that the capacity to therapeutically engage with patients partially mediates the association between propensity to have repetitive negative thoughts and perceived work related stress. The findings of this study suggests that protective factors that support staff to engage with

patients who exhibit behaviours that challenge may also be helpful in reducing repetitive negative thoughts and work related stress within mental healthcare professionals.

NB: People accessing mental healthcare services will be referred to as patients in the subsequent section as indicative of the nomenclature used by participants, who took part in this study, during data collection.

3.1 Background

In 2013, over 60,000 incidences of healthcare professionals being physically assaulted were recorded, with 43,699 of the assaults being documented to have occurred within mental healthcare services (NHS Protect, 2013). Frontline nursing staff, who work within mental healthcare services, have reported that encountering patients who exhibit acts of verbal and physical aggression can be the most stressful aspect of their occupation (Jenkins & Elliot, 2004). Work related stress has been posited as being a contributory factor for healthcare professionals, such as Nurses, to experience low levels of job satisfaction and to leave caring professions in the UK (Coomber & Barriball, 2007). Thus, there is a need to gain a thorough understanding of how to support staff in the safe prevention/management of behaviours that challenge as a strategy to reduce some of the stress that can be experienced by mental healthcare professionals. TEST was developed as a means to provide explanations for the causes of and protective factors against work related stress within health/social care professionals who manage behaviours that challenge. This chapter reports the findings of a study that specifically focused on how a quality that is intrinsic to health/social care professionals (propensity to have repetitive negative thoughts on work related issues) and care recipients can influence the capacity for mental healthcare professionals to engage with patients and levels of work related stress.

3.2 The propensity to have repetitive negative thoughts on incidences of behaviours that challenge.

Section 1.10 illustrated how the intrinsic qualities of health/social care professionals can be beneficial in either facilitating or inhibiting their capacity to engage with patients who exhibit behaviours that challenge. One of the intrinsic qualities reported in section 1.10.3 indicated that the propensity to have repetitive negative thoughts about experienced incidences of behaviours that challenge could influence the quality of interactions with patients and levels of work related stress experienced.

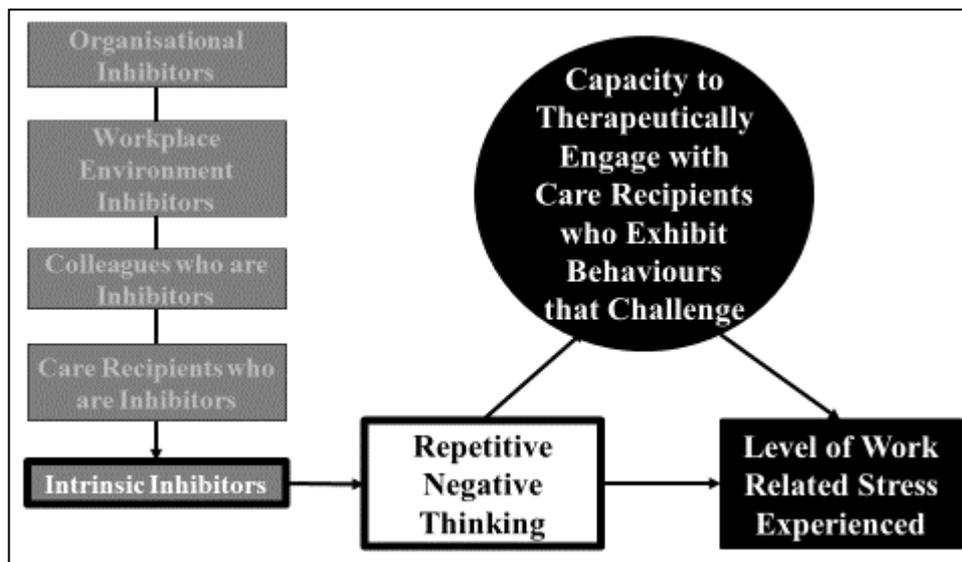


Figure 3.1. The component of the TEST model that was investigated to ascertain the relationships between propensity to experience repetitive negative thoughts, perceived capacity to engage with patients who exhibit behaviours that challenge and work related stress.

Rumination has been defined as a cognitive process that consists of the repeat activation of thoughts that serve to focus attention on past incidences that were perceived as being stressful (Nolen-Hoeksema, 1991). Ruminative thinking has been recognised as a symptom of post-traumatic stress disorder following incidences of

being subject to physical assault, which can consist of intrusive, repetitive and unproductive thoughts on the incident (Michael, Halligan, Clark & Ehlers, 2007). Mental healthcare workers have reported that encountering patients who exhibit overt acts of aggression can trigger ruminative thinking on previous incidences where care recipients have been overtly aggressive (Bonner, Lowe, Rawcliffe & Wellman, 2002). Thus, mental healthcare workers may be vulnerable to the negative consequences of rumination following incidences behaviours that challenge, which may then manifest as work related stress. This is concerning given that ruminating on work related issues can negate the effective problem solving of occupational issues (Querstet & Cropley, 2012). Thus, ruminative thinking may inhibit mental healthcare professionals to effectively reflect on their practice and devise strategies to engage with patients as a means to prevent incidences of behaviours that challenge.

Section 1.7.6 has illustrated how planning future interactions with care recipients can also cause frontline staff to worry about the prospect for incidences of behaviours that challenge to occur. Worry has been defined as the thought process that consists of repetitive thinking about the prospect for negative events to occur in the future (Roemer & Borkovec, 1993). Reflective practice can be a common feature in mental healthcare professions as a means to facilitate frontline staff in their appraisal of previous professional conduct and planning strategies for future interactions with patients in order to improve care delivery (Graham, 2000). Models of behaviour management in mental healthcare settings, such as Positive Behaviour Support (Koegel, Koegel & Dunlap, 1996), Safewards (Bowers, 2014) and Trauma Informed Care (Bloom, 2008), advocate the use of reflective practices to proactively identify and negate triggers for behaviours that challenge. Thus, mental healthcare professionals are required to exercise some foresight when considering future

interactions with patients in order to prevent incidences of behaviours that challenge and ensure the successful delivery of therapeutic interventions. However, mental healthcare professionals who are prone to repetitive negative thoughts may be vulnerable to worry about future interactions with patients who exhibit behaviours that challenge as opposed to engaging in reflective thinking as indicated in section 1.7.6. The anticipation of having difficult or challenging interactions with patients who exhibit behaviours that challenge could manifest into worrying thoughts, which could elicit/perpetuate the symptoms of stress and potentially suppress effective problem solving (Brosschot, Gerin & Thayer, 2006). Thus, mental healthcare professionals who are vulnerable to worry about future interactions with patients, to the extent of inhibiting reflective thinking/problem solving, may have difficulties in devising strategies to effectively engage with care recipients who exhibit behaviours that challenge and could therefore be prone to stress.

Thus, there is a need to ascertain how rumination and worry can affect the professional practices of and work related stress experienced by mental healthcare professionals who provide care for people who exhibit behaviours that challenge. The Perseverative Thinking Questionnaire (PTQ; Ehring, et al., 2011) was developed to encapsulate rumination and worry into a single construct of repetitive negative thinking. Thus, the PTQ was administered in this study to investigate if repetitive negative thinking was associated with the perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge and levels of work related stress within mental healthcare professionals.

3.3 Perceived conflict with patients who exhibit behaviours that challenge

Part A of this thesis has illustrated how overt acts of aggression (section 1.9.1) and perceiving that care recipient are fully in control of such behavioural conduct (section 1.10.2) can potentially elicit notions of conflict within health/care professionals towards patients who exhibit behaviours that challenge. It is therefore necessary to ascertain how perceived conflict with patients could potentially impact levels of work related stress experienced by mental healthcare professionals who encounter behaviours that challenge in their role.

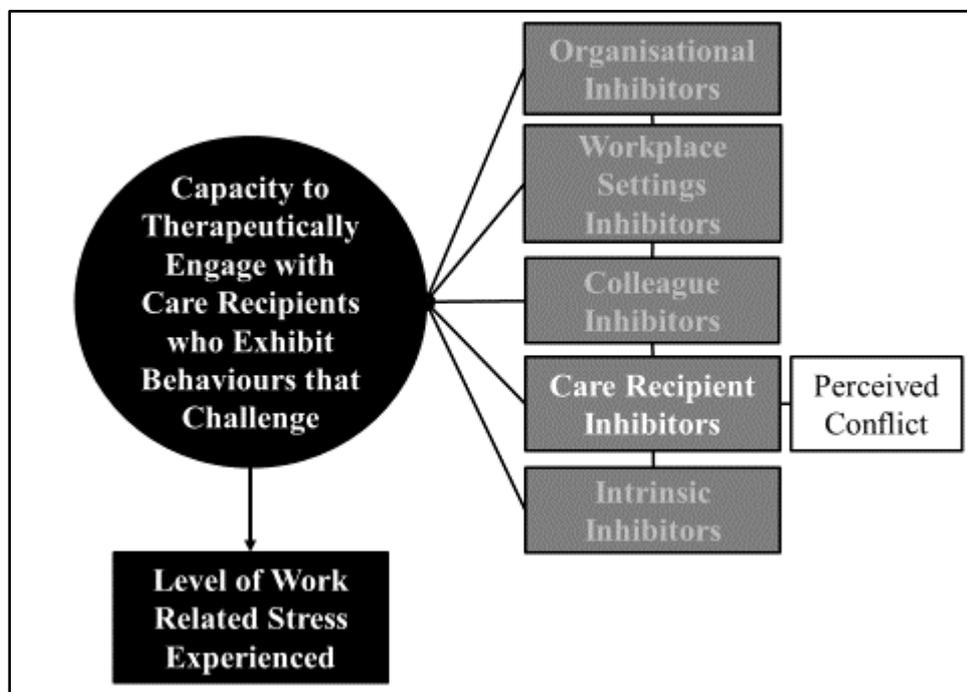


Figure 3.2. The current section also aimed to explore how perceived conflict with care recipients, who exhibit behaviours that challenge, could influence levels of work related stress.

Within workplace settings, it has been posited that conflict can arise when the attainment of occupational goals are obstructed by others (Van de Vliert, Nauta, Euwema & Janssen, 1997). Within Social Services settings, conflict can arise towards

colleagues who thwart professional aims of individual members of staff (Giebels & Janssen, 2005). As described in sections 1.9.1 and 1.10.2, frontline staff may also perceive conflict towards care recipients when their behavioural conduct prevents the successful delivery of therapeutic interventions. This type of professional dynamic with care recipients could therefore make mental healthcare professionals vulnerable to work related stress. It is therefore necessary to consider how notions of conflict with patients who exhibit behaviours that challenge could influence levels of work related stress experienced by mental healthcare professionals. The Conflict subscale within the Therapeutic Engagement Scale, as described in section 2.1 was utilised to investigate this component of TEST model.

3.4 Research questions and hypotheses

The first research question for this study was, ‘To what extent does the perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge, correlate with the levels of subjective stress experienced by mental healthcare professionals?’ This research question was posed to ascertain if a relationship between the perceived capacity to engage with patients and perceived stress would be observed through administration of the TES and PSS. It was hypothesised that greater perceived capacity to engage therapeutically with patients who exhibit behaviours that challenge would correlate with lower levels of work related stress within mental healthcare professionals.

The second research question for this study was ‘What is the relationship between the propensity to have repetitive negative thoughts and perceived work related stress within mental healthcare professionals who provide care for patients who exhibit

behaviours that challenge?’ It was hypothesised that higher levels of repetitive negative thinking would be associated with greater perceived stress.

The third research question for this study was ‘What is the relationship between the perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge and repetitive negative thinking?’ It was hypothesised that greater perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge would be associated with lower levels of repetitive negative thinking.

The fourth research question for this study was ‘Does the perceived capacity to therapeutically engage with patients, who exhibit behaviours that challenge, mediate any association between repetitive negative thoughts on occupational issues and work related stress’. It was hypothesised that the perceived capacity to therapeutically engage with patients would explain any observed relationship between repetitive negative thinking and work related stress.

The final research question was ‘How do levels of perceived conflict with care recipients, who exhibit behaviours that challenge, influence levels of work related stress within mental healthcare professionals?’ It was hypothesised that greater perceived conflict towards care recipients, who exhibit behaviours that challenge, would be associated with higher levels of work related stress.

3.5 Method

3.5.1 Design

A cross sectional correlational research design was employed in this study to ascertain the relationships between the extent to which mental health care professionals are able to therapeutically engage with patients who exhibit behaviours that challenge, repetitive negative thinking and perceived stress. A mediation analysis of cross

sectional data was also conducted to ascertain if the perceived capacity to therapeutically engage with patients, who exhibit behaviours that challenge, mediated any association between propensity of repetitive negative thinking and work related stress. A bivariate correlation was also conducted on cross sectional data to ascertain if there was a relationship between perceived conflict with care recipients, who exhibit behaviours that challenge, and work related stress.

3.5.2 Participants

Frontline mental health care professionals ($N = 85$) took part in this study, 61 of which were female (mean age = 39.33, SD = 11.04) and 24 were male (mean age = 46.75, SD 9.61). The occupations of the participants are provided in table 3.1. The length of time that the participants have worked with mental healthcare professions is indicated within table 3.2. I presented the aims of this study at Directorate/Manager's meetings in the organisation that employed the participants in order to obtain the required authority to recruit frontline mental health care professionals to take part in this research.

Table 3.1. The occupations of participants who took part in the current study.

Job Title	n
Nurse	41
Support Worker	17
Social Worker	9
Psychologist	6
Occupational Therapist	5
Assistant Nursing Practitioner	2
Ward Manager	2
Doctor	2
Psychological Therapist	1

Table 3.2. The length of time, in months, that the participants had worked as a mental healthcare professional.

Months in profession	n
0 – 24 months	14
25 – 48 months	7
49 – 72 months	10
73 – 96 months	3

3.5.3 Materials

3.5.3.1 Core category of Therapeutic Engagement Stress Theory (TEST)

The Therapeutic Engagement Scale and Perceived Stress Scale (PSS; Cohen, Kamarck & Mermelstein, 1983) were administered in this study as a means to tap into the core category of TEST (details of these measures are provided in section 2.1).

3.5.3.2 Repetitive Negative Thinking

The Perseverative Thinking Questionnaire (PTQ; Ehring, et al., 2011) was administered to assess the tendency for participants to engage in repetitive negative thinking regarding interactions with patients who have exhibited behaviours that challenge. The PTQ consists of 15 items in which participants are required to respond on a 5 point Likert scale, ranging from 0 = never to 4 = almost always. Participants were asked to respond to the questions on the PTQ in relation to how they typically think about work related issues. The authors of the PTQ have recommended totalling the responses for all 15 items, with higher scores indicating greater tendencies to engage in repetitive negative thinking. A Cronbach's alpha of 0.95 has been reported for all items on the PTQ when tapping into the single construct of repetitive negative thinking. However, 3 lower-order factors were also revealed in a factor analysis of the PTQ as conducted by Ehring, et al. (2011) which are 1) the core characteristics of repetitive negative thinking, i.e. intrusiveness, repetitive thoughts (Cronbach's alpha = .94) unproductiveness (Cronbach's alpha = .83) and mental capacity (Cronbach's alpha = .86). The authors of the PTQ do provide caution when reporting findings concerning the subscales of 'unproductiveness' and 'mental capacity' as only 3 items

load onto each of these factors. Thus, for the purposes of the current study, the PTQ was administered and analysed as a measure that tapped into the single factor of repetitive negative thinking only.

3.5.3.3 Perceived conflict with care recipients who exhibit behaviours that challenge

The *Conflict* subscale within the TES was utilised as a means to tap into the perceived conflict with care recipients who exhibit behaviours that challenge, as described in section 2.1.

3.5.4 Procedure

This study gained ethical approval from the Ethics Committee at the Faculty of Health and Life Sciences, University of Northumbria at Newcastle. Research and Development within the Northumberland, Tyne and Wear NHS Foundation Trust also provided approval for this study to be conducted. Participants were required to meet with the researcher in a private and quiet location within their place of employment. Participants were then asked to read an information sheet, which provided relevant details of the study and an opportunity to ask the researcher questions regarding the study. Participants were required to sign an informed consent sheet to document their agreement to take part in the research. Once informed consent was provided, participants were required to complete a battery of pen and paper self-reported measures. Participants were provided with the assurance that they could ask the researcher questions or request clarity at any point throughout their completion of the measures. The first measure that participants were required to complete was the PTQ. Participants were provided with instructions to answer each of the 15 items in relation to their thinking patterns on incidences of behaviours that challenge over the previous month. Participants were then required to complete the TES. The final measure of the

battery to be completed by participants was the PSS. Participants were instructed to answer each of the 10 items on the PSS regarding their thoughts and feelings about work related issues over the previous month. Participants were then required to hand in the completed battery of measures to the researcher and were provided with an opportunity to ask any questions about the study. Participants were given a debrief sheet and contact details for their Occupational Health service. Participants took, on average, approximately 20 minutes to complete all aspects of the procedure.

3.5.5 Statistical Analyses

A series of bivariate correlations were conducted on cross-sectional data to ascertain the relationships between:

1. The perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge and work related stress.
2. Levels of repetitive negative thinking on interactions with patients who exhibit behaviours that challenge and perceived stress.
3. The perceived capacity to therapeutically engage with patients and levels of repetitive negative thinking on patients who exhibit behaviours that challenge.
4. The perceived conflict with care recipients who exhibit behaviours that challenge and work related stress.

A mediation analysis was also conducted to investigate if repetitive negative thinking (M) mediates the relationship between the extent to which mental health care professionals perceive that they are able to therapeutically engage with patients who exhibit behaviours that challenge (X) and work related stress (Y). The PROCESS macro for SPSS (Hayes, 2013), along with the recommended 5000 bootstrap

replications, was used to run this mediation analysis. In order to establish if repetitive negative thinking (M) fully mediated the relationship between the perceived capacity to therapeutically engage with service users who exhibit behaviours that challenge (X) and occupational stress (Y), the following assumptions were required:

- 1) The lower and upper confidence intervals did not cross the value of 0.
- 2) The direct effect between X and Y became non-significant when M was entered into the mediation model.

The bootstrap mediation model that was analysed is illustrated in figure 3.7 within the results section.

3.6 Results

3.6.1 Capacity to therapeutically engage with patients and work related stress

Pearson's product moment correlation coefficients were computed, which indicated that there was a significant negative correlation between the perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge and work related stress, $r = -.39$, $p < .001$. Thus, a correlation was observed suggesting that greater perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge was associated with lower subjective work related stress.



Figure 3.3. Illustration of the significant negative correlation observed between perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge and work related stress.

3.6.2 Perceived conflict with care recipients who exhibit behaviours that challenge

A bivariate correlation also revealed a positive correlation between the subscale of *Conflict*, within the TES, and scores on the PSS, $r = .39, p < .001$. This suggested that mental health care professionals who experience greater conflict with patients who exhibit behaviours that challenge, report higher levels of work related stress.



Figure 3.4. Illustration of the significant positive correlation between perceived conflict with patients who exhibit behaviours that challenge and work related stress experienced by mental healthcare professionals.

3.6.3 Repetitive Negative Thinking and Perceived Work Related Stress

Pearson's product moment correlation coefficients also revealed a positive correlation between repetitive negative thinking, on interactions with patients who exhibit behaviours that challenge, and perceived work related stress, $r = .67$, $p < .001$. This indicated that higher levels of repetitive negative thoughts on incidences of behaviours that challenge correlated with greater levels of perceived work related stress.



Figure 3.5. Illustration of significant positive correlation between levels of repetitive negative thinking on work related issues and self-reported occupational stress.

3.6.4 Capacity to therapeutically engage with patients and repetitive negative thinking

Bivariate correlational analysis also indicated a negative correlation between the perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge and repetitive negative thinking, $r = -.23$, $p = .03$. This indicated that greater levels of perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge is associated with lower propensity to have repetitive negative thoughts.

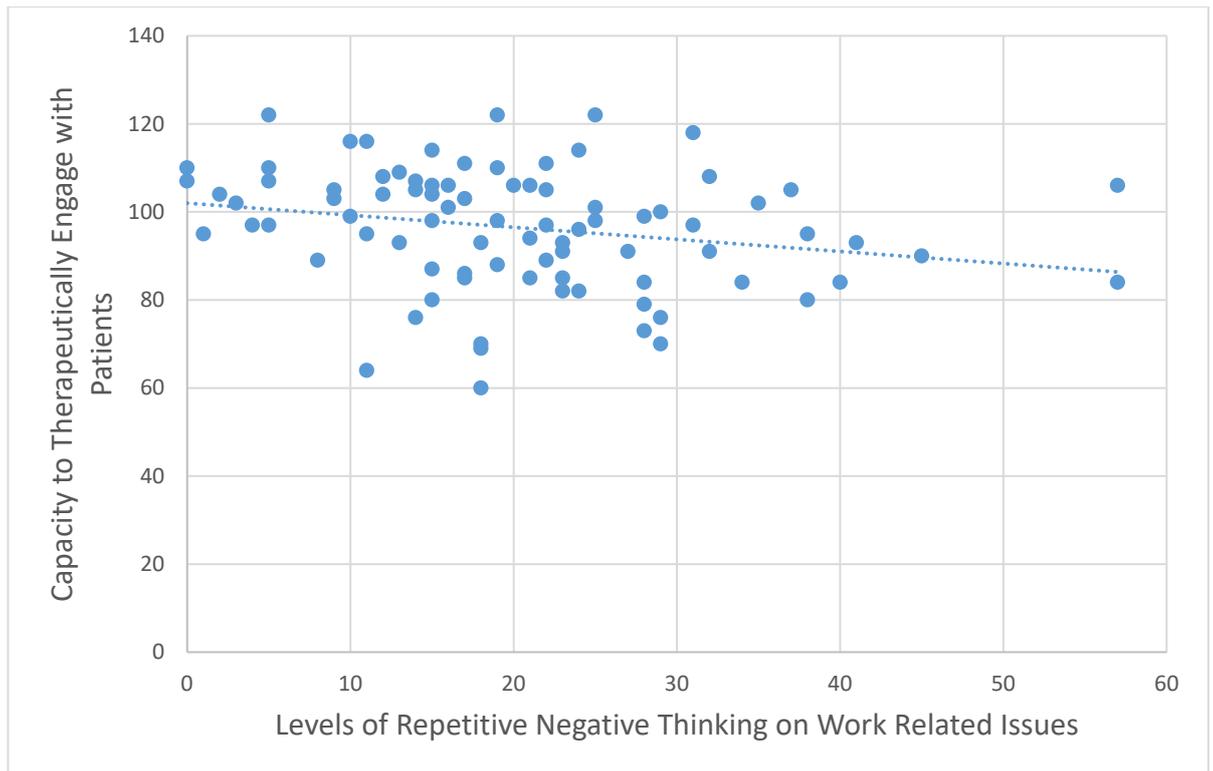


Figure 3.6. Illustration of the significant negative correlation between perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge and propensity to have repetitive negative thoughts.

3.6.5 Mediation Analysis

A mediation analysis was conducted to ascertain the extent to which the perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge could explain the association between repetitive negative thinking and occupational stress. There was a significant indirect effect of repetitive negative thinking on work related issues and perceived occupational stress $b = .031$, BCa CI [.01, .08]. This represents a medium effect size, $R^2 = .09$, 95% BCa CI [.02, .21].

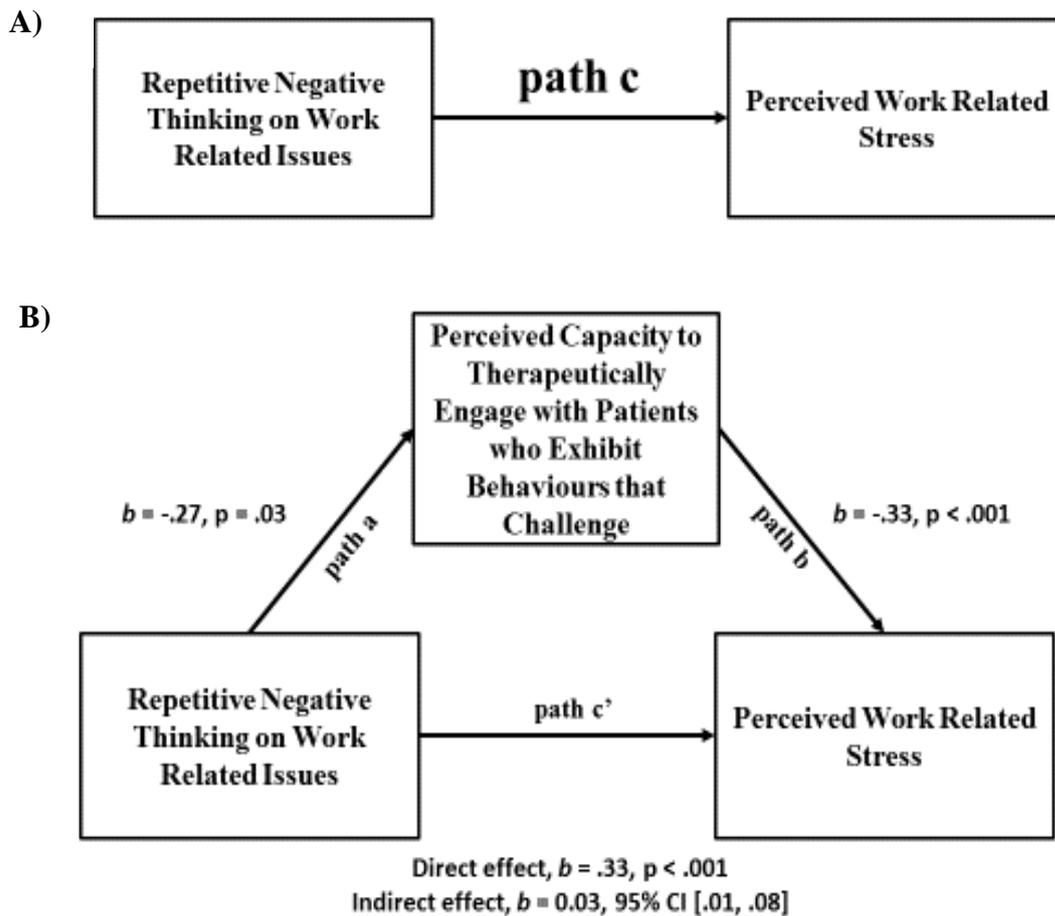


Figure 3.7. An illustration of the non-mediated (A) and partially mediated pathways between propensity to have repetitive negative thoughts, perceived capacity to engage with patients and work related stress.

Section 3.6.3 reported that there was a significant positive correlation between propensity to have repetitive negative thoughts and work related stress, $r = .67, p < .001$. Figure 3.8 illustrates that the direct effect of repetitive negative thinking and perceived work related stress remained significant when the construct of perceived capacity to engage with patients was included in the mediation analysis ($p < .001$). This would suggest that the perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge, partially mediated the relationship between

repetitive negative thinking and work related stress within mental healthcare professionals.

3.7 Discussion

The current study aimed to ascertain if the TEST model could be applied to provide explanations for work related stress, in mental healthcare professionals, using a quantitative, self-report methodology. It was observed that the greater perceived capacity to therapeutically engage with patients, who exhibit behaviours that challenge, was associated with lower levels of work related stress. The results also indicated that the greater propensity to have repetitive negative thoughts on difficult interactions with care recipients, was associated with higher levels of perceived stress and lower capacity to engage with patients who exhibit behaviours that challenge. The perceived capacity to engage with patients was also shown to partially mediate the positive correlation between propensity to have repetitive negative thoughts and work related stress within mental healthcare professionals. This study has also suggested that notions of conflict with patients who exhibit behaviours that challenge may contribute towards any work related stress experienced by mental healthcare professionals.

3.7.1 Capacity to engage, perceived conflict and work related stress

The first hypothesis for the current study was supported by the finding that greater perceived capacity to engage with patients was related to lower levels of occupational stress in mental healthcare professionals. This demonstrates some support for the core category within the TEST framework, which indicates that the quality of interactions with patients who exhibit behaviours that challenge, may determine the levels of work related stress experienced. Thus, the TEST framework illustrates how a specific factor, the capacity to engage therapeutically with care recipients who exhibit behaviours that

challenge, could determine levels of work related stress in frontline staff. It is also promising that the relationship illustrated in the core category (Figure 3.8), as derived from the Grounded Theory, was also observed through quantitative data analysis. Thus, it could be that self-reported quantitative measures may be used in applied settings to ascertain the extent to which the capacity to engage with people who exhibit behaviours that challenge contributes to levels of work related stress in mental healthcare professionals.



Figure 3.8. Core category within Therapeutic Engagement Stress Theory

The results also suggested that notions of conflict with patients who exhibit behaviours that challenge could be factor that inhibits the successful delivery of care and contributes to the manifestation of work related stress. This is consistent with previous research which suggested that Social Workers can experience conflict towards colleagues who inhibit the achievement of occupational goals, which in turn can lead to emotional exhaustion, taking leaves of absence and also thoughts of leaving the

profession (Giebels & Janssen, 2005). Thus, mental healthcare professionals who experience conflict towards patients, to the extent that it inhibits the successful delivery of care, may experience work related stress due to not being able to carry out their role effectively. Section 1.7.6 illustrated how the process of being assaulted by care recipients can inhibit the successful delivery of care and cause members of frontline staff to take a leave of absence. It could be that overt incidences of behaviours that challenge as exhibited by care recipients, such as physical aggression, may elicit notions of conflict towards patients concerned. Thus, protective factors that are conducive in reducing notions of conflict with patients, may assist frontline staff to complete caregiver duties and negate the onset of frontline staff. Such protective factors may consist of facilitating frontline staff to conduct Functional Assessments gain an understanding of the factors underpin the manifestation of behaviours that challenge (as illustrated in section 1.8.4), which may then reduce notions of conflict.

However, a limitation to this study was that the *Conflict* scale, within the TES, was used to ascertain perceived levels of conflict with patients who exhibit behaviours that challenge. Thus, it was not viable to run a correlation between the scores observed on conflict subscale and total scores the TES. Thus, there is a need to develop separate measures that tap into perceived conflict and also capacity to engage with patients who exhibit behaviours that challenge. This would enable analyses to be conducted to ascertain how perceived conflict with patients could influence the capacity for mental healthcare professionals to engage therapeutically with care recipients who exhibit behaviours that challenge.

3.7.2 Repetitive negative thoughts, capacity to engage with patients and work related stress

The second hypothesis was also supported through observation of a strong positive correlation between the propensity to have repetitive negative thoughts regarding interactions with patients who exhibit behaviours that challenge and perceived work related stress. It has been purported that rumination, consisting of thoughts that are repetitive, intrusive and unproductive, can be a feature of post-traumatic stress within victims of assault (Michael, Halligan, Clark & Ehlers, 2007). Ruminative thinking has also been shown to potentially suppress the successful problem solving of work related issues (Querstet & Cropley, 2012). Rumination may also coincide with worrying about future interactions with patients who exhibit behaviours that challenge, a thought process that has also been posited to disrupt the effective problem solving of challenging situations (Brosschot, Gerin & Thayer, 2006). This is concerning given that effective problem solving could be integral to overcome the stress of providing mental healthcare for patient who exhibit behaviours that challenge (Jenkins & Elliot, 2007). Thus, the propensity to have repetitive negative thoughts may inhibit the effective problem solving required to devise strategies that enable the delivery of interventions to patients who exhibit behaviours that challenge, which could then manifest into work related stress.

The results of the current study have suggested that the perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge, could be a mechanism that partially explains the observed association between the propensity to have repetitive negative thoughts and occupational stress. Thus, support mechanisms that increase the perceived capacity of mental healthcare professionals to engage therapeutically with patients, could be conducive to reducing repetitive negative thinking and occupational stress. Section 1.6.11 of this thesis has indicated that immediate post incident debriefs may be beneficial in preventing chronic

rumination on incidences of behaviours that challenge through facilitating staff to reflect on previous professional practice and initiate strategies to prevent further exacerbation of patients' behavioural symptoms. Sections 1.8.2, 1.8.3 and 1.8.4 have also illustrated how peer support, which consists of discussing difficult interactions with patients and applying the principles of Functional Assessments, can be helpful in nullifying triggers to avoid further incidences of behaviours that challenge. Thus support mechanisms, such as post incident debriefs and peer support, could be effective in facilitating mental healthcare professionals to reflect and refine their practices to ensure the continued delivery of therapeutic interventions to patients who exhibit behaviours that challenge. However, although previous research has suggested that debriefing can be effective in reducing stress within caring professions (Gunasingham, et al. 2014), it has been debated that clear guidelines are still required to ensure consistencies in the standards and content of post incident debriefings within health/social care services (Needham & Sands, 2010). This is integral to avoid unintended outcomes, such as re-traumatisation, as the process of discussing difficult situations could serve to perpetuate rumination, or worry, as opposed to facilitating helpful processing of or reflection on traumatic events (Hawker, Durkin & Hawker, 2011). Thus, there may be a need to further ascertain what post incident debriefs should consist of, and who should deliver them, in order to be effective in supporting staff in negating repetitive negative thoughts, increasing capacity to therapeutically engage with patients and offsetting stress. The development of replicable guidelines and evidence base for post incident debriefs, in reducing repetitive negative thinking, is therefore recommended in order to ensure that frontline staff are supported appropriately after incidences of behaviours that challenge. Nonetheless, the results indicate that the TEST framework could be used as a means to identify how factors,

such as repetitive negative thinking, may inhibit staff in their capacity to care for patients who exhibit behaviours that challenge and contribute to work related stress.

3.7.3 Strengths and Limitations

The potential issue of using cross-sectional data to conduct a mediation analysis warrants some discussion. Maxwell and Cole (2007) have illustrated some of the issues concerned with the use of cross-sectional data when conducting mediation analyses, which will be summarised in the context of the current study. Cross-sectional studies only consist of collecting data at a single point in time. However, it has been argued that mediation analyses should be conducted /considered in conjunction with the principles of the Autoaggressive Model of Changes; thus take into account that the independent (X), moderator (M) and dependent (Y) variables are subject to change over the course of time. Therefore, any changes over time in the propensity to have repetitive negative thoughts (X), capacity to engage with patients who exhibit behaviours that challenge (M) and perceived stress (Y) cannot be ascertained by conducting a mediation analysis on cross sectional data. Thus, mediation of longitudinal data would illustrate how any reductions or increases in the capacity to engage with patients could influence levels of perceived stress and propensity to have repetitive negative thoughts over a course of time. Figure 3.9 illustrates the suggested further research in conducting a mediation analysis using longitudinal data.

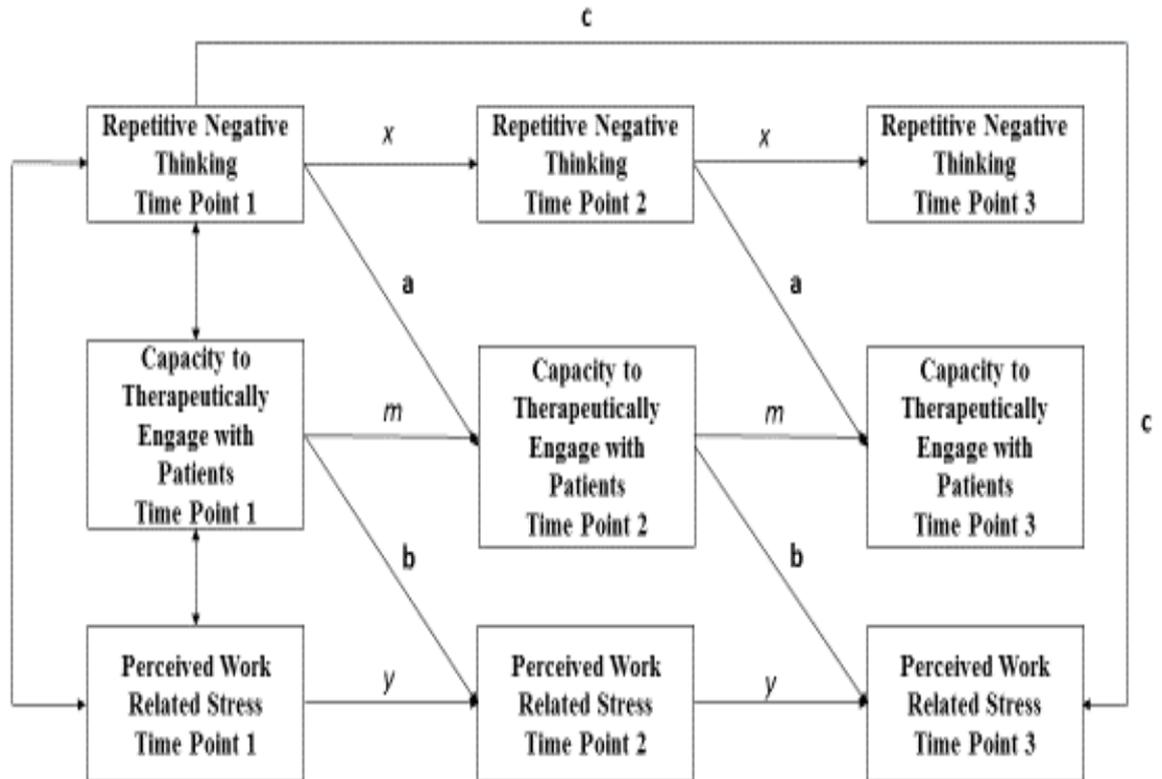


Figure 3.9. Suggested longitudinal mediation analysis to ascertain how changes in the capacity to engage with patients could influence propensity to have negative thoughts and work related stress.

Within figure 3.9, the denotations of **a**, **b** and **c** also illustrate how the direct effects of the independent, mediator and dependent variables could be ascertained when conducting the recommended mediation analysis using longitudinal data. The *x*, *m* and *y* paths demonstrate how changes in repetitive negative thinking, capacity to engage with patients and stress could be ascertained over a period of time. This would be useful when conducting research on developing interventions, which is beyond the scope of this thesis. However, conducting mediation analysis on longitudinal data would help to demonstrate if positive change in perceived capacity to engage with patients, as elicited by a given intervention, has beneficial outcomes on other constructs, such as reduced negative thinking and stress.

However, to defend the reasoning for collecting cross-sectional data, the current study needs to be considered in the context of being one part of an exploratory sequential mixed methods research programme. Denzin (1978) purported that methodological triangulation, or the use of multiple research methods, can be appropriate when investigating a particular social phenomenon. The primary focus of this research programme was to develop a theoretical model, using qualitative and quantitative research methodologies, to provide some explanations for the causes of and protective factors against work related stress within caring professions that consist of managing behaviours that challenge. The applications of cross-sectional studies, in which quantitative measures have been explicitly informed by findings of a qualitative study, has been recognised as an important step within exploratory sequential mixed methods research designs that aim to demonstrate development of a particular theory (Ivankova, Creswell & Stick, 2006). Section 1.10.3 clearly illustrated how the intrinsic quality of being prone to experiencing repetitive negative thoughts could inhibit capacity to engage with patient and contribute to work related stress. It was therefore a logical step, after the Grounded Theory study, to use a cross-sectional research design to continue with theory development and to ascertain if the TEST model could be applied to explain causes of and protective factors against stress within health/social care professionals.

3.7.4 Conclusion

The current study aimed to ascertain the relationships between the perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge, work related stress and propensity to have repetitive negative thoughts on work related issues within frontline mental healthcare professionals. The findings of this study provide an indication that the TEST model could be effective in teasing out how the

propensity to have negative thoughts on incidences of behaviours that challenge could impact professional practice and stress levels within health/social care professionals who manage behaviours that challenge.

The implications of this study are that the propensity to engage in repetitive negative thinking could inhibit mental healthcare professionals to successfully deliver therapeutic interventions to patients, which can then manifest into the onset of work related stress. It was also suggested that perceived conflict with patients who exhibit behaviours that challenge could also inhibit the professional practices and contribute towards any stress experienced by mental healthcare professionals. It is therefore recommended that health/social care organisations provide frontline staff with the necessary resources to engage therapeutically with patients who exhibit behaviours that challenge as a means to reduce activation of repetitive negative thoughts and perceived stress.

Chapter 4. The Impact of Workplace Settings on the Perceived Capacity to Therapeutically Engage with Patients who Exhibit Behaviours that Challenge and Work Related Stress.

This chapter reports the findings of a study that aimed to ascertain the differences in perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge, and work related stress between mental healthcare professionals who worked in either community or inpatient services. The study aimed to investigate the component of the TEST model, which posits that the work place environment of health/social care professionals can influence their capacity to therapeutically engage with patients who exhibit behaviours that challenge and work related stress. 55 community and 29 ward based mental healthcare professionals completed the Therapeutic Engagement Scale and Perceived Stress Scale. A between subjects design revealed that professionals who provided care in community services reported higher levels of perceived stress than mental healthcare staff who worked within inpatient settings. In addition, staff working within inpatient settings reported greater capacity to engage with and professional closeness towards patients than mental healthcare professionals working in community services. The findings of this study indicated that the working environments of mental healthcare professionals can influence their interactions with patients and levels of work related stress experienced.

4.1 Background

As healthcare initiatives aim to reduce the number of hospital admissions, through increasing the provision of care in peoples' own homes, the demand for mental healthcare professionals to work alone within community settings is on the rise. Lone working has been defined as work related situations where occupational tasks are carried out without the presence or support of colleagues (NHS Protect, 2014). Community based healthcare practitioners, who spend the majority of their work related time as a lone worker, have been identified as an at risk occupational group for being victims of assault (NHS Protect, 2015). Section 1.7.6 has illustrated how the process of being a lone worker in the community and encountering incidences of behaviours that challenge, without the support of colleagues, can potentially impinge on the successful delivery of therapeutic interventions and elicit work related stress. The current section aimed to investigate the components of TEST which posit that the work place environment, and quality of interactions with patients, can impact the professional practices of and work related stress within frontline staff who manage behaviours that challenge.



Figure 4.1. The components of TEST investigated and reported in this section.

Winning (2010) investigated how the process of lone working could impact the wellbeing of healthcare practitioners through conducting a qualitative study that explored the experiences of Counsellors who spent a large proportion of their occupation working in isolation from colleagues. Counsellors reported that lone working can coincide with notions of being *socially*, *environmentally* and *professionally* isolated from others, which can then manifest into work related stress (Winning, 2010). *Social* isolation was defined as lone working conditions that inhibit the effective communication and opportunities to form professional relationships with colleagues. *Environmental* isolation refers to the occupational demand of providing care within buildings or settings as a sole Counsellor, without the presence of colleagues, which can potentially elicit perceptions of threat to personal safety. *Professional* isolation was indicative of how lone working can prevent a sense of belonging and collaboration with fellow Counsellors. Thus, community mental healthcare professionals may also be prone to experiencing social, environmental and

professional isolation when providing care as lone workers, which could have negative consequences on employee wellbeing. Social, environmental and professional isolation could be problematic for community health/social care professionals, as illustrated in section 1.7.6, particularly in the event where patients exhibit behaviours that challenge without the support of colleagues to assist in the safe de-escalation of incidences.

Section 1.7.2 illustrated that providing mental healthcare and being exposed to behaviours that challenge can also be stressful when working within inpatient settings, particularly with wards/residential settings that have not been designed specifically for the safe prevention or de-escalation of behaviours that challenge. However, the environmental characteristic of being in the presence or close proximity of colleagues, as apparent within mental health inpatient settings, can serve as a source of social support that may be effective in enabling frontline staff to contain and de-escalate incidences of behaviours that challenge in a safe manner, as illustrated in section 1.8.2. It has also been recognised that working in close proximity with colleagues, who are perceived to provide optimal levels of social support, can significantly reduce the number of incidences where frontline staff encounter incidences of patients exhibiting aggressive behaviours within inpatient mental healthcare settings (Magnavita, 2014). It has been purported that inpatient services that comprise of staff members who are trained and assigned to the safe de-escalation of incidences of behaviours that challenge can also be conducive in ensuring the safety of frontline healthcare workers (Petska, et al., 2012). Thus, working within mental health inpatient settings, in the presence of colleagues who are trained in the safe management of behaviours that challenge, could provide the notions safety required when engaging with patients who

have unhelpful behavioural symptoms (McCaughey, Delli-Fraime, McGhan & Bruning, 2012).

There is currently a lack of research that has empirically investigated how the process of lone working in community settings can potentially impact the capacity for mental healthcare professionals to therapeutically engage with patients who exhibit behaviours that challenge and elicit work related stress. This is concerning, given that community healthcare workers could be vulnerable to the risk of encountering incidences of behaviours that challenge without the support of suitably trained colleagues (NHS Protect, 2015). Thus, there is a need to ascertain if there are any differences in the perceived stress levels and capacity to engage with patients who exhibit behaviours that challenge between lone worker community and inpatient based mental healthcare professionals. This would help to indicate if lone workers in community mental health teams are particularly vulnerable to experiencing the work related stress that can coincide when providing care for people who exhibit behaviours that challenge (NHS Protect, 2015).

The first research question was ‘What is the difference in the perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge between community and ward based mental healthcare professionals?’ It was hypothesised that due to the demands of lone working, community mental healthcare workers would report having lower capacity to therapeutically engage with patients who exhibit behaviours that challenge than professionals working within inpatient settings.

The second research question was ‘What is the difference in the levels of perceived stress between community and ward based mental healthcare professionals?’ It was

hypothesised that community mental healthcare workers would report higher levels of perceived stress than professionals who worked within inpatient settings.

4.2 Method

4.2.1 Design

A between-subjects design were employed in which the independent variable for all analyses was whether participants delivered the mental healthcare within community or ward based settings. Within separate between subject analyses, perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge and work related stress served as the dependent variables.

4.2.2 Participants

A total of 85 frontline mental healthcare workers took part in the current study. 44 females (mean age = 40.89, SD = 10.26) and 12 males (mean age = 46.42, SD = 10.48) worked with community mental healthcare services which involved providing care as a lone worker. Participants, whose roles were based within mental healthcare wards, comprised of 17 females (mean age = 35.29, SD = 12.27) and 12 males (mean age = 47.08, SD = 9.11). Table 4.1 provides details of the occupations of both community and ward based mental healthcare professionals. The aims of this study were presented at a Directorate/Manager's meeting, within the organisation that employed the participants, who granted authority to recruit frontline mental health care professionals to take part in this research.

Table 4.1. The occupations of participants.

Job Title	n Community Mental Healthcare	n Inpatient Mental Healthcare
Nurse	26	15
Social Worker	8	1
Support Worker	6	11
Psychologist	6	0
Occupational Therapist	5	0
Assistant Nursing Practitioner	1	1
Clinical Lead	1	0
Doctor	2	0
Psychological Therapist	1	0
Ward Manager		1

4.2.3 Materials

The Therapeutic Engagement Scale, as modified from the STRS (Pianta, 2001), and the Perceived Stress Scale (Cohen, Karmarck & Mermelstein, 1983) were administered as part of this study. Details of these measures are provided in Chapter 2.

4.2.4 Procedure

The procedure applied in this study has been detailed in section 3.5.4. However, the scores obtained from the TES and PSS were the only measures considered for the purpose of answering the research questions posed in this section of the thesis.

4.2.5 Statistical Analyses

A series of between-subjects t-tests were conducted to ascertain whether:

- 1) Community mental healthcare professionals would report as having lower perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge than frontline staff in mental health inpatient services.
- 2) Community mental healthcare professionals would report as having higher perceived stress than frontline staff in mental health inpatient services.

Between-subjects t-tests were also conducted as exploratory analyses to ascertain any differences between community and ward based staff on the 3 lower order factors within the TES which are level of perceived conflict, closeness towards and dependency from patients who exhibit behaviours that challenge.

4.3 Results

Community mental healthcare professionals reported higher levels of perceived stress (mean = 17.91, SD = 5.86) than ward based staff (mean = 14.79, SD = 6.51), $t(83) = 2.24$, $p = .03$, indicative of a medium effect size $d = .51$. Community based mental healthcare professionals reported having lower capacity to engage therapeutically with patients (mean = 93.98, SD = 14.91) than ward based staff ($M = 101.17$, $SD = 8.94$), $t(83) = -2.77$, $p = .01$, representing a medium effect size $d = .54$. Mental healthcare staff working within ward settings, reported higher levels of professional closeness towards patients who exhibit behaviours that challenge ($M = 38.17$, $SD = 6.05$), than mental healthcare professionals who provide care in community settings ($M = 34.86$, $SD = 5.97$), $t(83) = -2.42$, $p = .02$, representing a medium effect size $d = .55$. This would suggest that ward based staff may perceive as having a higher capacity to harness caring professional relationships with patients who exhibit that challenge, conducive to the successful delivery of therapeutic interventions, than community based mental healthcare professionals.

There was no significant difference in reported levels of conflict towards patients between community ($M = 31.34$, $SD = 10.12$) and ward based staff (Mean = 27.83, $SD = 7.23$), $t(83) = 1.84$, $p = .07$. There was also no difference between the perceived dependency of patients towards staff between community (Mean = 11.84, $SD = 4.20$) and ward based mental healthcare professionals (Mean = 11.17, $SD = 3.69$), $t(83) = .72$, $p = .47$. Table 4.2 provides a summary of descriptive and inferential statistics

Table 4.2. Descriptive and inferential statistics for between subjects t-test.

Inpatient	Community
based	based staff

	staff					
	M	SD	M	SD	<i>t</i>	<i>p</i>
Perceived Levels of Stress	14.79	6.51	17.91	5.76	2.24	.03
Capacity to Engage with Patients	101.17	8.94	93.98	14.91	-2.77	.01
Professional Closeness with Patients	38.17	6.05	34.86	5.97	-2.42	.02
Perceived Conflict with Patients	27.83	7.23	31.34	10.12	1.84	.07
Perceived Dependency of Patients	11.17	3.69	11.84	4.20	.72	.47

4.4 Discussion

This study aimed to ascertain if community mental healthcare professionals could be more vulnerable to experiencing higher perceived stress and lower capacity to engage with patients who exhibit behaviours that challenge than frontline staff who work within inpatient settings. The findings indicated that community mental healthcare staff experience higher levels of perceived stress and lower capacity to therapeutically

engage with patients who exhibit behaviours that challenge than frontline staff working in inpatient settings. The results also indicated that inpatient environments may be more conducive in facilitating staff to develop professional closeness towards patients who exhibit behaviours that challenge in comparison to health/social care workers in community services.

This study has provided some support for the component of the TEST model, which posits that the workplace environment could influence the capacity for health/social care professionals to therapeutically engage with patients who exhibit behaviours that challenge. The first hypothesis was supported, as the results indicated that interacting with patients, who exhibit behaviours that challenge, could be more stressful when working in community services as opposed to inpatient settings. Grey literature has identified community healthcare professionals as being an at risk group of being victims of physical and verbal aggression, due to the occupational demand of working alone and without the presence or support of colleagues (NHS Protect, 2013). Mental healthcare practitioners, such as Counsellors, have reported that lone working can coincide with perceptions of being socially, environmentally and professionally isolated within their profession (Winning, 2010). The current study would also indicate that the higher perceived stress levels reported by community mental healthcare professionals could be due to the demands of providing care as a lone worker for people who exhibit behaviours that challenge, within unfamiliar settings and without access to immediate assistance from colleagues in the event of challenging incidences.

Thus, working within inpatient settings, and being in the presence of colleagues, may serve as a buffer against work related stress when providing care for patients who exhibit behaviours that challenge. It has been recognised that having access to

adequate social support, as provided by colleagues, can be beneficial in negating incidences of behaviours that challenge within mental health inpatient settings (Magnavita, 2014). This notion is consistent with sections 1.8.1 and 1.8.2 where participants have articulated the importance of collaborating with colleagues who have shared knowledge of patients, in order to identify triggers and implementing care strategies to prevent incidences of behaviours that challenge. Thus, the environmental characteristic of being in the presence of colleagues who provide social support and opportunities to collaborate, could explain the lower levels of stress/higher capacity to engage with patients reported by participants who worked in inpatient settings.

The results reported would also suggest that working within inpatient settings could be conducive in enabling staff to have sufficient contact with patients in order to develop professional closeness with care recipients who exhibit behaviours that challenge. The construct of professional closeness, as measured by the Therapeutic Engagement Scale, is defined by the perceived capacity of healthcare professionals to yield relationships with patients that enables openness, therapeutic engagement and effective communication between the carer and care-recipient (Pianta, 2001). The relationship between practitioners and care recipients has been observed to be an integral component to the effective delivery of mental healthcare interventions such as Cognitive Behavioural Therapy and Interpersonal Therapy (Krupnick, et al., 1996). Patients who have accessed mental health inpatient services have reported that positive relationships with frontline staff was an integral feature in eliciting safe/trusting environments for care recipients and enabling the successful delivery of therapeutic interventions (Gilburt, Rose & Slade, 2008). Thus, the higher levels of professional closeness and capacity to engage with patients, as reported by inpatient staff in the current study, could be due to the ward environment enabling the proximity and time

required to forge relationships with care recipients that are conducive to the successful delivery of therapeutic interventions. This provides further indication as to how the TEST framework can illustrate how work related factors, such as workplace environment, may determine the capacity for frontline staff to therapeutically engage with care recipients who exhibit behaviours that challenge and thus work related stress.

4.5 Strengths and Limitations

There is a need to gain further clarity as to which components of providing care within inpatient settings could be conducive in supporting staff in their therapeutic engagement with patients and negating perceived stress when compared to community mental healthcare staff. For instance, increases in patient caseload has been posited by district nurses as being a potential stressor within professions that consist of providing care in community settings (Stuart, Jarvis & Daniel, 2007). This would suggest that there are factors, other than the demand of lone working, that could be contributing to the lower capacity to engage with patients and greater perceived stress levels reported by community mental health workers when compare to frontline staff working within inpatient settings. It is necessary to ascertain how variables such as organisational factors, case load and levels of social support from colleagues may differ between inpatient and community based staff. Such research would help to further explain as to why mental healthcare professionals, working in inpatient settings, reported lower levels of perceived stress and greater capacity to engage with patients than practitioners in community services.

The current study also consisted of classifying participants who worked within mental health inpatients services as a single group when analysing the data. It is necessary to acknowledge that inpatient mental healthcare settings consist of both acute and long

stay rehabilitation services (Care Quality Commission, 2017). Thus, there is a need to ascertain if any differences in the perceived capacity to engage with patients and work related stress would be observed between mental health care professionals who work within community, acute wards and long-term/rehabilitation inpatient settings. It could be argued that mental healthcare staff who work within long-term inpatient settings would have a greater duration of time to engage with care recipients and ascertain the patient specific knowledge required to implement strategies to prevent incidences of behaviours that challenge. Thus, the recruitment of participants who provide care within community, acute wards and long-term inpatient settings would help to ascertain any differences in the amount of contact time, patient specific knowledge and work related stress across these services.

4.6 Conclusion

The current study has provided some further support in the development of the TEST model in providing valid explanations for the cause of and protective factors against work related stress within health/social care professionals who manage behaviours that challenge. It was observed that work place settings (community/inpatient) may influence the perceived capacity for mental healthcare professionals to therapeutically engage with patients who exhibit behaviours that challenge and work related stress. It was also observed that community mental healthcare workers may perceive being more inhibited in their therapeutic engagement with patients than staff working within inpatients settings, which could contribute to the manifestation of work related stress. It is necessary that mental healthcare services ensure that community practitioners have regular access to protective factors, such as opportunities to collaborate with colleagues, to reduce notions of being isolated when providing care for people who exhibit behaviours that challenge and offset work related stress. Further research is

therefore required to ascertain the specific components of providing care within inpatient settings that may be effective in facilitating staff in their therapeutic engagement with patients and offsetting work related stress.

Chapter 5. The Influence of Organisational Factors and
Colleagues on Professional Carers' Capacity to

Therapeutically Engage with Residents who have Dementia.

Chapters 3 and 4 provided some indication of how work place settings and processes that are intrinsic to health/social care professional can influence the perceived capacity to engage with people who exhibit behaviours that challenge and levels of work related stress in mental healthcare professionals. The current chapter will aim to explore the component of the TEST model which posits that organisational factors and colleagues can also impact the ability for frontline staff to engage with care recipients who display behaviours that challenge. This aspect of the TEST model was investigated within a population of professional dementia carers, an occupation that also involves providing care for people who exhibit behaviours that challenge. Professional dementia carers (N = 41) completed the Perceived Organisational Support Scale, Therapeutic Engagement Scale and the Perceived Stress Scale. Participants also completed the Brief Version of Fear of Negative Evaluation scale which was administered to ascertain how perceived negative evaluation from colleagues could influence capacity to engage with residents and work related stress. Mediation analysis indicated that perceived capacity to engage with residents fully mediated the positive correlation between fear of being negatively evaluated by colleagues and work related stress. Higher levels of perceived organisational support was shown to correlate with lower work related stress. However, no correlation between perceived organisational support and the capacity to therapeutically engage with residents who exhibit behaviours that challenge was observed. The findings of this study further demonstrated that the capacity for health/social care professionals to engage with people who exhibit behaviours that challenge could be a mechanism

of change for stress reduction interventions. Discussion will also be provided regarding the need to develop a battery of measures that are specifically designed to tap into the categories and core category within the TEST model.

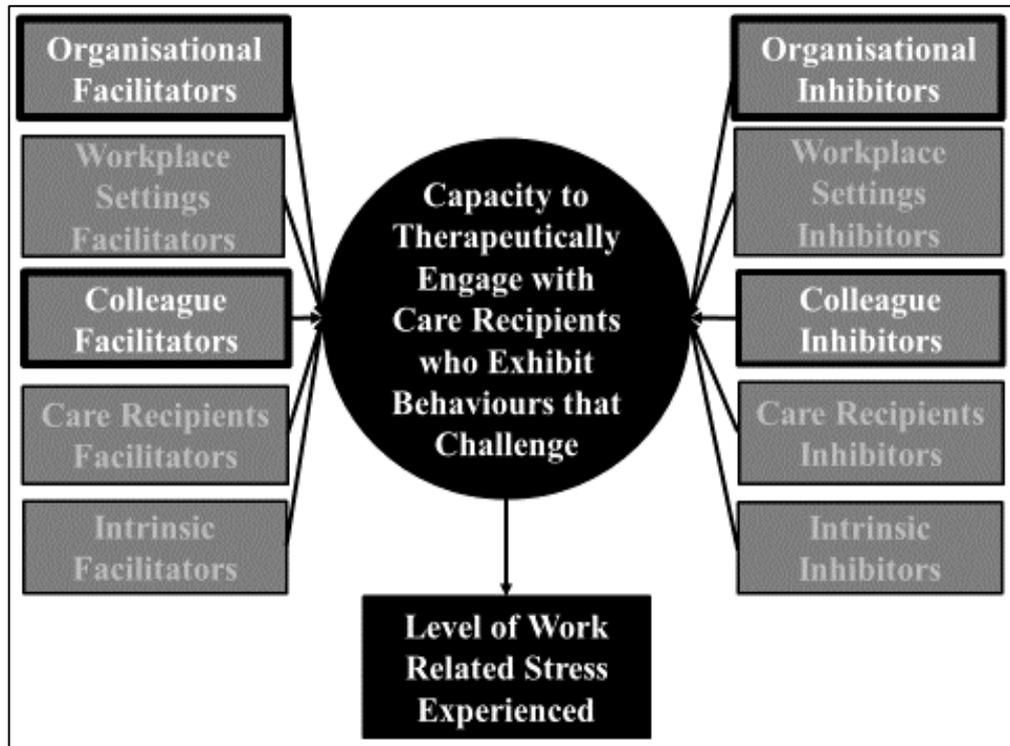


Figure 5.1. The current chapter focused on the categories concerning organisational factors and colleagues.

5.1 Background

Existing literature has indicated that the process of caring for people who have the behavioural and psychological symptoms of dementia (BPSD) can be challenging for

professional carers. BPSD can manifest as verbal/physical aggression, social withdrawal and repetitive vocalisations, all of which can be construed as being behaviours that challenge for carers of people with dementia (James, 2011). It has been posited that unhelpful behavioural symptoms can manifest when a person with dementia has difficulties in communicating their needs and therefore experiences an unmet need for an enduring length of time (Cohen-Mansfield, 2000). Sensory deprivation, loneliness and lack of opportunity to engage in meaningful activities have all been identified as factors that could contribute to people with dementia experiencing unmet needs when residing within nursing home care settings (Cohen-Mansfield, Dakheel-Ali, Marx, Thein & Regier, 2015). This would suggest that carers who work within nursing home settings, in which residents with dementia may be prone to experiencing unmet needs for enduring periods of time, may be vulnerable to encountering residents who exhibit behaviours that challenge.

Strong positive correlations have been observed between the frequency/intensity at which residents exhibit behaviours that challenge and levels of caregiver burden within informal carers of people with dementia (Huang, Lee, Liao, Wang & Lai, 2012). Within care home settings, greater incidences of behaviours that challenge, as exhibited by residents who have dementia, can also coincide with higher levels of work related stress within frontline staff (Edvardsson, Sandman, Nay & Karlsson, 2008). This would suggest that frontline staff who are frequently exposed to behaviours that challenge, within dementia care settings, could be at risk of experiencing carer burden to the extent of being detrimental to wellbeing. Given the challenges of providing care for people who have BPSD, this sample provide a meaningful opportunity to ascertain if there was a relationship between perceived capacity to engage with residents and stress as posited in the TEST.

5.2 Organisational factors, therapeutic engagement with residents who have dementia and work related stress.

Section 1.6 provided illustrations of how organisational policies/protocol can consist of factors that either inhibit or facilitate health/social care professionals in their capacity to therapeutically engage with service users who exhibit behaviours that challenge and influence levels of work related stress.

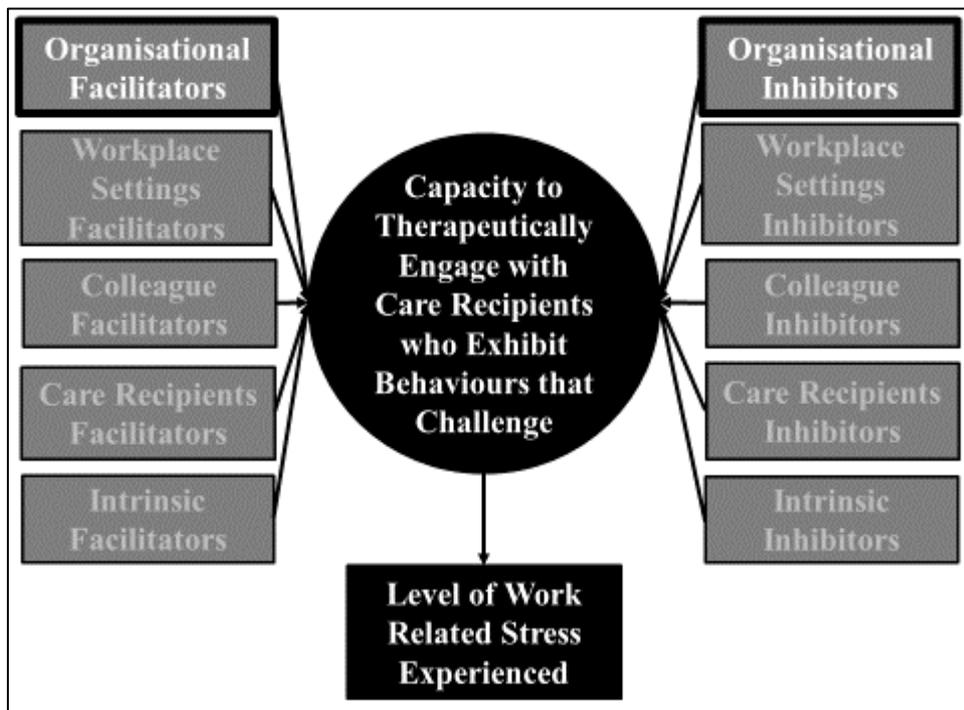


Figure 5.2. The current study aimed to investigate the ‘Organisational’ component of the TEST model to ascertain the relationships between levels of perceived organisational support, capacity to engage therapeutically with residents and work related stress within professional dementia carers.

The occupational support provided by health/social care organisations can be essential to the professional development of caring practitioners (Keating, Thompson & Lee, 2010). Frontline care home staff have purported that the quality of support, as provided by employing organisations, can be integral to job satisfaction (Mahmoud, 2008).

However, working within organisations that provide inadequate salaries, suboptimal staffing levels and unsociable shift patterns could harness cultures in which frontline care staff are vulnerable to the onset of stress (McVicar, 2003). Thus, the current study aimed to investigate the organisational component of the TEST model (figure 31), to ascertain how the perceived support of employing health/social care services could influence professional dementia carers in their capacity to engage with residents and levels of work related stress experienced.

5.3 The impact of perceived negative evaluation from colleagues on the capacity to therapeutically engage with residents and work related stress within professional dementia carers.

Section 1.8 of this thesis illustrated how colleagues can also serve to facilitate or inhibit the caring practices of frontline health/social care professionals. The current study aimed to explore a specific facet of collegiate influence, as reported in section 1.8.8, to investigate how the perceived negative evaluation of colleagues could influence perceived capacity to engage with residents and work related stress levels within professional dementia carers.

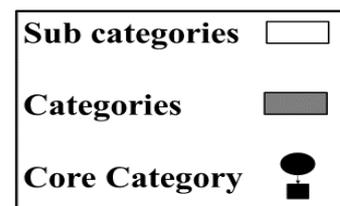
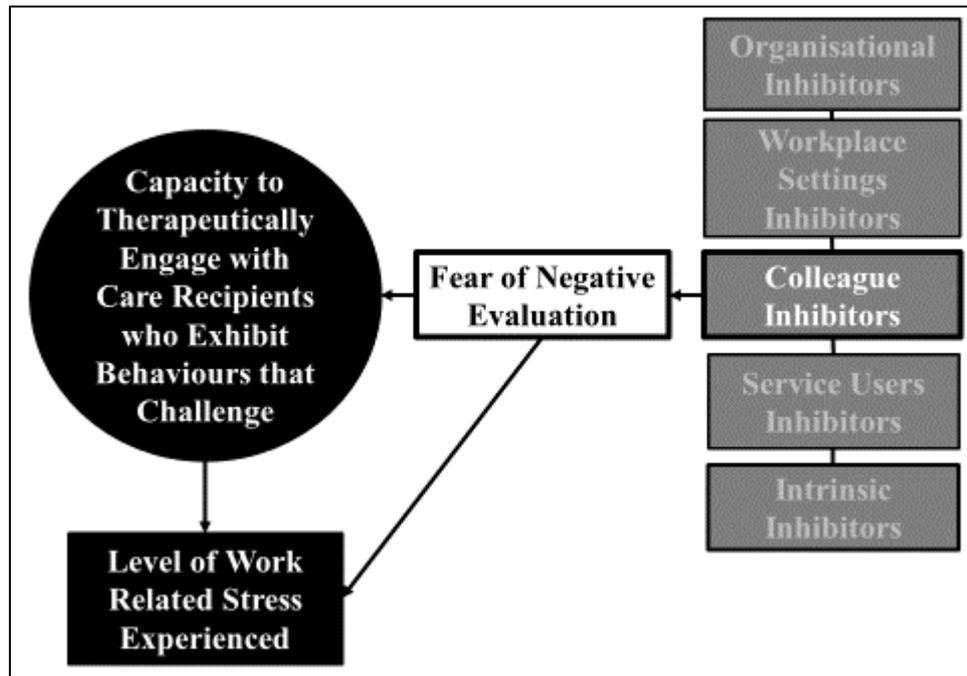


Figure 5.3. The current study aimed to investigate how the perception of being negatively evaluated by colleagues could influence capacity to engage therapeutically with residents and work related stress experienced by professional dementia carers.

The process of being socially evaluated by others has the potential to activate acute biological stress responses, as indicated by elevated heart rate, along with increases in self-reported anxiety, shame and negative affect (Bosch, et al., 2009). Section 1.8.8 has illustrated how the process of working alongside colleagues who have divergent philosophies on the management of behaviours that challenge, can potentially elicit notions of being negatively evaluated when managing challenging incidences or delivering caring intervention. Thus, frontline staff who hold the perception that their professional practices are being negatively evaluated by colleagues, could be

vulnerable to the onset of work related stress and negative affective states. Thus, an aim for the current study was to ascertain how the fear of being negatively evaluated by colleagues could influence the perceived capacity to engage with residents and levels of work related stress within professional dementia carers.

The first hypothesis for this study was that there would be a negative relationship between the perceived capacity to therapeutically engage with residents who exhibit behaviours that challenge and work related stress. This hypothesis was established to ascertain whether higher capacity to engage with service users would also coincide with lower levels of perceived stress within professional dementia carers, as previously observed in mental healthcare professionals (section 3.6.1).

The second hypothesis was that higher levels of perceived organisational support would be related to lower work related stress.

The third hypothesis was that a positive relationship would exist between perceived organisational support and the subjective capacity to therapeutically engage with residents who exhibit behaviours that challenge.

The fourth hypothesis for the current study was that higher levels of perceived negative evaluation from colleagues would be related to greater work related stress.

It was also hypothesised that higher levels of perceived negative evaluation from colleagues would be related to with lower capacity to therapeutically engage with residents who exhibit behaviours that challenge.

Finally, it was hypothesised that the relationship between perceptions of being negatively evaluated by colleagues and work related stress would be mediated by the perceived capacity to engage with residents.

5.4 Method

5.4.1 Design

A series of bivariate correlations were conducted to ascertain relationships between perceived organisational support, subjective capacity to therapeutically engage with residents who exhibit behaviours that challenge and work related stress within professional dementia carers. Bivariate correlations were also conducted to observe if perceived negative evaluation from colleagues was associated with the capacity to engage therapeutically with residents and work related stress.

5.4.2 Participants

41 professional carers of people with dementia were recruited to take part in the current study, 38 were female (mean age = 42.68, SD = 12.46) and 3 were male (mean age = 23.33, SD = 4.04). I attended Care Home Manager's meetings, where I presented the aims of this study, as a means to gain approval to recruit relevant participants. Table 5.1 provides an illustration of participants' occupations and the behaviours that they deemed to be most challenging to manage when exhibited by care recipients.

Table 5.1. Details concerning job titles and behaviours deemed as being most challenging for participants

Characteristic	n	%
Job Role		
Care Assistant	15	37
Care Home Manager	9	22
Senior Carer	7	17
Deputy Care Home Manager	5	12

Clinical Lead	2	5
Registered Mental Health Nurse	2	5
Activities Co-ordinator	1	2

**Behaviour deemed most
challenging**

Physical Aggression	27	65
Agitation	9	22.5
Verbal Aggression	3	7.5
Repetitive Vocalisations	1	2.5
Self-harm	1	2.5

5.4.3 Materials

The PSS (Cohen, Kamarck & Mermelstein, 1983) and Therapeutic Engagement Scale (Pianta, 2001), which have been detailed in section 2.1, were used in the current study. The Perceived Organisational Support Scale (POSS; Eisenberger, Huntington, Hutchison & Sowa, 1986) was used to ascertain the extent to which participants felt supported by their employing organisations in achieving caring related duties. The POSS comprises of 36 items, in which participants can respond on a 7 point Likert scale, ranging from ‘strongly disagree’ to ‘strongly agree’. Scores on this measure range from 36 to 252, with greater scores indicating higher levels of perceived support as provided by the organisations that employed the participants. All 36 items load onto a single factor entitled Perceived Support with a Cronbach’s alpha level being reported at .97, which indicates high internal consistency.

The Brief Fear of Negative Evaluation Scale (BFNE; Leary, 1983) was also used to document the extent to which participants experienced perceived negative evaluation from their colleagues in the workplace over the preceding month. The BFNE is a 12-item measure where participants are required respond on a 5-point Likert scale, ranging from 'not at all a characteristic of me' to 'extremely characteristic of me'. 8 of the items consist of negatively phrased questions such as 'I am afraid that people will find fault with me'. 4 of the items consist of positively phrased questions, such as 'Other people's opinions of me do not bother me'. The 4 negatively phrased items were reversed scored. Scores obtained on the BFNE range from 12 to 60, with higher scores indicating greater levels of fear of being negatively evaluated in the workplace. Participants were asked to consider the items on the BFNE in relation to their perceptions of colleagues in the workplace. A Cronbach's alpha of .81 has been reported when considering all 12 items as loading onto a single factor (Weeks, et al., 2005).

5.4.4 Procedure

Prior to data collection, the current study received ethical approval from the Research Ethics Committee at the School of Health and Life Sciences, University of Northumbria at Newcastle. Participants were asked to meet with the researcher, in groups, in order to receive a briefing on the aims of the study. Once participants had read the information sheet, participants were required to sign an informed consent form to document their consent to take part in the study. Participants were required to complete questions concerning their age, occupation and length of time working in a

caring profession. Once this had been completed, participants were required to complete the following measures in the order as presented; the Perceived Organisational Support Scale (POSS; Eisenberger, Huntington, Hutchison & Sowa, 1986), the Brief Fear of Negative Evaluation (BFNE; Leary, 1983), Therapeutic Engagement Scale (Pianta, 2001) and the Perceived Stress Scale (Cohen, Kamarck & Mermelstein, 1983). To note, once these measures had been completed, 34 of the 41 participants then provided hair samples in accordance with the study reported in section 6 of the current thesis. Once the measures, and hair samples had been provided by relevant participants, the researcher then provided a debriefing. Participants were not constrained to a particular time limit to complete the measures.

5.4.5 Statistical Analyses

A bivariate correlation was conducted to ascertain if a negative relationship exists between the perceived capacity to therapeutically engage with residents who exhibit behaviours that challenge and work related stress, as observed within mental healthcare professionals in section 3.6.1.

Bivariate correlations were conducted to ascertain if higher levels of perceived organisational support were related to greater capacity to engage therapeutically with residents who exhibit behaviours that challenge and lower work related stress.

Bivariate correlations were also conducted to observe whether the fear of being negatively evaluated by colleagues in the work place was related with lower perceived capacity to engage therapeutically with residents who exhibit behaviours that challenge and higher work related stress.

A mediation analysis was performed to ascertain whether the perceived capacity to engage with residents, who exhibit behaviours that challenge, would mediate any

observed relationship between fear of being negatively evaluated by colleagues and work related stress.

5.5 Results

5.5.1 Therapeutic Engagement and Work Related Stress

Pearson's product moment correlation coefficients indicated that there was a significant negative correlation between the perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge and work related stress, $r = -.50$, $p = .001$. This indicates a strong negative relationship between the capacity to engage therapeutically engage with residents who exhibit behaviours that challenge and work related stress. The observed relationship also replicates the findings as observed within mental healthcare professionals (section 3.6.1) that greater perceived capacity to therapeutically engage with residents who exhibit behaviours that challenge can correlated with lower levels of work related stress.



Figure 5.4. Significant negative correlation between the perceived capacity to engage therapeutically with residents who exhibit behaviours that challenge and work related stress.

5.5.2 Organisational Support

A bivariate correlational analysis indicated a negative correlation between perceived organisational support and work related stress, $r = -.48$, $p = .002$. This would suggest that greater levels of support, as provided by organisations, correlated with less perceived work related stress within professional dementia carers.

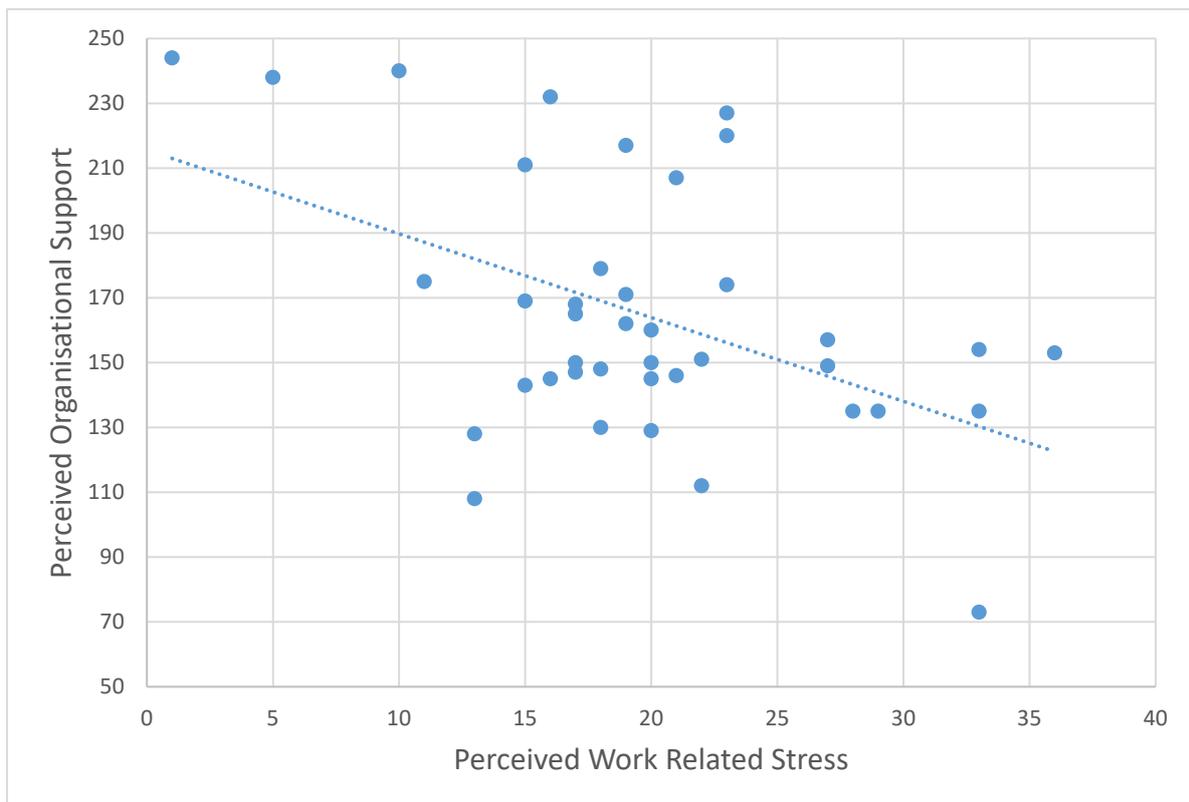


Figure 5.5. Illustration of negative correlation between perceived organisational support and work related stress within professional dementia carers.

However, a non-significant relationship was observed between perceived organisational support and capacity to therapeutically engage with residents who exhibit behaviours that challenge, $r = .22$, $p = .18$.

5.5.3 Fear of negative evaluation from colleagues in the workplace

A positive bivariate correlation was observed between the fear of being negatively evaluated by colleagues and work related stress, $r = .32$, $p = .04$. This would indicate that greater fear of being negatively evaluated by colleagues in the work place is related with higher levels of perceived stress within professional dementia carers.

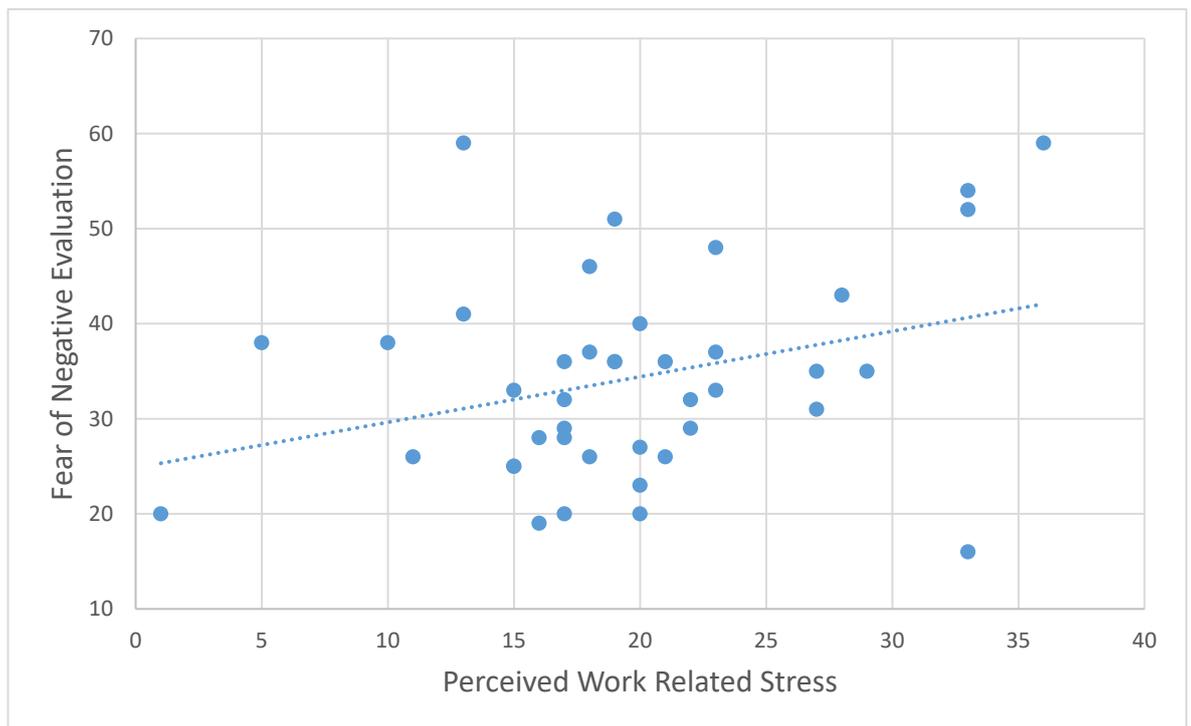


Figure 5.6. Observed positive correlation between fear of being negatively evaluated in the workplace and perceived work related stress.

A negative correlation was observed between fear of being negatively evaluated and perceived capacity to therapeutically engage with residents who exhibit behaviours that challenge, $r = -.39$, $p = .01$. This would suggest that greater fear of being negatively evaluated by colleagues in the work place is related to lower capacity to engage therapeutically with residents who exhibit behaviours that challenge.

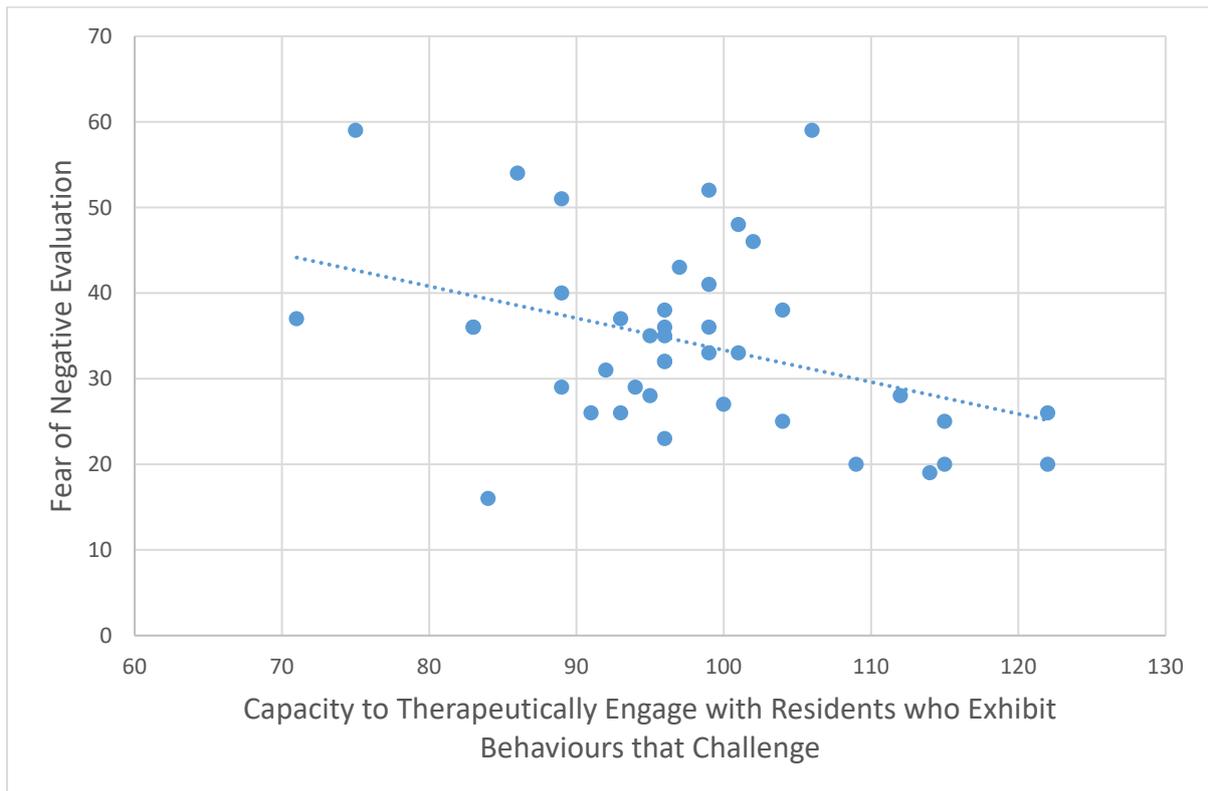


Figure 5.7. Negative correlation between fear of being negatively evaluated by colleagues in the work place and the perceived capacity of professional dementia carers to engage therapeutically with residents who exhibit behaviours that challenge.

5.5.4 Mediation Analysis

A mediation analysis was conducted to ascertain the extent to which the perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge could explain the association between the fear of being negatively evaluated in the workplace and occupational stress within professional carers of people with dementia.

There was a significant indirect effect of the fear of being negatively evaluated by colleagues and perceived work related stress $b = .11$, BCa CI [.02, .28]. This represents a medium effect size, $R^2 = .08$, 95% BCa CI [.01, .32].

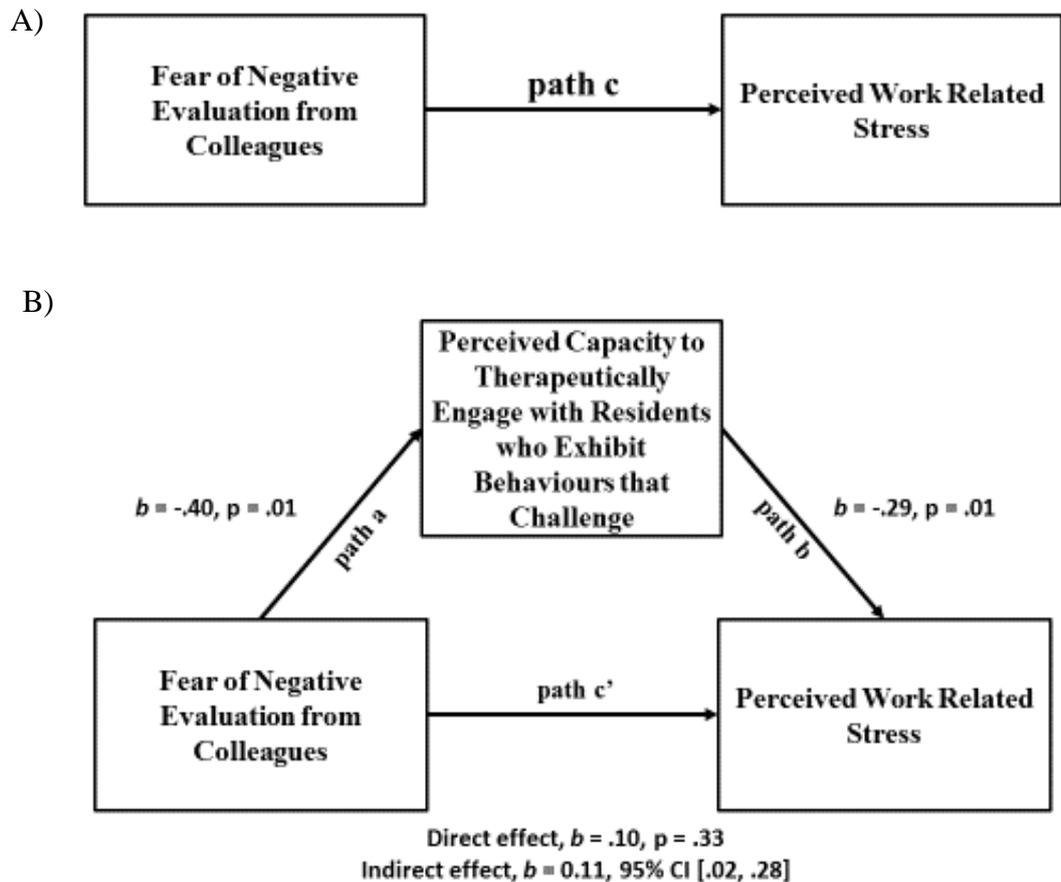


Figure 5.8. An illustration of the full mediation of perceived capacity to therapeutically engage with residents who exhibit behaviours that challenge between fear of negative evaluation from colleagues and work related stress.

The c path in the mediation model was observed as being significant, $p = .04$. However, figure 5.8 illustrates that the direct effect between fear of negative evaluation from colleagues and perceived work related stress became non-significant when the construct of perceived capacity to engage with residents who exhibit behaviours that

challenge was included in the mediation analysis ($p = .33$). This would suggest that the perceived capacity to therapeutically engage with patients who exhibit behaviours that challenge, fully mediates the relationship between the fear of being negatively evaluated by colleagues and work related stress.

5.6 Discussion

The aim for this study was to investigate specific components of the TEST model, which posit that organisational factors and colleagues can serve to influence levels of work related stress and the capacity for frontline staff to engage therapeutically with residents who exhibit behaviours that challenge. Firstly, the findings of this study converge with the results reported in section 3.6.1 in that higher perceived capacity to engage therapeutically with residents who exhibit behaviours that challenge can correlated with lower levels of subjective work related stress within professional dementia carers. The capacity to engage with residents who exhibit behaviours that challenge was also observed to fully mediate the positive correlation between the fear of being negatively evaluated by colleagues in the workplace and work related stress. Higher levels of perceived organisational support was also observed to correlate with lower levels of self-reported stress within professional dementia carers. However, no relationship was observed between perceived organisational support and the capacity for dementia carers to engage therapeutically with residents who exhibit behaviours that challenge.

The negative correlation observed between perceived capacity to engage with residents who exhibit behaviours that challenge and work related stress has replicated the findings as reported in section 3.6.1 within mental healthcare professionals. This adds further support for the core category within the TEST model in providing a valid

explanation as to why health/social care professional, who encounter incidences of behaviours that challenge in their occupation, may experience work related stress.

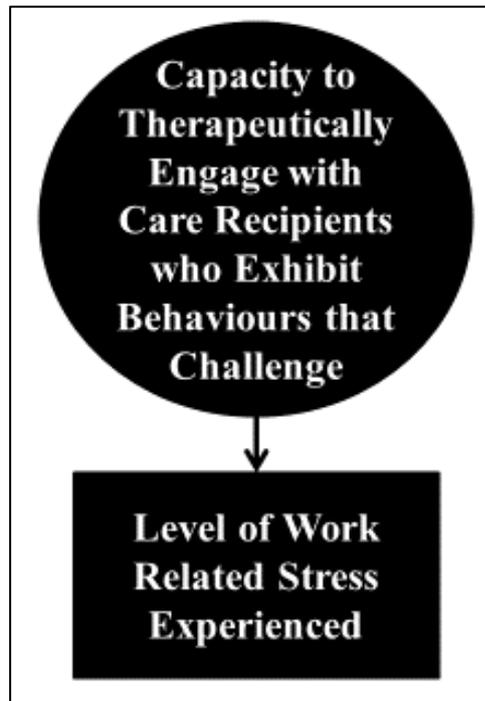


Figure 5.9. Core category within the TEST model.

This also provides further demonstration that the core category within the TEST model could be operationalised using quantitative measures to ascertain that the extent to which staff are able to engage with care recipients can influence work related stress. However, it would be useful to further explore the core category within the TEST model to ascertain if the negative correlations observed in sections 3.6.1 and 5.5.1 can also be replicated in other health/social care settings, such as Autism and Learning Disability services, where frontline staff could also be prone to encountering behaviours that challenge.

5.6.1 Fear of Negative Evaluation from Colleagues

The current study has indicated that greater fear of being negatively evaluated by colleagues correlated with reduced capacity to engage with residents and higher levels

of work related stress. This could be explained by section 1.8.8 whereby healthcare professionals purported that their application of behaviour management strategies, as advocated by accredited training programmes, can be negatively evaluated by colleagues who are resistant to changing their professional practice. The process of being evaluated by others, who do not share the same values on a given issue, can elicit biological and perceived stress to the extent of potentially having detrimental consequences to wellbeing (Hausser, Kattenstroth, van Dick & Mojzisch, 2012). Thus, working alongside colleagues who have conflicting philosophies in the management of behaviours that challenge could be perceived as sources of evaluative threat to the extent of eliciting work related stress. In accordance to the TEST framework, perceptions of being negatively evaluated by colleagues may also inhibit frontline health/social care professionals to successfully engage with care recipients who exhibit behaviours that challenge which could then manifest into work related stress. This could explain the relationship between higher levels of work related stress and greater fear of being negatively evaluated by colleagues. It is recommended that further research be conducted that specifically focusses on how conflicting ideologies in the management of behaviours that challenge could influence fear of negative evaluation, capacity to deliver caring interventions and stress within health/social care professionals. However, it could be argued that factors, other than holding conflicting philosophies in the management of behaviours that challenge, could underpin notions of being negatively evaluated in the presence of colleagues. There may be other sources of negative evaluation, such as family members of residents and members of the public (section 1.7.6), that could impinge on the practices of professional dementia carers to the extent of being stressful. For example, judgement by others is a significant cause of distress in parents of children with developmental disorders; however, this is

buffered to some extent in partnered parents who have a source of social support (Lovell & Wetherell 2018). It is therefore necessary to conduct further research to ascertain the factors that may cause professional carers to perceive their practice as being negatively evaluated by colleagues and perhaps others, who they may encounter in their role.

The perceived capacity to engage with residents was also shown to fully mediate the relationship between fear of being negatively evaluated by colleagues and work related stress. This would suggest that interventions, which are effective in supporting staff to increase their capacity to engage with residents who exhibit behaviours that challenge, could potentially reduce fear of being negatively evaluated by colleagues and also offset work related stress. In accordance to the TEST model, there can be protective factors embedded within employing organisations, workplace environment, colleagues and interactions with residents that can serve to facilitate staff in their delivery of care to people who exhibit behaviours that challenge. An example being, colleagues who present as being collaborative in the safe prevention/management of behaviours that challenge may facilitate frontline staff in their capacity to engage with residents who have the BPSD (sections 1.8.2, 1.8.3 and 1.8.4). Thus, interventions that are conducive in harnessing collaboration and eliciting convergent philosophies in the safe management of behaviours that challenge may be effective in increasing capacity to engage with residents who exhibit behaviours that challenge and thus reducing work related stress.

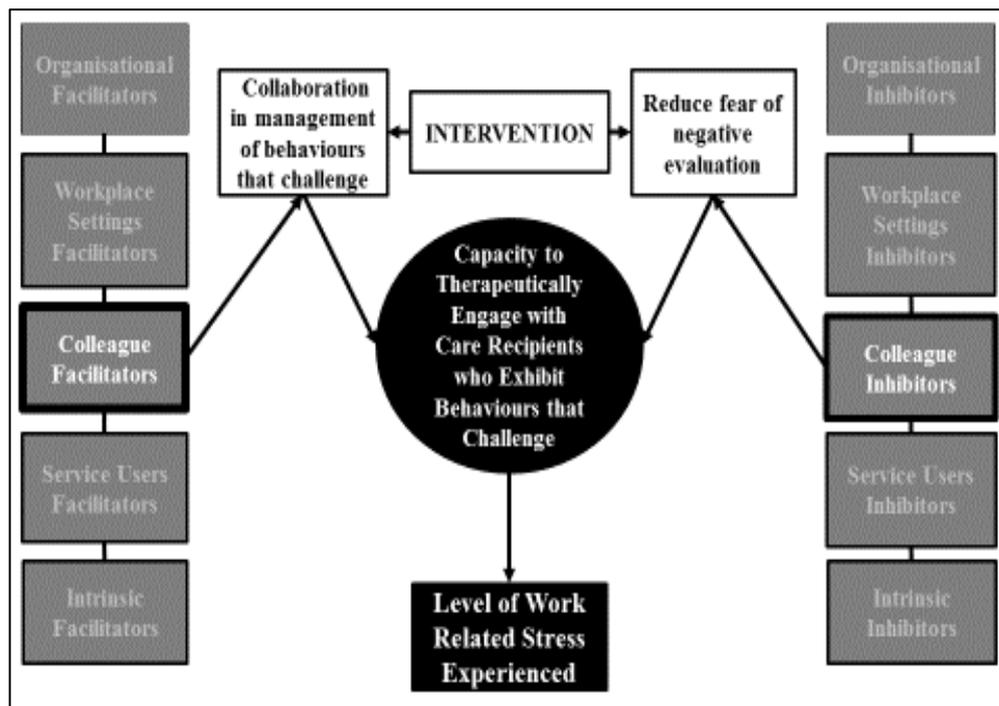


Figure 5.10. Interventions that encourage collaborative working with colleagues and reduce notions of being negatively evaluated could increase capacity to engage with residents, who have BPSD, and thus reduce work related stress.

5.6.2 Perceived organisational support and the capacity to engage therapeutically with residents who exhibit behaviours that challenge

The results reported would suggest that organisational support may influence levels of work related stress but does not have any relationship with the perceived capacity for professional dementia carers to engage with residents who exhibit behaviours that challenge. Thus, the hypothesis that higher levels of organisational support would correlate with greater capacity to engage with residents, was not supported. There are several possible reasons why this relationship was not observed in the current study. It has been purported that work related factors, such as terms of employment and amount of salary received, are important contributor to the way in which frontline staff evaluate the quality of support provided by employing organisations (McVicar, 2003).

Healthcare organisations that fail to provide frontline nurses with the necessary resources to develop their expertise and career progression may also elicit perceptions of being inadequately supported by employers (Keating, Thompson & Lee, 2010). Therefore, it could be argued that participants may have also considered factors such as terms of employment and their career development, as opposed to their interactions with residents, when considering the items on the Perceived Organisational Support Scale (POSS; Eisenberger, Huntington, Hutchison & Sowa, 1986) in the current study. These occupational factors, which are also integral to employee welfare, could explain the significant negative correlation observed between perceived work related stress and organisational support. However, it could be argued that questionnaire items that pose concerning salary, as those that appear on the POSS, do not tap into the perceived capacity to therapeutically engage with care recipients who exhibit behaviours that challenge. Thus, there is a need to develop a measure that consists of items that specifically taps into the extent to which health/social care organisations support frontline staff in their delivery of care for people who exhibit behaviours that challenge. The next steps of the research programme, which are beyond the scope of the current thesis, will be to develop a battery of quantitative measures that consist of items that are specifically relevant in tapping into the categories and core category within the TEST model.

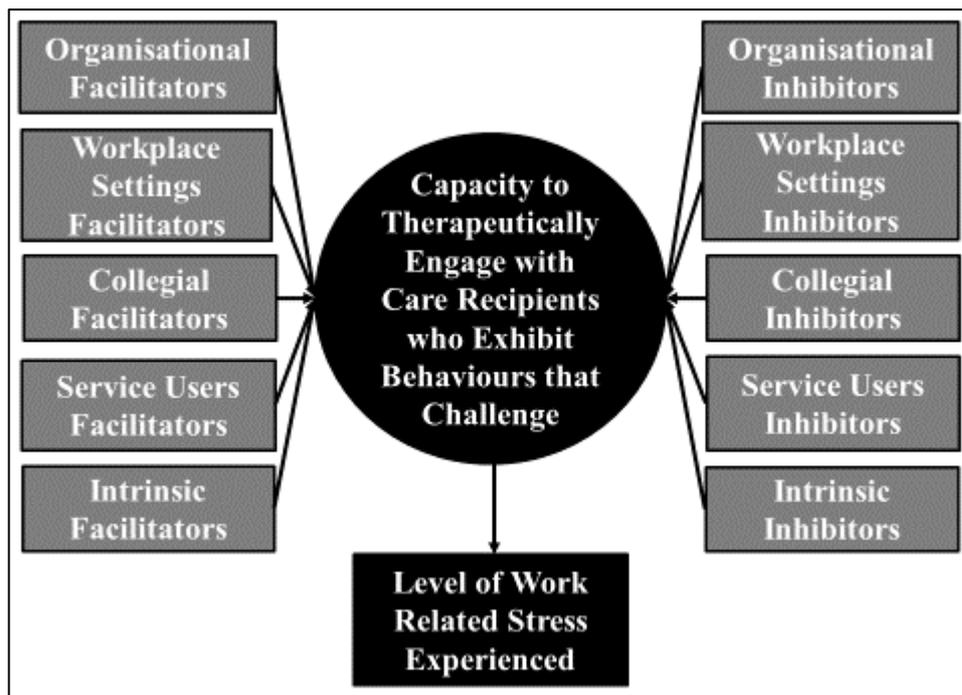


Figure 5.11. There is a need to develop quantitative measures consisting of items that are specific in tapping into how the categories influence the core category within the TEST model.

5.6.3 Conclusion

The current study aimed to ascertain how organisational factors and colleagues could influence the perceived capacity of professional dementia carers in being able to engage with residents who exhibit behaviours that challenge. It was observed that the perceived capacity to engage with residents is a construct that fully mediated the observed positive correlation between fear of being negatively evaluated by colleagues and work related stress. It is suggested that interventions that support carers in their direct interactions with residents who have dementia could be effective in reducing perceptions of evaluative threat from colleagues and negating work related stress. Furthermore, higher levels of perceived organisational support were related to less work related stress. However, no relationship between perceived organisational

support and the capacity to engage with residents was observed. The implications of these results is that the core category of the TEST model may represent a key mechanism for change for interventions to target as a means to negate work related stressors and perceived stress within professional dementia carers. Further research is required to develop a battery of measures that are capable of assessing the way in which specific organisational factors, work place settings, colleagues, service users and qualities intrinsic to health/social care professionals influence capacity to engage with residents who exhibit behaviours that challenge.

Chapter 6: Hair Cortisol Concentration and Work Related Stress within Professional Carers of People with Dementia

Previous sections of this thesis have indicated that the occupational demands of providing health or social care to people who exhibit behaviours that challenge could elicit perceived stress to the extent that it may inhibit the successful delivery of therapeutic interventions. The following chapter reports a study that aimed to ascertain the levels of biological stress that professional dementia carers experience in relation to other vocations which have also been deemed as being stressful. Hair cortisol concentration (HCC) was used as the biological marker for chronic stress experienced over a 1-month period. A one-way ANOVA revealed that higher levels of HCC was observed in professional dementia carers than people who worked within University settings and undergraduate students. The higher levels of HCC observed within professional dementia carers suggest they may be vulnerable to stress-related illness in comparison to people working in other stressful vocations. These results further demonstrate the essential requirement for professional dementia carers to have regular access to protective factors that may be effective in offsetting work related stress.

6.1 Work related stress and health

This thesis has indicated that employing organisations, work place settings, colleagues, relationships with service users and qualities that are intrinsic to health/social care professionals, can all influence the levels of perceived stress experienced by frontline staff who provide care for people who exhibit behaviours that challenge. The way in which perceived psychological and physical stressors can elicit biological stress

responses has received some notable attention within existing literature. The Hypothalamic-Pituitary-Adrenal (HPA) axis is one of the biological systems activated when encountering perceived stressors (Tsigos & Chrousos, 2002). Psychological stressors, including such demanding activities as public speaking (Kudielka, Buske-Kirschbaum, Hellhammer & Kirschbaum, 2004) and intense physical exertion (Cardoso, Ellenbogen, Orlando, Bacon & Jooper, 2013) have been observed to elicit stress to the extent of activating the HPA axis; which results in the release of the stress hormone, cortisol. Thus, regular activation of the HPA axis and release of cortisol could occur within health/social care professionals when frequently exposed to service users who exhibit behaviours that challenge. However, chronic activation of the HPA axis can have deleterious effects on immune system functioning and contribute to the manifestation of physical ill health (Glaser & Kiecolt-Glaser, 2005). It has also been posited that chronic activation of the HPA axis can cause degradation to hippocampal functions and can thus lead to deficits in cognitive functioning (Raber, 1998). This would suggest that health/social care professionals who encounter work related stressors on a regular basis could be vulnerable to chronic activation of the HPA axis to the extent of having deleterious consequences on physical and cognitive health. Therefore, there is a need to ascertain whether health/social care professionals, who work within occupations that consist of providing care for people who exhibit behaviours that challenge, are particularly vulnerable to the biological consequences of chronic work related stress.

Hair cortisol concentration (HCC) is a relatively innovative method for ascertaining HPA axis activity over a given period of time. HCC is a retrospective measure for HPA activity as 1cm of hair, proximal to the scalp, provides an indication of the amount of cortisol produced over the 1-month preceding the collection of hair samples

(Stalder, et al., 2017). Thus, HCC is a useful biological marker to ascertain chronic, rather than acute, HPA axis and cortisol activity on a month by month basis (Russell, Koren, Rieder & Van Uum, 2011). Analysis of HCC has demonstrated that informal caregivers of people with dementia could be more vulnerable to the deleterious effects of chronic stress to that of non-caregivers (Stalder, Tietze, Steudte, Alexander, Dettenborn & Kirschbaum, 2014). Thus, the current study aimed to use HCC as a biological marker to ascertain whether professional carers of people with dementia, who manage behaviours that challenge, are more susceptible to chronic activation of HPA axis activation and cortisol release when compared with other vocational groups.

Existing literature has suggested that academic/support staff within university settings and undergraduate students could be prone to experiencing work related stress due to their vocations. Factors such as inadequate support from senior managers, high workloads and insufficient recognition for professional input have shown to have negative consequences on the personal wellbeing of academics and support staff working within university settings (Gillespie, Walsh, Winefield, Dua & Stough, 2001). Work related stress within academic staff can be further compounded when having less time to spend on social activities, due to high working hours (Kinman & Court, 2010), which could contribute to physical ill health, low job satisfactions and intentions to leave the profession (Kinman & Jones, 2008). Symptoms of anxiety and depression can also manifest within undergraduate students after embarking on Higher Education, which can negatively impact academic performance (Andrews & Wilding, 2004). It has been recognised that significant increases in depression and physical ailments can occur within undergraduate students during their 2nd year of studying at Higher Education (Macaskill, 2012). This would suggest that professionals who work within university settings and undergraduate students, may be vulnerable to the

negative consequences of work related stress, and were therefore deemed an appropriate comparator group to that of professional dementia carers when analysing HCC levels.

The previous sections of this thesis have indicated that health/social care professionals, who are required to manage behaviours that challenge, can encounter numerous work related factors, such as lone working in community settings (Chapter 4), which can contribute to perceived levels of stress. Thus, previous chapters of this thesis have only investigated the self-reported experiences of or measures of perceived stress in health/social care professionals who provide services for people who exhibit behaviours that challenge. Given the negative consequences that chronic stress can have on physical (Glaser & Kiecolt-Glaser, 2005) and cognitive (Raber, 1998) wellbeing, there is a need to ascertain the biological consequences of working in occupations that consist of providing care to people who exhibit behaviours that challenge. The aim for the current study was to compare HCC levels between professional carers of people with dementia who exhibit behaviours that challenge, academics and undergraduate students. Professional carers of people who have dementia were deemed an appropriate group to investigate this topic, given that their occupation can consist of encountering incidences of behaviours that challenge in the workplace (Edvardsson, Sandman, Nay & Karlsson, 2008). Academics (Kinman & Court, 2010) and undergraduate students were deemed as being appropriate comparator groups as their vocations have been identified as being potentially stressful (Macaskill, 2012). The research question was ‘Does the occupation of providing care for people with dementia who exhibit behaviours that challenge, elicit higher levels of HCC than vocations that constitute as working in university settings or being an undergraduate student?’ Given the occupational demands of providing care for people

who exhibit behaviours that challenge (as illustrated in Part A of this thesis) it was hypothesised that higher levels of HCC would be observed within the professional carers of people with dementia than employees working within academia and undergraduate students.

6.2 Method

6.2.1 Design

A between-subjects design was employed in the current study. The independent variable was the vocation of participants and had 3 levels; 1) professional dementia carers, 2) university employees (Academics/Support Staff) and 3) undergraduate Students. The dependent variable in this study was levels of HCC in pg/mg.

6.2.2 Participants

Hair samples were taken from 168 participants for HCC analysis. The study comprised of 34 professional carers of people with dementia, 32 females (mean age = 46.19, SD = 10.91) and 2 males (Mean age = 24.50, SD = 4.95). Hair samples were also provided by 46 professionals working within University settings, 43 of which were females (mean age = 38.45, SD = 10.61) and 3 were males (mean age = 31.89, SD = 7.97). Finally, 88 of the participants were undergraduate students, 67 of which were females (mean age = 24.04, SD = 7.27) and 21 were males (mean age = 23.91, SD = 6.10). In order to recruit participants for this study, I presented the aims of my research at attended Care Home Manager's meetings, who granted me approval for recruiting frontline staff in their organisations.

6.2.3 Collection of hair samples

Strands of hair, 3mm in diameter, were cut from the scalp at the posterior vertex position. The 1 cm of hair proximal to the scalp was used in the HCC analysis, which

is an indicator of cortisol activity over the 1-month preceding collection of hair samples. Individual hair samples, from each participant, were then sealed in breathable foil and sent to the Biomarker Analysis Laboratory at Anglia Ruskin University for analysis. The protocol for HCC analysis has been illustrated by Kirschbaum, Tietze, Skoluda and Dettenborn (2009).

6.2.4 Procedure

Ethical approval for this study to be conducted was granted by the research ethics committees with the School of Health and Life Sciences at the University of Northumbria at Newcastle and the Faculty of Science & Technology at Anglia Ruskin University. The 34 dementia carers all met with the principal researcher as a single group and were briefed on the aims of the study. The dementia carers were then required to provide written informed consent to document that they agreed to provide hair samples for the purpose of the study. Participants then completed the Perceived Stress Scale (Cohen, Kamarck & Mermelstein, 1983). Hair samples were collected as described in section 6.2.3. Once all of the hair samples had been collected, the dementia carers received a debrief from the researcher and were thanked for their participation in the study. Hair samples, as provided by university staff and undergraduate students, were collected by researchers at the Biomarker Analysis Laboratory at Anglia Ruskin University.

6.2.5 Statistical analyses

A one-way ANOVA was used to determine whether there were any differences in HCC levels between professional dementia carers, academic/support staff within universities and undergraduate students. Post-hoc analyses were conducted as appropriate. Adopting the principles of Cook's Distance (Cook, 1979), data points that

were indicative of hair cortisol concentration levels being 3 times greater than the group mean were removed from the data set prior to analysis. This led to data from 2 participants from the dementia carer group (with hair cortisol levels as being at 2199.28 pg/mg and 293.73 pg/mg) being removed from the data set prior to analysis. Data from 1 participant from the University staff participant group was also removed from the data set where the hair cortisol concentration level was reported as being 73.76 pg/mg.

6.3 Results

Levene’s F indicated that the homogeneity of variance assumption was violated, $F = 23.70$, $p < .001$, thus Welch’s F was used to conduct the one-way ANOVA. *Welch’s F* ($2, 57.16$) = 7.81, $p = .001$ indicated a significant difference in HCC levels between the 3 groups. Games-Howell post-hoc analysis indicated that significantly higher levels of HCC were observed within professional carers of people with dementia (mean =13.48 pg/mg, SD = 9.57), in comparison to University staff (M = 8.21 pg/mg, SD = 5.31) and undergraduate students (M = 6.92 pg/mg, SD = 3.27) as illustrated in table 6.1.. This suggests that professional dementia carers have greater HPA activation and cortisol secretion over a 1-month period, than employees working within university settings and undergraduate students.

Table 6.1. Means and standard deviations of HCC levels (pg/mg) observed within professional dementia carers, academic/support University staff and undergraduate students.

Hair Cortisol Concentration Levels			
pg/mg			
Vocation	n	M	SD

Dementia carers	32	13.48	9.57
Academic/support staff	45	8.21	5.31
Undergraduate students	88	6.92	3.27

However, a one-way ANOVA revealed no significant difference between dementia carers ($M = 19.94$, $SD = 7.94$), University staff members ($M = 19.29$, $SD = 6.71$) and undergraduate students ($M = 19.77$, $SD = 6.95$) in perceived levels of stress $F(2,164) = .10$, $p = .91$. Means and standard deviations concerning perceived stress levels reported by participants are illustrated in table 6.2 This would suggest that there are no differences in the levels of perceived stress experienced by dementia carers, University staff members and undergraduate students.

Table 6.2. Means and standard deviations of scores observed on the Perceived Stress Scale (Cohen, Kamarck & Mermelstein, 1983) as reported by professional dementia carers, academic/support University staff and undergraduate students.

Vocation	n	Perceived Stress Levels	
		M	SD
Dementia carers	32	19.94	7.94
Academic/support staff	45	19.29	6.71
Undergraduate students	88	19.77	6.95

6.4 Discussion

The current study aimed to ascertain if higher levels of HCC would be observed in professional dementia carers in comparison to vocations that also consist of work related stressors. Higher levels of HCC were observed in professional dementia carers than in employees working within university settings and students studying at Higher Education institutions. Elevated levels of HCC have also been observed within informal caregivers of people with dementia in comparison to non-caregivers (Stalder, Tietze, Steudte, Alexander, Dettenborn & Kirschbaum, 2014). In conjunction with the findings of the current study, this would suggest that the demands of providing both care for people with behavioural symptoms of dementia elicit chronic activation of biological stress responses as measured via the HPA axis for both informal and formal carers.

Behavioural symptoms, such as exhibiting overt aggression, have been purported as being a prominent work related stressor for nurses who provide care for people with dementia (Rodney, 2000). Other symptoms of dementia, such as degradation of memory, can also inhibit effective communication between professional carers and care recipients (Eggenberger, Hiemerl & Bennet, 2013). It has been posited that the inability for people with dementia to communicate their needs to caregivers can lead to situations where the care recipient experiences an unmet need, which then manifests into agitation and the exhibition of aggressive behaviours (Cohen-Mansfield, 2000). In accordance to the TEST model, such behavioural and psychological symptoms as exhibited by care recipients could potentially present as barriers for health/social care professionals in their delivery of therapeutic interventions which could then contribute to work related stress (Sections 1.9.1 – 1.9.6). Thus, chronic activation of the HPA

axis may occur due to the daily working stressors that coincide with the difficulties of engaging with and providing direct care for people who have the behavioural and psychological symptoms of dementia, as illustrated in the TEST framework (figure. 6.1). The current study would suggest that the occupation of providing care for people with dementia could involve demands that trigger the HPA axis at greater frequency/intensity in comparison to the stressors that occur within university staff (Gillespie, Walsh, Winefield, Dua & Stough, 2001; Kinman & Court, 2010) and undergraduate students (Andrews & Wilding, 2004; Macaskill, 2012). This would suggest that professional carers of people with dementia could be prone to the deleterious effects of chronic activation of the HPA axis.

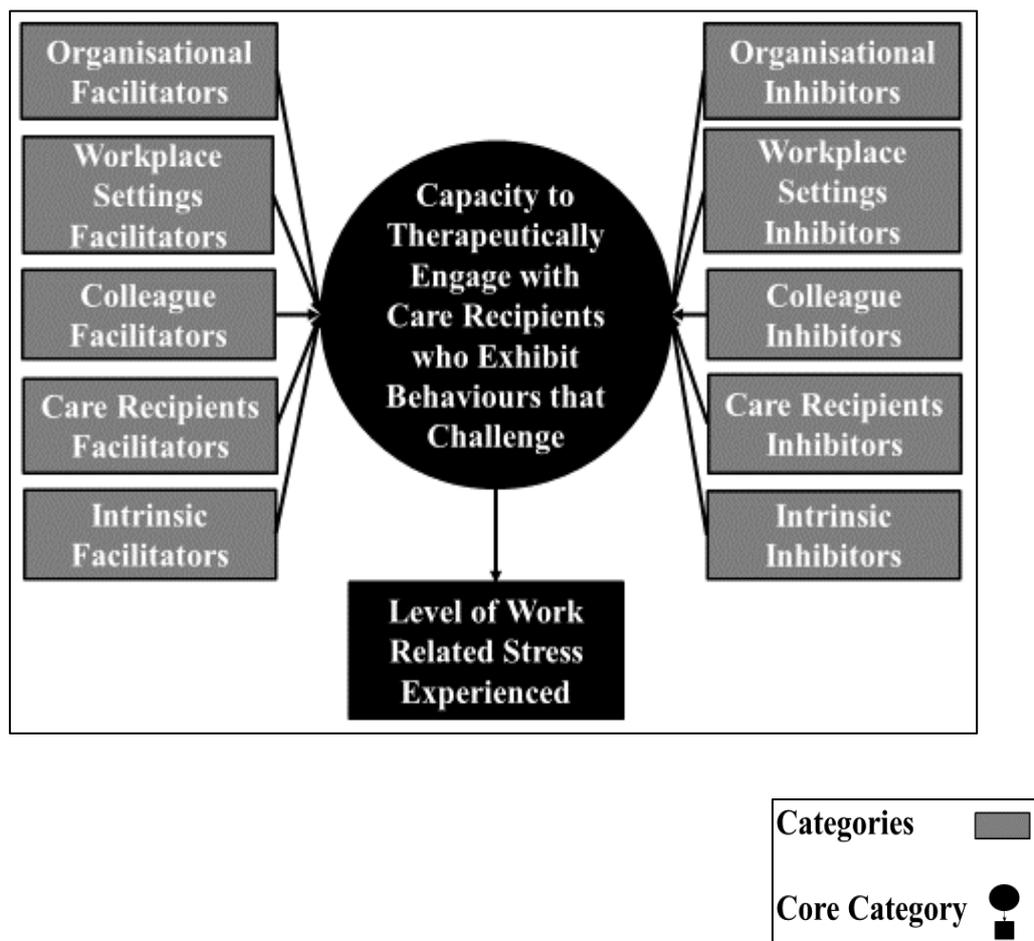


Figure 6.1. Therapeutic Engagement Stress Theory

The findings of the current study would also suggest that carers of people with dementia may be more vulnerable to impaired immune system (Glaser & Kiecolt-Glaser, 2005) and cognitive functioning (Raber, 1998), as caused by chronic activation of the HPA axis, than other vocations that have also been deemed as being stressful. Thus, there is a need to identify protective factors that could be effective supporting dementia carers in delivering caring interventions to residents and negating the onset of chronic activation of biological stress responses in order to ensure employee wellbeing. Part A of this thesis has illustrated that protective factors may need to be bespoke in order to be effective in facilitating health/social care staff in their capacity to engage therapeutically with residents who exhibit behaviours that challenge and offsetting work related stress.



Figure 6.2. Protective factors that may facilitate professional dementia carers in their capacity to engage with residents and offset work related stress.

Figure 6.2 illustrates that employing organisations, work place environments, colleagues, residents and qualities intrinsic to health/social care professionals can consist of protective factors that facilitate professional carers in their delivery of caring practices and offsetting work related stress. It is therefore recommended that future intervention studies be conducted to identify specific protective factors within each category of the TEST framework, then test their effectiveness in reducing HCC and thus negating chronic stress. Dementia care organisations that provide opportunities for staff to receive appropriate training and develop the communication skills required to effectively engage with people, who may be disoriented in time and place due to the symptoms of dementia (Eggenberger, Hiemerl & Bennet, 2013) could be conducive in negating chronic stress. Carers have also reported that working within nursing home settings that enable staff to de-escalate incidences of behaviours that challenge, through facilitating residents to engage in meaningful activities (Pulsford, Duxbury & Hadi, 2011), may also harness working environments that offset stress. Furthermore, it has been posited that dementia care settings that comprise of good collaborative working between senior managers and frontline carers may be conducive in ensuring the job satisfaction and retention of professional dementia carers (Manthorpe, 2010).

However, no differences in perceived stress were observed between professional dementia carers, University staff members and undergraduate students. This would suggest that University staff members and undergraduate students may perceive the stressors attached to their vocations as being just as stressful to that of the demands associated with providing care for residents who have BPSD. Equivocal findings have been reported regarding the association between hair cortisol concentration and self-reported measures of stress (Stalder, et al., 2012). Non-significant relationships

between HCC and scores reported on the PSS have previously been observed (Stalder, et al. 2010). This would indicate that biological markers, such as HCC, may not be indicative of the way in which people perceive work related stressors. Thus, in the context of the current thesis, it is suggested that future research considers HCC and PSS separately when considering how the perceived capacity to engage with people who exhibit behaviours that challenge can influence levels of stress within health/social care professionals.



Figure 6.3. Future studies could consider both biological and perceived indicators of stress when investigating the TEST model.

6.4.1 Strengths and Limitations

A limitation of this study is that it was uncertain as to what extent the high levels of HCC observed within the dementia carers were attributable to work related stress and the occupational demands that coincide with providing care for people who exhibit behaviours that challenge rather than other facets of their lives. Elevated HCC levels

can coincide with factors such as chronic pain (Van Uum, Sauve, Fraser, Morley-Forster, Paul & Koren, 2008), extreme physical exertion (Skoluda, Dettenborn, Stalder & Kirschbaum, 2012) and non-work related life events (Karlen, Ludvigsson, Frostell, Theodorsson & Faresjo, 2011). Thus, the 32 dementia carers in current study may have experienced life events that were not related to their profession within the 1-month preceding the collection of hair samples, but contributed to the observed elevation in HCC. It is therefore suggested that data concerning everyday stressors, such as pain/illness experienced, exercise activity and general life events, are also collected when using HCC as a biological marker to investigate the demands of managing behaviours that challenge and occupational stress. This would help to provide an indication of the extent to which work related stress and everyday stressors contribute to levels of HCC observed over a given period of time.

However, the primary aim of this study was to demonstrate the extent to which professionals, who provide care for people who exhibit behaviours that challenge, experience biological stress. Encountering incidences of behaviours that challenge has been acknowledged as a common occupational demand and work related stressor for professional carers of people with dementia. Thus, the current study consisted of recruiting relevant participants in order to investigate how the occupational demand of providing care for people who exhibit behaviours that challenge could elicit chronic activation of biological stress responses. Analysis of HCC has also been posited as a gold standard to retrospectively measure chronic stress, or cortisol activity, up to 3 months prior to the collection of hair samples (Russell, Koren, Rieder & Van Uum, 2012). Through recruiting an appropriate participant group and using a gold standard biological marker for chronic stress, the current study has provided some indication that professionals, who provide direct care for people who exhibit behaviours that

challenge, may be vulnerable to the negative consequences of prolonged occupational stress. In the context of the current thesis, this provides further demonstration that health and social care professionals, who are required to manage incidences of behaviours that challenge, require regular access to bespoke protective factors as a means to negate chronic stress and ensure the wellbeing of frontline staff.

6.4.2 Conclusion

In summary, the current study aimed to ascertain if higher levels of HCC would be observed in professional dementia carers than vocations that also involve work related stressors. Higher levels of HCC were observed in professional dementia carers than professionals working within university settings and undergraduate students who were studying at Higher Education institutions. The implications of this finding are that professional dementia carers may be prone to experiencing physical ailments and impaired cognition as caused by the repeat activation of biological stress responses. However, there was no observed differences in levels of perceived stress between professional dementia carers, University staff members and undergraduate students. It is suggested that further research identifies and investigates the effectiveness of potential protective factors in reducing HCC levels and negating the onset of chronic stress.

Chapter 7: General Discussion of Project Findings

The final chapter will summarise the PhD thesis concerning the development of a theoretical framework to illustrate the conditions under which health/social care professionals may experience stress when providing care for people who exhibit behaviours that challenge. Details of how this thesis has provided novel contributions to the literature will be provided, along with suggestions for future studies as informed by the current research programme. A general evaluation of this thesis will also be provided before drawing conclusions as to how Therapeutic Engagement Stress Theory (TEST) could be utilised in applied settings in order to identify bespoke causes for and protective factors against work related stress for health/social care professionals who manage behaviours that challenge.

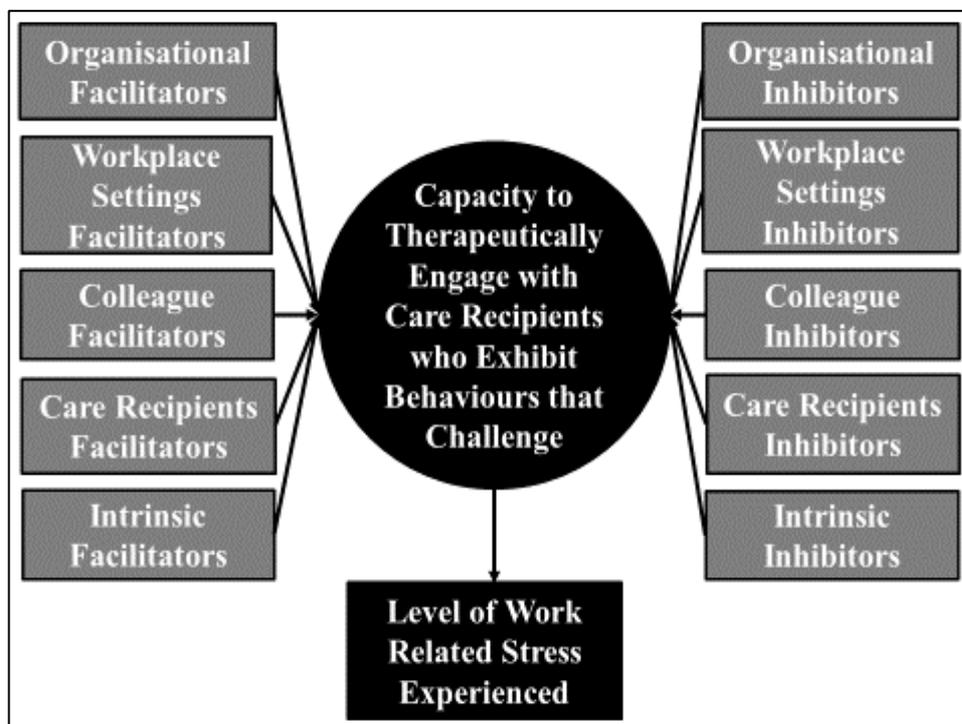
7.1 Recap of the project aims

The aim for this thesis was to develop a theoretical framework that was relevant in explaining and underpinning research relevant to work related stress in health/social care professionals who manage behaviours that challenge. A sequential exploratory mixed methods research design was utilised to facilitate theory development. A Grounded Theory study was conducted as a means to achieve the initial objective of

developing a theoretical framework. The subsequent step of this mixed methods research programme involved conducting quantitative studies in order to add further rigour to the process of theory development. This was to ascertain if the TEST model could be utilised to demonstrate causes of and protective factors against stress when using quantitative methods. The research programme then went on to demonstrate the levels of biological stress that health/social care professionals may experience as a result of providing care for people who exhibit behaviours that challenge.

7.2 Summary of findings

Chapter 1 of this thesis reported a Grounded Theory study which consisted of conducting a series of focus groups and 1:1 semi-structured interviews with health/social care professionals who worked across various specialisms and who also encountered incidences of behaviours that challenge in their role. This led to the development of Therapeutic Engagement Stress Theory (TEST).



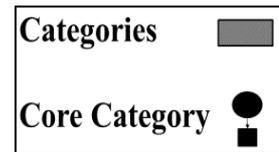


Figure 7.1. Illustration of Therapeutic Engagement Stress Theory.

TEST posits that the extent to which health/social care professionals are able to engage therapeutically with care recipients who exhibit behaviours that challenge can determine the levels of work related stress experienced by frontline staff. TEST also illustrates that an interplay between organisational factors (section 1.6), work place settings (section 1.7), colleagues (section 1.8), interactions with care recipients (section 1.9) and qualities intrinsic to health/social care professionals (section 1.10) may serve to influence the capacity for frontline staff to engage therapeutically with people who exhibit behaviours that challenge. Thus, this thesis has provided a novel framework that provides specific explanations of how stress levels can be determined by perceived capacity to therapeutically engage with care recipients who exhibit behaviours that challenge.

Subsequent chapters went on to ascertain if the relationships between the categories and core category within the TEST model could also be demonstrated when using appropriate quantitative methods. Chapters 3 and 4 consisted of investigating particular components of the TEST model within a cohort of mental healthcare professionals who had experience of providing care to people who exhibit behaviours that challenge. It was observed that higher capacity to therapeutically engage with people who exhibit behaviours that challenge is related to lower levels of perceived stress. This demonstrated some support for the core category within the TEST model in providing an explanation as to why stress may occur within frontline staff when providing care for people who have unhelpful behavioural symptoms.



Figure 7.2. Higher capacity to therapeutically engage with patients, who exhibit behaviours that challenge, was shown to correlate with lower levels of perceived stress within mental healthcare professionals.

It was also an aim to ascertain how qualities intrinsic to health/social care professionals may influence the capacity to engage with patients and levels of stress within mental healthcare staff, which consisted of investigating the specific intrinsic process of the propensity to have repetitive negative thoughts on incidences of behaviours that challenge (section 1.10.3). It was observed that greater propensity to have repetitive negative thoughts regarding challenging incidences are related to lower capacity to engage with patients who exhibit behaviours that challenge and higher stress. This demonstrated that health/social care professionals require access to protective factors, following incidences of behaviours that challenge, which may be conducive in

negating unhelpful rumination and worrying about interactions with patients.

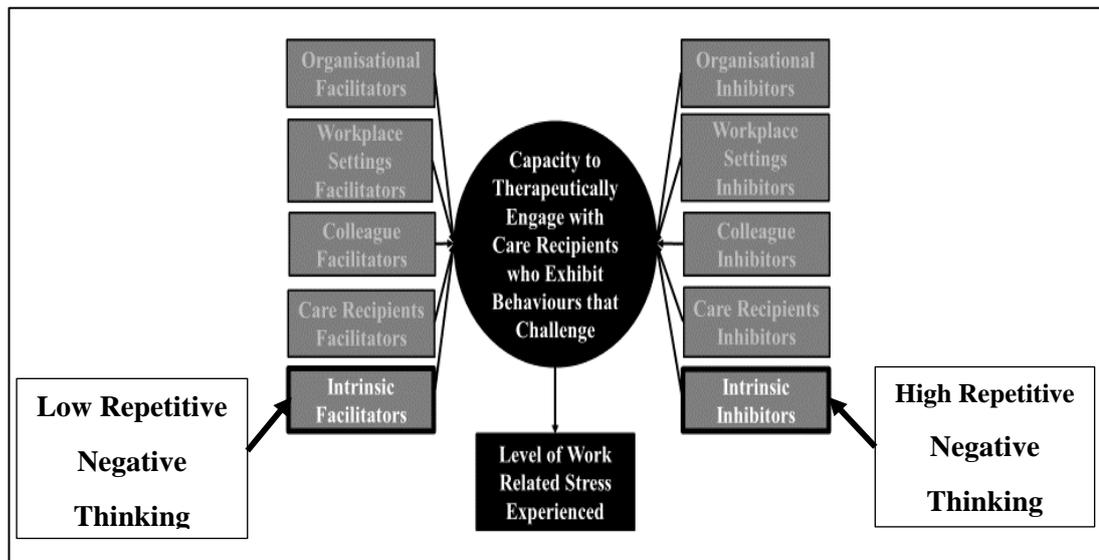


Figure 7.3. The propensity to have repetitive negative thoughts illustrated how factors that are intrinsic to mental healthcare professionals may influence their capacity to engage therapeutically with patients and work related stress.

Chapters 3 and 4 also demonstrated how care recipients could serve to influence levels of work related stress within mental healthcare professionals. It was observed that higher levels of perceived conflict with patients who exhibit behaviours that challenge was related to greater levels of work related stress. Mental healthcare professionals working within inpatient settings also reported higher levels of professional closeness towards patients who exhibit behaviours that challenge, which was related to lower stress than members of staff who worked within community services. This suggested that the perceived quality of interactions with patients could influence levels of stress experienced by frontline staff. However, this study also demonstrated a need to develop quantitative measures that can quantify the perceived quality of interactions with patients and capacity to therapeutically engage with care recipients, who exhibit behaviours that challenge, as completely separate constructs as illustrated within the TEST model. The findings, as reported in chapter 4, also demonstrated that working

within inpatient settings may serve to reduce the stress that can occur when managing incidences of behaviours that challenge than when required to do so within community settings. This further demonstrated how the work place settings may influence the ability to successfully deliver therapeutic interventions and stress levels within frontline health/social care staff.

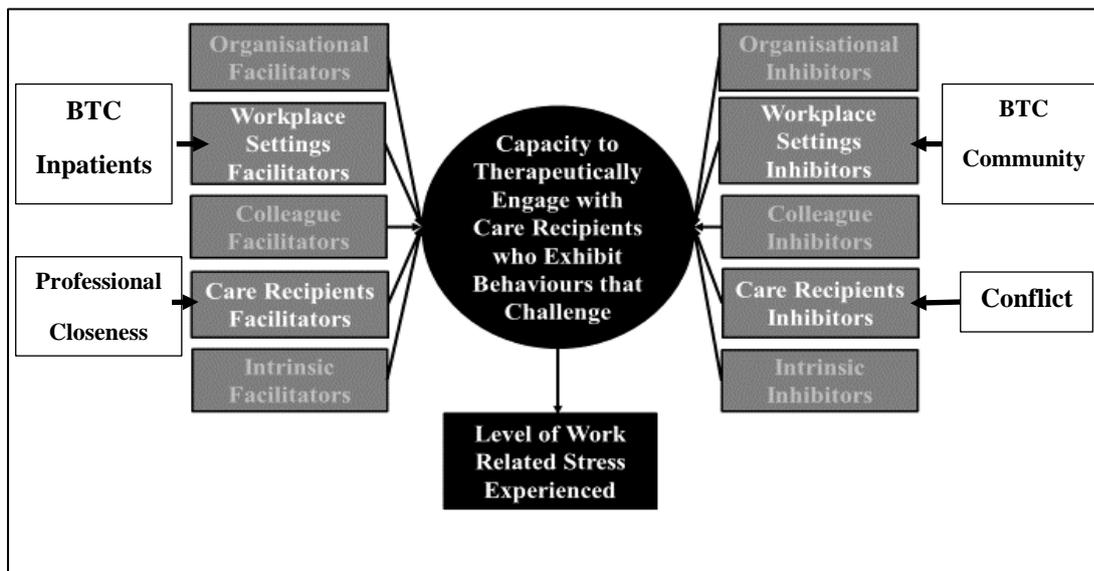


Figure 7.4. **BTC denotes Behaviours that Challenge.** Chapters 3 and 4 demonstrated how Workplace Settings and Care Recipients can influence the core category within the TEST model.

Chapter 5 investigated how organisational factors and colleagues could influence the capacity to engage with residents and stress levels in professional dementia carers. Firstly, the negative correlation between capacity to engage with care recipients and work related stress, as observed in mental healthcare professionals, was replicated in

professional dementia carers, providing further support for the core category in the TEST model. It was also observed that the capacity to engage with residents, fully mediated the positive correlation between the fear of being negatively evaluated by colleagues and work related stress. This suggested that interventions that were conducive in facilitating frontline staff in their interactions with care recipients, who exhibit behaviours that challenge, may also be effective in reducing notions of being negatively evaluated in the workplace and offsetting stress.

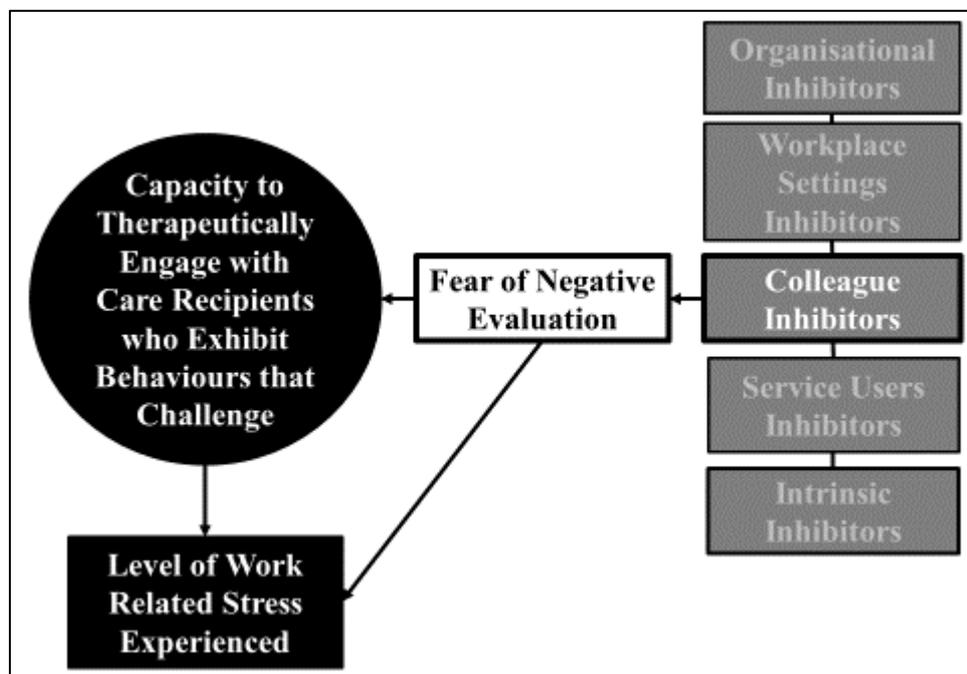


Figure 7.5. The capacity to engage with residents who exhibit behaviours that challenge was shown to fully mediate the relationship between fear of being negatively evaluated by colleagues and work related stress.

Chapter 5 also demonstrated how higher levels of perceived organisational support are related to lower work related stress within professional dementia carers. However, no relationship was observed between perceived organisational support and the capacity to therapeutically engage with care recipients who exhibit behaviours that challenge.

Chapter 6 to illustrate the extent to which professional dementia carers experience chronic biological stress. This was investigated through the collection and analysis of hair cortisol concentration levels, which has been recognised as a retrospective biological marker of chronic stress (Russell, Koren, Rieder & Van Uum, 2011). Significantly higher levels of hair cortisol concentration levels were observed within professional dementia carers in comparison to employees who worked within University settings and students studying at undergraduate level. However, no significant differences in perceived levels of stress were observed between the professional dementia carers, University staff members and undergraduate student. This demonstrated that caring for people who exhibit behaviours that challenge is a vocation that requires regular access to occupational supports and protective factors, which are conducive in negating chronic stress, as a means to ensure employee welfare.

7.3 Original contribution to knowledge

The current thesis has provided a novel theory that provides propositions and explanations for work related stress that are specific to professions that involve the provision of direct health or social care to people who exhibit behaviours that challenge. As illustrated in section 1.3, there are existing work stress theories, however, none of these were developed specifically to explain work related stress within health/social care settings and the management of behaviours that challenge. The Transactional Model of Stress and Coping (Lazarus and Folkman, 1984) posits that the appraisal of and the availability of resources to cope with particular stressors can determine levels of stress experienced. The TEST model illustrates a specific work related factor that could determine the levels of work related stress experience experienced by frontline staff, which is the perceived capacity to therapeutically engage with care recipients who exhibit behaviours that challenge. Thus, the TEST

framework illustrates that having the necessary capacity, or resources, to successfully engage with care recipients who exhibit behaviours that challenge could go help to ameliorate work related stress in frontline staff. The TEST framework also illustrates how organisational factors, environmental settings, colleagues and care recipients can influence the capacity at which frontline staff are able to provide care for people who exhibit behaviours that challenge. It has also been posited that existing work stress theories have tended to emphasise, or explain, the causes of stress as opposed to illustrating protective factors against occupational stressors (Hastings, 2010). The TEST model clearly illustrates that the factors that contribute to work related stress are multifaceted, and have provided propositions as to how stressors, relating to the safe management of behaviours that challenge, could be negated. The core category within TEST posits that the extent at which health/social care professionals are able to successfully deliver therapeutic interventions to care recipients, who exhibit behaviours that challenge, can determine the levels of work related stress experienced. Thus, health and social care professionals who perceive that their capacity to engage with service care recipients is inhibited by work related factors could be prone to experiencing work related stress. However, health/social care professionals who perceive that their delivery of therapeutic interventions are facilitated by work related factors, may have sufficient mechanisms in their occupation to offset stress when providing care for people who exhibit behaviours that challenge. The TEST model illustrates that the causes of and protective factors against stress can be idiosyncratic to each individual health/social care professional who is required to manage behaviours that challenge. Thus, not one single mechanism/process can explain work related stress within health/social care professionals as posited by existing theories such as The Person-Environment Fit model (French & Kahn, 1962), the Demand-

Control-Support model (Karasek & Theorell, 1990), the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984), and Equity Theory (Adams, 1965). Thus, the TEST framework could be applied within practical settings as a means to identify idiosyncratic stressors, which inhibit the professional practices of frontline staff, and implement bespoke strategies to support health/social care professionals to engage with care recipients and offset stress. For instance, application of the TEST model could identify specific factors, such as rumination on interactions with care recipients who exhibit behaviours that challenge. Identification of specific stressors could then inform the development of bespoke strategies, such as the provision of focussed post-incident debriefing, which would be useful in negating stressors that are idiosyncratic each individual frontline member of staff. Identification of bespoke stressors would also enable frontline staff to indicate to their supervisors/Occupational Health services the necessary support required to increase perceived capacity to therapeutically engage with people who exhibit behaviours that challenge. Thus, the TEST framework provides a novel formulation tool to identify specific factors that inhibit staff to engage with care recipients who exhibit behaviours that challenge, as a means to inform implementation of bespoke strategies that meet the idiosyncratic needs of health/social care professionals.

This programme of research has also utilised innovative methods of assessing the vulnerability for health/social care professionals, who manage behaviours that challenge, to experience chronic stress through analysis of hair cortisol concentration levels. Given that professional dementia carers were observed to have higher levels of hair cortisol concentration, when compared to other vocations that could be construed as being stressful, this has further demonstrated the essential requirement for the TEST model to be applied in health/social care settings as an occupation health tool. The

purpose of Occupational Health Services (OHS), within healthcare organisations such as the National Health Service, are to provide opportunities for employees to access appropriate support or services to ensure the physical and mental wellbeing of staff (NHS Staff Council, 2013). Supervisors, or managers, have also been recognised as having a key role in identifying the occupational health needs of frontline staff and ensuring the appropriate support mechanisms are in place to ensure the wellbeing of employees (Gilbreath & Benson, 2004). Occupational support that addresses the idiosyncratic needs of frontline healthcare staff who present as or disclose to be experiencing work related stress, have shown to be most effective in reducing stressors within caring professions (Weinberg & Creed, 2000). Thus, the TEST model could be applied by such professionals as OHS staff or supervisors to identify how organisational factors, work place, colleagues, care recipients or intrinsic factors specifically inhibit the delivery of therapeutic interventions for members of staff who present as experiencing work related stress. Identifying the specific work related stressors that inhibit the delivery of therapeutic interventions could be conducive in enabling the development and implementation of bespoke support strategies to facilitate frontline staff to successfully engage with service users and negate occupational stress.

7.4 Limitations and future directions

Some of the strengths and limitations of the studies, incorporated in this thesis, have been addressed within sections 1.11, 3.7.3, 4.5, 5.6.2 and 6.4.1. However, some general limitations within this thesis also require some discussion, along with indications of how future directions for this research programme will aim to address the highlighted issues. Firstly, Classic Grounded Theory studies tend to steer researchers away from conducting extensive literature reviews as means to ensure that

any theories derived are informed by the dataset or experiences of the participants concerned (Glaser & Strauss, 1967). Therefore, it could be argued that without conducting an initial literature review on work related stress and the management of behaviours that challenge, that it is difficult to ascertain any gaps in knowledge concerning this field of interest. However, a review conducted by Devereux, Hastings and Noone (2009), suggested that existing theories, such as the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984) and Equity Theory (Adams, 1965) offer different explanations as to how stress can manifest in frontline staff in Intellectual Disability services. Hastings (2010) also posed that there is a need for research to provide more theoretical explanations as to the conditions under which stress may occur in frontline staff working in Intellectual Disability services. This demonstrated a need to firstly develop a theoretical framework that was specific to explaining work related stress when providing care for people who exhibit behaviours that challenge. Secondly, the TEST model which has been developed in this thesis, has been shown that it provides appropriate theoretical underpinnings for quantitative research relevant to work related stress and management of behaviours that challenge, as demonstrated in Chapters, 3, 4 and 5. Thus, the current thesis has addressed issues raised by experts in the field of carer stress (Devereux, Hastings and Noone, 2009; Hastings, 2010), through developing a theoretical framework that could underpin research and practice in multiple settings where frontline staff are required to provide services for people who exhibit behaviours that challenge. Glaser and Strauss (1967) posited that multiple theories, each providing nuanced explanations, can serve to gain a greater understanding of a particular social phenomenon. The TEST model adds to the existing work stress theories and provides a nuanced detail in that perceived capacity to therapeutically engage with care recipients who exhibit behaviours that

challenge can also determine levels of stress experienced by frontline staff concerned. Despite not completing an extensive review of studies at the initial stage of this program, the Grounded Theory study yielded a novel theoretical framework that can direct future research in the field of interest and improvements in the practice of screening for stress in frontline staff who manage behaviours that challenge.

The Grounded Theory study also involved 1:1 semi structured interviews with health/social care professionals who worked within Autism, Dementia Care, Drug & Alcohol, Learning Disabilities and Mental Healthcare services. It must be acknowledged that health/social care professionals who work within other healthcare settings, such as Accident and Emergency services, can also encounter the demands of providing care for people who have unhelpful behavioural symptoms (Sowney & Barr, 2006). It could be argued that the data set yielded in the Grounded Theory study may have differed had interviews been conducted with health/social care professionals who worked within other services, such as Accident and Emergency departments. However, it is recommended that data collection ceases once the researcher has achieved theoretical saturation (Glaser & Strauss, 1967), which is the process by which the data derived from interviews/focus groups no longer elicits new concepts. The reason why I did not collect further qualitative data from other health/social care professionals was because no further information, conducive to expanding TEST, was emerging during the 1:1 semi-structured interviews with the theoretical sample (section 1.4.2.2). However, chapters, 3, 4 and 5 have demonstrated that the TEST framework can be investigated using quantitative research methods. Thus, it is recommended that quantitative methods, which can be less time consuming than qualitative research (Carr, 1994), are used to investigate the TEST in health/social care settings that were not explored in the Grounded Theory study. This would help to

ascertain if TEST can be applied to identify causes of and protective factors against stress within professionals who work within general hospital settings but may also be required to provide care for people who exhibit behaviours that challenge.

A further limitation to the current programme was that the quantitative studies employed pre-existing self-report measures. Thus, the measures used were not developed to specifically quantify the categories and core category of the TEST model. For example, a modified version of the Student-Teacher Relationship Scale (STRS; Pianta, 2001) and the Perceived Stress Scale (PSS; Cohen, Kamarck & Mermelstein, 1983) was used to assess the core category. The modified version was also not formally piloted to ensure that it was an appropriate measure to ascertain perceived capacity to therapeutically engage with care recipients who exhibit behaviours that challenge. However, prior to commencing with data collection for the quantitative studies reported in this thesis, I did engage in informal discussions with experts in the field which determined that the modified version of the STRS (Pianta, 2001) was appropriate in the empirical investigation of the core category in the TEST framework.

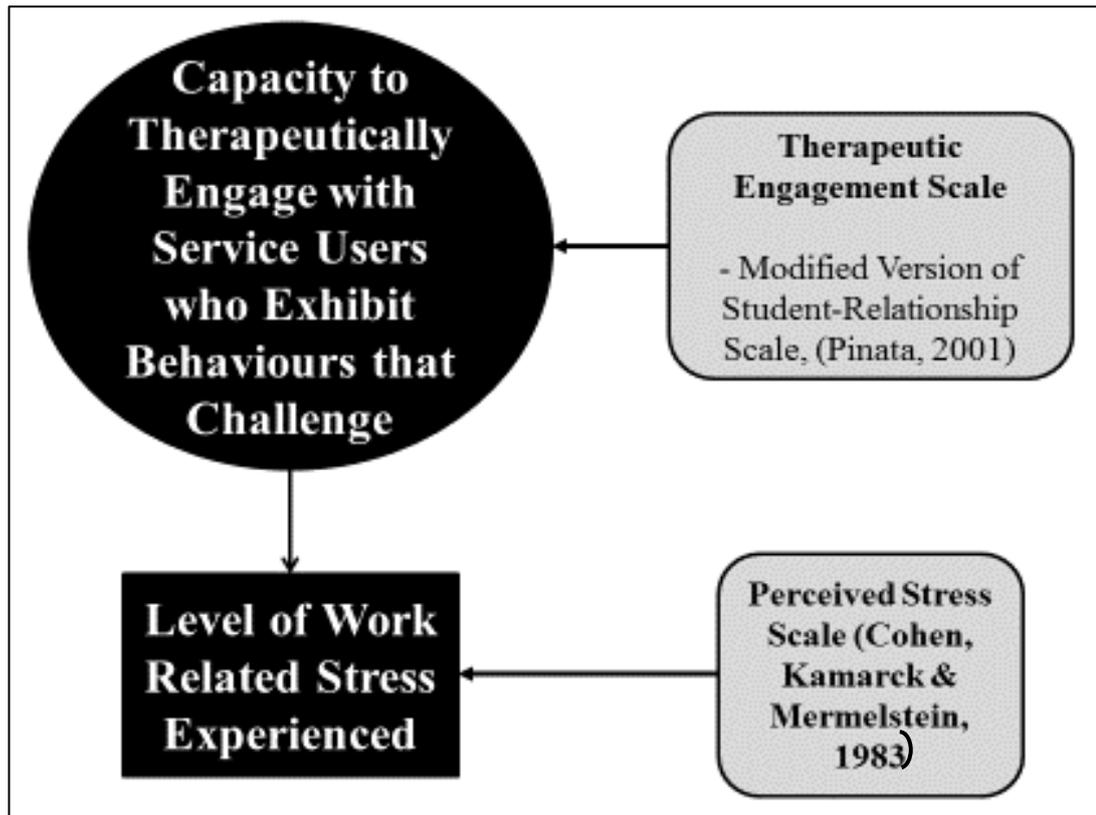


Figure 7.6. Measures used to tap into the core category of the TEST model.

Also, although participants were asked to consider the items on the PSS in the context of their occupation, none of the questions presented on the PSS are specific to the stress that can coincide with the management of behaviours that challenge. For example, item 1 on the PSS reads as ‘In the last month, how often have you been upset because of something that happened unexpectedly?’ A more appropriate question in assessing the core category of the TEST model could be, ‘In the last month, how often have you been upset because of a care recipient who has unexpectedly exhibited a behaviour that challenges you?’ Thus, it could be argued that some of the questions, as presented on the measures used in the current thesis, were not explicitly linked to the corresponding category or core category within the TEST model.

Chapter 5 potentially demonstrated some of the implications for using pre-existing measures as a means to investigate and quantify the individual categories/core

category within the TEST model. No significant correlation was observed between scores obtained on the modified version of the STRS and the Perceived Organisation Support Scale (POSS; Eisenberger, Huntington, Hutchison & Sowa, 1986). This, again, may have been due to the items on the POSS not being explicitly relevant to how organisational support influences the specific demand of providing care for people who exhibit behaviours that challenge (as discussed in section 5.6.2). Following on from this thesis, the next part of this research programme will consist of conducting studies, using Factor Analysis statistical methods, to develop measures that specifically assess each category and core category within the TEST model.

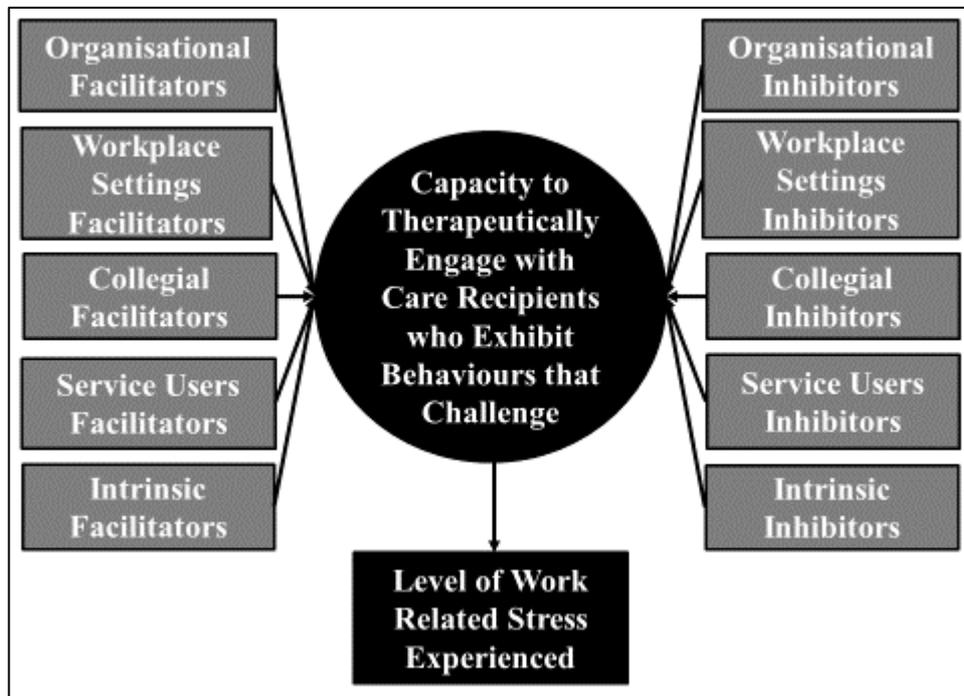


Figure 7.7. The next stage of the research programme, as informed by this thesis, will be to develop measures, which consists of items that are specific to tapping into each category and core category in the TEST model.

The quantitative studies within this thesis have also only investigated work related stressors through the collection of a subjective measure (PSS; Cohen, Karmarck &

Mermelstein, 1983), and Hair Cortisol Concentration, which is a biological marker for chronic stress (Russell, Koren, Rieder & Van Uum, 2011). Thus, the influence of acute stressors, upon the capacity to engage therapeutically with care recipients who exhibit behaviours that challenge and on work related stress, has not been investigated in the current thesis. The Grounded Theory study has provided illustrations of acute stressors, such as encountering incidences of behaviours that challenge (sections 1.9.1, 1.9.2 and 1.9.3), colleagues who exhibit unhelpful emotions in the workplace (section 1.8.6) and being challenged by members of the public in the community (section 1.7.6). Acute stress can stimulate the Sympathetic Adrenal Medullary (SAM) axis, which is responsible for activating the sympathetic nervous system, enhancing cognitive functioning and skeletal muscle blood flow as a means to cope with the demands presented by perceived stressors (Piazza, Almeida, Dmitrieva & Klien, 2010). Salivary Alpha-Amylase has been identified as a biological marker for SAM axis activity and acute stress responses (Rohleder, Nater, Wolf, Ehlert & Kirschbaum, 2004). Thus, it would be useful to conduct further studies to ascertain how acute stressors may also impact the capacity to therapeutically engage with care recipients, who exhibit behaviours that challenge and general levels of work related stress. This could be achieved through collection of self-reported measures that tap into the core category of the TEST model, and the analysis of saliva samples to ascertain levels of alpha-amylase as an indicator of acute stress. However, careful ethical considerations would need to be exercised when developing studies that concern the impact of acute stress on the professional practices of health/social care professionals.

7.5 Conclusions

In conclusion, this thesis has added knowledge to the field of research concerning work related stress in professionals who provide direct health and social care services

to people who exhibit behaviours that challenge. The most prominent outcomes of the current thesis are as follows:

- 1) The development of the Therapeutic Engagement Stress Theory (TEST) model. The TEST model illustrates how organisational factors, work place settings, colleagues care recipients and the intrinsic qualities of frontline staff can influence the capacity to therapeutically engage with care recipients and work related stress. The TEST model provides a theoretical framework that can be used to underpin research in caring groups and can be used to understand work related stress within practical health/social care settings.
- 2) Using pre-existing subjective measures, it has been identified that the TEST model can be used to identify the causes of and protective factors against work related stress within health/social care professional who manage behaviours that challenge. However, there is a need to develop a battery of self-reported measures that specifically assesses each category and the core category within the TEST model.
- 3) The collection and analysis of hair cortisol concentration has revealed that people working in occupations which involve providing health/social care for people who exhibit behaviours that challenge, may be particularly vulnerable to chronic work related stress.

This thesis has informed strategies to develop the TEST model further so that it can be can be applied in practical settings as a tool to ascertain bespoke techniques that facilitate the professional practices of frontline health/social care staff, who manage behaviours that challenge, as a means to reduce or negate work related stress. This thesis has also demonstrated, within chapters 3,4 and 5, that the TEST model can also be used as theoretical framework to

investigate the causes of and protective factors against stress in professionals who provide direct health and social care to people who exhibit behaviours that challenge.

References

- Abel, M. H. (2002). Humour, stress, and coping strategies. *Humour–International Journal of Humour Research*, 15(4), 365-381.
- Adams, J. S. (1965). Inequity in social exchange. *Advances in experimental social psychology*, 2, 267-299.
- Alderwick, H., Dunn, P., McKenna, H., Walsh, N., & Ham, C. (2016). *Sustainability and transformation plans in the NHS*. London:King's Fund.
- Andrews, G. J. (2006). Managing challenging behaviour in dementia: a person centred approach may reduce the use of physical and chemical restraints. *BMJ: British Medical Journal*, 332(7544), 741.
- Andrews, B., & Wilding, J. M. (2004). The relation of depression and anxiety to life-stress and achievement in students. *British Journal of Psychology*, 95(4), 509-521.
- Azeem, M. W., Aujla, A., Rammerth, M., Binsfeld, G., & Jones, R. B. (2011). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing*, 24(1), 11-15.
- Baghdadli, A., Pascal, C., Grisi, S., & Aussilloux, C. (2003). Risk factors for self-injurious behaviours among 222 young children with autistic disorders. *Journal of Intellectual Disability Research*, 47(8), 622-627.
- Baikie, E. (2002). The impact of dementia on marital relationships. *Sexual and Relationship Therapy*, 17(3), 289-299.

- Banerjee, S. (2009). *The use of antipsychotic medication for people with dementia: time for action. A report for the Minister of State for Care Services*. London:Department of Health.
- Bang, J., Spina, S., & Miller, B. L. (2015). Frontotemporal dementia. *The Lancet*, 386(10004), 1672-1682.
- Barnhart, W. J., Makela, E. H., & Latocha, M. J. (2004). SSRI-induced apathy syndrome: a clinical review. *Journal of Psychiatric Practice*, 10(3), 196-199.
- Bartram, T., Joiner, T. A., & Stanton, P. (2004). Factors affecting the job stress and job satisfaction of Australian nurses: implications for recruitment and retention. *Contemporary nurse*, 17(3), 293-304.
- Beach, M. C., Saha, S., & Cooper, L. A. (2006). *The role and relationship of cultural competence and patient-centeredness in health care quality (Vol. 36)*. New York: Commonwealth Fund.
- Beauchamp, T. L., & Childress, J. F. (2001). *Principles of biomedical ethics*. Oxford University Press:USA.
- Bigwood, S., & Crowe, M. (2008). 'It's part of the job, but it spoils the job': A phenomenological study of physical restraint. *International journal of mental health nursing*, 17(3), 215-222.
- Bilszta, J., Ericksen, J., Buist, A., & Milgrom, J. (2010). Women's experience of postnatal depression-beliefs and attitudes as barriers to care. *Australian Journal of Advanced Nursing*, 27(3), 44-55.
- Bloom, S. L., & Sreedhar, S. Y. (2008). The sanctuary model of trauma-informed organizational change. *Reclaiming children and youth*, 17(3), 48-53.

- Bolton, C., Calam, R., Barrowclough, C., Peters, S., Roberts, J., Wearden, A., & Morris, J. (2003). Expressed emotion, attributions and depression in mothers of children with problem behaviour. *Journal of Child Psychology and Psychiatry*, *44*(2), 242-254.
- Bonner, G., Lowe, T., Rawcliffe, D., & Wellman, N. (2002). Trauma for all: a pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. *Journal of Psychiatric and Mental Health Nursing*, *9*(4), 465-473.
- Bosch, J. A., De Geus, E. J., Carroll, D., Goedhart, A. D., Anane, L. A., van Zanten, J. J. V., Helmerhorst, E.J., & Edwards, K. M. (2009). A general enhancement of autonomic and cortisol responses during social evaluative threat. *Psychosomatic medicine*, *71*(8), 877.
- Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. *Journal of psychiatric and mental health nursing*, *21*(6), 499-508.
- Bowlby, J. (1951). *Maternal care and mental health (Vol. 2)*. Geneva: World Health Organization.
- Brosschot, J. F., Gerin, W., & Thayer, J. F. (2006). The perseverative cognition hypothesis: A review of worry, prolonged stress-related physiological activation, and health. *Journal of psychosomatic research*, *60*(2), 113-124.
- Breckenridge, J., & Jones, D. (2009). Demystifying theoretical sampling in grounded theory research. *Grounded Theory Review*, *8*(2). 113 – 126.
- British Industrial Society. (2001). *Managing Best Practice, Occupational Stress*. London:British Industrial Society.

- Burns, J. M. (1978). *Leadership*. New York: Harper & Row.
- Cardoso, C., Ellenbogen, M. A., Orlando, M. A., Bacon, S. L., & Jooper, R. (2013). Intranasal oxytocin attenuates the cortisol response to physical stress: a dose–response study. *Psychoneuroendocrinology*, *38*(3), 399-407.
- Care Quality Commission. (2017). *The state of care in mental health services 2014 to 2017*. Newcastle Upon Tyne:Care Quality Commission.
- Carr, L. T. (1994). The strengths and weaknesses of quantitative and qualitative research: what method for nursing?. *Journal of advanced nursing*, *20*(4), 716-721.
- Castille, K., Prout, M., Marczyk, G., & Shmidheiser, M. (2007). The early maladaptive schemas of self-mutilators: Implications for therapy. *Journal of Cognitive Psychotherapy*, *21*(1), 58.
- Castro, F. G., Kellison, J. G., Boyd, S. J., & Kopak, A. (2010). A methodology for conducting integrative mixed methods research and data analyses. *Journal of mixed methods research*, *4*(4), 342-360.
- Chiang, Y. M., & Chang, Y. (2012). Stress, depression, and intention to leave among nurses in different medical units: Implications for healthcare management/nursing practice. *Health Policy*, *108*(2-3), 149-157.
- Coffey, M., & Coleman, M. (2001). The relationship between support and stress in forensic community mental health nursing. *Journal of advanced nursing*, *34*(3), 397-407.
- Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress. *Journal of health and social behavior*, *24*(4), 385-396.

- Cohen-Mansfield, J. (2000). Theoretical Frameworks for Behavioral Problems in Dementia. *Alzheimer's Care Today*, 1(4), 8 – 21.
- Cohen-Mansfield, J., Dakheel-Ali, M., Marx, M. S., Thein, K., & Regier, N. G. (2015). Which unmet needs contribute to behavior problems in persons with advanced dementia?. *Psychiatry research*, 228(1), 59-64.
- Collins, A. (2014). Measuring what really matters. *Towards a coherent measurement system to support personcentred care*. London: The Health Foundation.
- Cook, R. D. (1979). Influential observations in linear regression. *Journal of the American Statistical Association*, 74(365), 169-174.
- Coomber, B., & Barriball, K. L. (2007). Impact of job satisfaction components on intent to leave and turnover for hospital-based nurses: a review of the research literature. *International journal of nursing studies*, 44(2), 297-314.
- Coulter, A., Roberts, S., & Dixon, A. (2013). *Delivering better services for people with long-term conditions. Building the house of care*. London: The King's Fund.
- Coyne, I. T. (1997). Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries?. *Journal of advanced nursing*, 26(3), 623-630.
- Cullen, B., Coen, R. F., Lynch, C. A., Cunningham, C. J., Coakley, D., Robertson, I. H., & Lawlor, B. A. (2005). Repetitive behaviour in Alzheimer's disease: description, correlates and functions. *International Journal of Geriatric Psychiatry*, 20(7), 686-693.

- Cunningham, C. E., Woodward, C. A., Shannon, H. S., MacIntosh, J., Lendrum, B., Rosenbloom, D., & Brown, J. (2002). Readiness for organizational change: A longitudinal study of workplace, psychological and behavioural correlates. *Journal of Occupational and Organizational psychology*, 75(4), 377-392.
- Cunningham, F. C., Ranmuthugala, G., Plumb, J., Georgiou, A., Westbrook, J. I., & Braithwaite, J. (2012). Health professional networks as a vector for improving healthcare quality and safety: a systematic review. *BMJ Quality & Safety*, 21(3), 239-249.
- Dale, K., & Fox, M. L. (2008). Leadership style and organizational commitment: Mediating effect of role stress. *Journal of Managerial Issues*, 20(1), 109-130.
- D'Amour, D., Goulet, L., Labadie, J. F., San Martín-Rodríguez, L., & Pineault, R. (2008). A model and typology of collaboration between professionals in healthcare organizations. *BMC health services research*, 8 (1), 188.
- Deacon, B., & Olatunji, B. O. (2007). Specificity of disgust sensitivity in the prediction of behavioral avoidance in contamination fear. *Behaviour research and therapy*, 45(9), 2110-2120.
- De Dreu, C. K., Van Dierendonck, D., & Dijkstra, M. T. (2004). Conflict at work and individual well-being. *International journal of conflict management*, 15(1), 6-26.
- De Schipper, J. C., & Schuengel, C. (2010). Attachment behaviour towards support staff in young people with intellectual disabilities: associations with challenging behaviour. *Journal of Intellectual Disability Research*, 54(7), 584-596.

- Department of Health (2005). *Mental Capacity Act*. London:HMSO.
- Department of Health (2012). *Health and Social Care Act*. London:HMSO.
- Denzin, N.K. (1978). *The Research Act: A Theoretical Introduction to Sociological Methods*. New York: McGraw-Hill.
- Devereux, J., Hastings, R., & Noone, S. (2009). Staff stress and burnout in intellectual disability services: Work stress theory and its application. *Journal of Applied Research in Intellectual Disabilities*, 22(6), 561-573.
- Digiuseppe, R., & Tafrate, R. C. (2001). A comprehensive treatment model for anger disorders. *Psychotherapy: Theory, Research, Practice, Training*, 38(3), 262.
- Dinç, L., & Gastmans, C. (2013). Trust in nurse–patient relationships: A literature review. *Nursing Ethics*, 20(5), 501-516.
- Edvardsson, D., Sandman, P. O., Nay, R., & Karlsson, S. (2008). Associations between the working characteristics of nursing staff and the prevalence of behavioral symptoms in people with dementia in residential care. *International Psychogeriatrics*, 20(4), 764-776.
- Edwards, M., & Miller. C. (2003). *Integrating Health and Social Care and Making it Work*. London: OPM.
- Edwards, N. (2014). *Community Services: How they Can Transform Care*. London:King's Fund.
- Eggenberger, E., Heimerl, K., & Bennett, M. I. (2013). Communication skills training in dementia care: a systematic review of effectiveness, training content, and didactic methods in different care settings. *International Psychogeriatrics*, 25(3), 345-358.

- Ehring, T., Zetsche, U., Weidacker, K., Wahl, K., Schönfeld, S., & Ehlers, A. (2011). The Perseverative Thinking Questionnaire (PTQ): Validation of a content-independent measure of repetitive negative thinking. *Journal of behavior therapy and experimental psychiatry*, *42*(2), 225-232.
- Eisenberger, R., Huntington, R., Hutchison, S., & Sowa, D. (1986). Perceived organizational support. *Journal of Applied psychology*, *71*(3), 500.
- Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science*, *196* (4286), 129-136.
- Eriksen, H. R., Ihlebæk, C., & Ursin, H. (1999). A scoring system for subjective health complaints (SHC). *Scandinavian Journal of Social Medicine*, *27*(1), 63-72.
- Evers, W., Tomic, W., & Brouwers, A. (2002). Aggressive behaviour and burnout among staff of homes for the elderly. *International journal of mental health nursing*, *11*(1), 2-9.
- Ewbank, L., Thompson, J. and McKenna, H. (2017). *NHS Hospital Bed Numbers: Past, Present, Future*. London: The King's Fund.
- Felblinger, D. M. (2008). Incivility and bullying in the workplace and nurses' shame responses. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *37*(2), 234-242.
- Franz, S., Zeh, A., Schablon, A., Kuhnert, S., & Nienhaus, A. (2010). Aggression and violence against health care workers in Germany-a cross sectional retrospective survey. *BMC health services research*, *10*(1), 51.
- French, J. R., & Kahn, R. L. (1962). A programmatic approach to studying the industrial environment and mental health. *Journal of social issues*, *18*(3), 1-47.

- Gabriels, R. L., Cuccaro, M. L., Hill, D. E., Ivers, B. J., & Goldson, E. (2005). Repetitive behaviors in autism: Relationships with associated clinical features. *Research in developmental disabilities, 26*(2), 169-181.
- George, J. M. (1992). Extrinsic and intrinsic origins of perceived social loafing in organizations. *Academy of Management Journal, 35*(1), 191-202.
- Giebels, E., & Janssen, O. (2005). Conflict stress and reduced well-being at work: The buffering effect of third-party help. *European journal of work and organizational psychology, 14*(2), 137-155.
- Gilburt, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC health services research, 8*(1), 92.
- Gilbreath, B., & Benson, P. G. (2004). The contribution of supervisor behaviour to employee psychological well-being. *Work & Stress, 18*(3), 255-266.
- Gillespie, N. A., Walsh, M. H. W. A., Winefield, A. H., Dua, J., & Stough, C. (2001). Occupational stress in universities: Staff perceptions of the causes, consequences and moderators of stress. *Work & stress, 15*(1), 53-72.
- Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory*. Mill Valley, California: Sociology Press.
- Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Mill Valley, California: Sociology Press.
- Glaser, B. G. (2003). *The Grounded Theory Perspective II: Description's remodeling of grounded theory methodology*. Mill Valley, California: Sociology Press.

- Glaser, R., & Kiecolt-Glaser, J. K. (2005). Stress-induced immune dysfunction: implications for health. *Nature Reviews Immunology*, 5(3), 243 - 251.
- Gold, M., Doreian, P., & Taylor, E. F. (2008). Understanding a collaborative effort to reduce racial and ethnic disparities in health care: Contributions from social network analysis. *Social science & medicine*, 67(6), 1018-1027.
- Goñi, S. (1999). An analysis of the effectiveness of Spanish primary health care teams. *Health Policy*, 48(2), 107-117.
- Graham, I. W. (2000). Reflective practice and its role in mental health nurses' practice development: a year-long study. *Journal of Psychiatric and Mental Health Nursing*, 7(2), 109-117.
- Gratz, K. L. (2003). Risk factors for and functions of deliberate self-harm: An empirical and conceptual review. *Clinical Psychology: Science and Practice*, 10(2), 192-205.
- Gruber-Baldini, A. L., Boustani, M., Sloane, P. D., & Zimmerman, S. (2004). Behavioral symptoms in residential care/assisted living facilities: prevalence, risk factors, and medication management. *Journal of the American Geriatrics Society*, 52(10), 1610-1617.
- Haimowitz, S., Urff, J., & Huckshorn, K. A. (2006). *Restraint and seclusion: A risk management guide*. Vancouver:National Association of State Mental Health Program Directors.
- Hall, K., Gibbie, T., & Lubman, D. I. (2012). Motivational interviewing techniques: Facilitating behaviour change in the general practice setting. *Australian family physician*, 41(9), 660-667.

- Hastings, R. P. (2010). Support staff working in intellectual disability services: The importance of relationships and positive experiences. *Journal of Intellectual and Developmental Disability, 35*(3), 207-210.
- Häusser, J. A., Kattenstroth, M., van Dick, R., & Mojzisch, A. (2012). “We” are not stressed: Social identity in groups buffers neuroendocrine stress reactions. *Journal of Experimental Social Psychology, 48*(4), 973-977.
- Hawkins, S., Allen, D., & Jenkins, R. (2005). The use of physical interventions with people with intellectual disabilities and challenging behaviour—the experiences of service users and staff members. *Journal of Applied Research in Intellectual Disabilities, 18*(1), 19-34.
- Hayes, A. (2013). *Introduction to Mediation, Moderation, and Conditional Process Analysis: A Regression-Based Approach*. New York: The Guilford Press
- Head, J., Kivimäki, M., Siegrist, J., Ferrie, J. E., Vahtera, J., Shipley, M. J., & Marmot, M. G. (2007). Effort–reward imbalance and relational injustice at work predict sickness absence: The Whitehall II study. *Journal of psychosomatic research, 63*(4), 433-440.
- Health and Safety Executive. (2016). *Violence at work, 2015/16*. Liverpool:Health and Safety Executive.
- Health and Safety Executive. (2017). *Work-related stress, depression or anxiety statistics in Great Britain 2017*. Liverpool:Health and Safety Executive.
- Herbig, B., Büssing, A., & Ewert, T. (2001). The role of tacit knowledge in the work context of nursing. *Journal of Advanced Nursing, 34*(5), 687-695.

- Ho, S. K. (2017). The relationship between teacher stress and burnout in Hong Kong: positive humour and gender as moderators. *Educational Psychology, 37*(3), 272-286.
- Hooley, J. M., & Gotlib, I. H. (2000). A diathesis-stress conceptualization of expressed emotion and clinical outcome. *Applied and Preventive Psychology, 9*(3), 135-151.
- Huang, S. S., Lee, M. C., Liao, Y. C., Wang, W. F., & Lai, T. J. (2012). Caregiver burden associated with behavioral and psychological symptoms of dementia (BPSD) in Taiwanese elderly. *Archives of gerontology and geriatrics, 55*(1), 55-59.
- Huckshorn, K. A. (2004). Reducing seclusion & restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services, 42*(9), 22-33.
- Humphries, R. (2015). Integrated health and social care in England—progress and prospects. *Health Policy, 119*(7), 856-859.
- Hunt, G., & Arend, A. V. D. (2002). Treatment, custody, support: an exploratory qualitative dialogue to map the ethics of interagency co-operation in hospital emergency departments in the UK and the Netherlands. *Journal of interprofessional care, 16*(3), 211-220.
- Hupcey, J. E., & Miller, J. (2006). Community dwelling adults' perception of interpersonal trust vs. trust in health care providers. *Journal of clinical nursing, 15*(9), 1132-1139.

- Hurley, A. D. (2008). Depression in adults with intellectual disability: symptoms and challenging behaviour. *Journal of Intellectual Disability Research*, 52(11), 905-916.
- Ivankova, N. V., Creswell, J. W., & Stick, S. L. (2006). Using mixed-methods sequential explanatory design: From theory to practice. *Field methods*, 18(1), 3-20.
- Jackson, J. W. (2002). Intergroup attitudes as a function of different dimensions of group identification and perceived intergroup conflict. *Self and identity*, 1(1), 11-33.
- James, I. A. (2011). *Understanding behaviour in dementia that challenges: a guide to assessment and treatment*. London:Jessica Kingsley Publishers.
- Jeffery, D., & Warm, A. (2002). A study of service providers' understanding of self-harm. *Journal of Mental Health*, 11(3), 295-303.
- Jenkins, R., & Elliott, P. (2004). Stressors, burnout and social support: nurses in acute mental health settings. *Journal of advanced nursing*, 48(6), 622-631.
- Jones, P., & Tanay, M. A. (2016). Perceptions of nurses about potential barriers to the use of humour in practice: a literature review of qualitative research. *Contemporary nurse*, 52(1), 106-118.
- Karasek, R., & Theorell, T. (1992). *Healthy work: stress, productivity, and the reconstruction of working life*. New York:Basic books.
- Karlén, J., Ludvigsson, J., Frostell, A., Theodorsson, E., & Faresjö, T. (2011). Cortisol in hair measured in young adults-a biomarker of major life stressors?. *BMC clinical pathology*, 11(1), 12.

- Katz-Navon, T. A. L., Naveh, E., & Stern, Z. (2005). Safety climate in health care organizations: A multidimensional approach. *Academy of Management Journal*, *48*(6), 1075-1089.
- Keating, S. F., Thompson, J. P., & Lee, G. A. (2010). Perceived barriers to the sustainability and progression of nurse practitioners. *International emergency nursing*, *18*(3), 147-153.
- Keatinge, D., Scarfe, C., Bellchambers, H., McGee, J., Oakham, R., Probert, C., & Stokes, J. (2000). The manifestation and nursing management of agitation in institutionalised residents with dementia. *International journal of nursing practice*, *6*(1), 16-25.
- Kertz, S. J., Koran, J., Stevens, K. T., & Björgvinsson, T. (2015). Repetitive negative thinking predicts depression and anxiety symptom improvement during brief cognitive behavioral therapy. *Behaviour Research and Therapy*, *68*, 54-63.
- Kim, E. Y., & Miklowitz, D. J. (2004). Expressed emotion as a predictor of outcome among bipolar patients undergoing family therapy. *Journal of Affective Disorders*, *82*(3), 343-352.
- Kinman, G., & Jones, F. (2008). Effort-reward imbalance, over-commitment and work-life conflict: testing an expanded model. *Journal of Managerial Psychology*, *23*(3), 236-251.
- Kinman, G., & Court, S. (2010). Psychosocial hazards in UK universities: adopting a risk assessment approach. *Higher Education Quarterly*, *64*(4), 413-428.
- Kirschbaum, C., Tietze, A., Skoluda, N., & Dettenborn, L. (2009). Hair as a retrospective calendar of cortisol production—increased cortisol incorporation

into hair in the third trimester of pregnancy. *Psychoneuroendocrinology*, 34(1), 32-37.

Kitwood, T. M. (1997). *Dementia reconsidered: The person comes first*. Open university press:London

Koegel, L. K. E., Koegel, R. L., & Dunlap, G. E. (1996). *Positive behavioral support: Including people with difficult behavior in the community*. Paul H Brookes Publishing:Baltimore.

Koekkoek, B., van Meijel, B., & Hutschemaekers, G. (2006). " Difficult patients" in mental health care: a review. *Psychiatric Services*, 57(6), 795-802.

Kramer, A., Schwebke, I., & Kampf, G. (2006). How long do nosocomial pathogens persist on inanimate surfaces? A systematic review. *BMC infectious diseases*, 6(1), 130.

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (Eds.). (2002). *World report on violence and health*. Geneva: WHO.

Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., & Pilkonis, P. A. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology*, 64(2), 532-539.

Kudielka, B. M., Buske-Kirschbaum, A., Hellhammer, D. H., & Kirschbaum, C. (2004). Differential heart rate reactivity and recovery after psychosocial stress (TSST) in healthy children, younger adults, and elderly adults: the impact of age and gender. *International journal of behavioral medicine*, 11(2), 116-121.

- Lambert, S. D., & Loisel, C. G. (2008). Combining individual interviews and focus groups to enhance data richness. *Journal of advanced nursing*, 62(2), 228-237.
- Laming. (2003). *The Victoria Climbié Inquiry. Report of an Inquiry by Lord Laming (chairman) January 2003*. The Stationery Office: London.
- Lawlor, B. (2002). Managing behavioural and psychological symptoms in dementia. *The British Journal of Psychiatry*, 181(6), 463-465.
- Lazarus, R. S., & Folkman, S. (1984). Coping and adaptation. *The handbook of behavioral medicine*. New York: Guilford.
- Leary, M. R. (1983). A brief version of the Fear of Negative Evaluation Scale. *Personality and Social Psychology Bulletin*, 9(3), 371-375.
- Lee, Y., Lee, M., & Bernstein, K. (2013). Effect of workplace bullying and job stress on turnover intention in hospital nurses. *Journal of Korean Academy of Psychiatric and Mental Health Nursing*, 22(2), 77-87.
- Lequerica, A. H., Donnell, C. S., & Tate, D. G. (2009). Patient engagement in rehabilitation therapy: Physical and occupational therapist impressions. *Disability and rehabilitation*, 31(9), 753-760.
- Lewis, M., Taylor, K., & Parks, J. (2009). Crisis prevention management: a program to reduce the use of seclusion and restraint in an inpatient mental health setting. *Issues in Mental Health Nursing*, 30(3), 159-164.
- Li, I. C., Chen, Y. C., & Kuo, H. T. (2008). The relationship between work empowerment and work stress perceived by nurses at long-term care facilities in Taipei city. *Journal of Clinical Nursing*, 17(22), 3050-3058.

- Liden, R. C., Wayne, S. J., Jaworski, R. A., & Bennett, N. (2004). Social loafing: A field investigation. *Journal of Management*, *30*(2), 285-304.
- Ling, S., Cleverley, K., & Perivolaris, A. (2015). Understanding mental health service user experiences of restraint through debriefing: a qualitative analysis. *The Canadian Journal of Psychiatry*, *60*(9), 386-392.
- Littrell, J. (2009). Expression of emotion: When it causes trauma and when it helps. *Journal of evidence-based social work*, *6*(3), 300-320.
- Litz, B. T. (2008). Early intervention for trauma: Where are we and where do we need to go? A commentary. *Journal of traumatic stress*, *21*(6), 503-506.
- Lovell, B., Moss, M., & Wetherell, M. A. (2011). Perceived stress, common health complaints and diurnal patterns of cortisol secretion in young, otherwise healthy individuals. *Hormones and behavior*, *60*(3), 301-305.
- Lu, W., Mueser, K. T., Shami, A., Siglag, M., Petrides, G., & Schoepp, E. (2011). Posttraumatic reactions to psychosis in people with multiple psychotic episodes. *Schizophrenia Research*, *127*, 66-75.
- Lyubomirsky, S., Sousa, L., & Dickerhoof, R. (2006). The costs and benefits of writing, talking, and thinking about life's triumphs and defeats. *Journal of personality and social psychology*, *90*(4), 692.
- Macaskill, A. (2013). The mental health of university students in the United Kingdom. *British Journal of Guidance & Counselling*, *41*(4), 426-441.
- Mackenzie, C. S., & Peragine, G. (2003). Measuring and enhancing self-efficacy among professional caregivers of individuals with dementia. *American Journal of Alzheimer's Disease & Other Dementias*, *18*(5), 291-299.

- Magnavita, N. (2014). Workplace Violence and Occupational Stress in Healthcare Workers: A Chicken-and-Egg Situation—Results of a 6-Year Follow-up Study. *Journal of nursing scholarship, 46*(5), 366-376.
- Mahmoud, A. H. (2008). A study of nurses' job satisfaction: the relationship to organizational commitment, perceived organizational support, transactional leadership, transformational leadership, and level of education. *European journal of scientific research, 22*(2), 286-295.
- Mangnall, J., & Yurkovich, E. (2008). A literature review of deliberate self-harm. *Perspectives in Psychiatric Care, 44*(3), 175-184.
- Manthorpe, J. (2014). Enjoying the front-line of dementia care: an integrative analysis of what care home staff report makes them happy at work. *Working with Older People, 18*(4), 167-175.
- Martin, J. K., Pescosolido, B. A., & Tuch, S. A. (2000). Of fear and loathing: The role of 'disturbing behavior,' labels, and causal attributions in shaping public attitudes toward people with mental illness. *Journal of health and social behaviour, 41*(2), 208-223.
- Martin, R. A., Puhlik-Doris, P., Larsen, G., Gray, J., & Weir, K. (2003). Individual differences in uses of humor and their relation to psychological well-being: Development of the Humor Styles Questionnaire. *Journal of research in personality, 37*(1), 48-75.
- Matson, J. and Williams, L. (2014). Functional Assessment of Challenging Behavior, *Current Developmental Disorders Reports, 1*(2), 58-66.

- Matson, J. L., & Rivet, T. T. (2008). Characteristics of challenging behaviours in adults with autistic disorder, PDD-NOS, and intellectual disability. *Journal of intellectual and developmental disability, 33*(4), 323-329.
- Maxwell, S. E., & Cole, D. A. (2007). Bias in cross-sectional analyses of longitudinal mediation. *Psychological methods, 12*(1), 23.
- McAllister, M., Creedy, D., Moyle, W., & Farrugia, C. (2002). Nurses' attitudes towards clients who self-harm. *Journal of Advanced Nursing, 40*(5), 578-586.
- McColl-Kennedy, J. R., & Anderson, R. D. (2002). Impact of leadership style and emotions on subordinate performance. *The Leadership Quarterly, 13*(5), 545-559.
- McDonnell, A., Breen, E., Deveau, R., Goulding, E., & Smyth, J. (2014). How nurses and carers can avoid the slippery slope to abuse. *Learning Disability Practice, 17*(5), 36-39.
- McCaughey, D., DelliFraine, J. L., McGhan, G., & Bruning, N. S. (2013). The negative effects of workplace injury and illness on workplace safety climate perceptions and health care worker outcomes. *Safety Science, 51*(1), 138-147.
- McGillivray, J. A., & McCabe, M. P. (2005). The relationship between residence and the pharmacological management of challenging behavior in individuals with intellectual disability. *Journal of Developmental and Physical Disabilities, 17*(4), 311-325.
- McHugh, M. D., Kutney-Lee, A., Cimiotti, J. P., Sloane, D. M., & Aiken, L. H. (2011). Nurses' widespread job dissatisfaction, burnout, and frustration with health benefits signal problems for patient care. *Health Affairs, 30*(2), 202-210.

- McVicar, A. (2003). Workplace stress in nursing: a literature review. *Journal of advanced nursing, 44*(6), 633-642.
- Mendel, P., Damberg, C. L., Sorbero, M. E., Varda, D. M., & Farley, D. O. (2009). The growth of partnerships to support patient safety practice adoption. *Health services research, 44*(2), 717-738.
- Mendes, W. B., Major, B., McCoy, S., & Blascovich, J. (2008). How attributional ambiguity shapes physiological and emotional responses to social rejection and acceptance. *Journal of personality and social psychology, 94*(2), 278-291.
- Michael, T., Halligan, S. L., Clark, D. M., & Ehlers, A. (2007). Rumination in posttraumatic stress disorder. *Depression and anxiety, 24*(5), 307-317.
- Michie, S. (2002). Causes and management of stress at work. *Occupational and environmental medicine, 59*(1), 67-72.
- Mills, S., & Rose, J. (2011). The relationship between challenging behaviour, burnout and cognitive variables in staff working with people who have intellectual disabilities. *Journal of Intellectual Disability Research, 55*(9), 844-857.
- Mitchell, G., & Hastings, R. P. (2001). Coping, burnout, and emotion in staff working in community services for people with challenging behaviors. *American Journal on Mental Retardation, 106*(5), 448-459.
- Miyamoto, Y., Tachimori, H., & Ito, H. (2010). Formal caregiver burden in dementia: impact of behavioral and psychological symptoms of dementia and activities of daily living. *Geriatric Nursing, 31*(4), 246-253.

- Mogg, K., Bradley, B., Miles, F., & Dixon, R. (2004). Brief report time course of attentional bias for threat scenes: testing the vigilance-avoidance hypothesis. *Cognition and emotion*, *18*(5), 689-700.
- Moncrieff, J., Cohen, D., & Mason, J. P. (2009). The subjective experience of taking antipsychotic medication: a content analysis of Internet data. *Acta Psychiatrica Scandinavica*, *120*(2), 102-111.
- Moniz-Cook, E., Stokes, G., & Agar, S. (2003). Difficult behaviour and dementia in nursing homes: five cases of psychosocial intervention. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, *10*(3), 197-208.
- Moran, C. C., & Hughes, L. P. (2006). Coping with stress: Social work students and humour. *Social Work Education*, *25*(5), 501-517.
- National Health Service Staff Council. (2012). *Guidelines on prevention and management of sickness absence*. London: NHS Employers.
- National Health Service Protect. (2013). *Meeting Needs and Reducing Distress Guidance on the prevention and management of clinically related challenging behaviour in NHS settings*. London: NHS Employers.
- National Health Service Protect. (2014). *NHS Lone Worker Protection Service User Guide*. London: NHS Employers.
- National Health Service Protect. (2015). *Lone Working Estate Mapping Exercise*. London: NHS Employers.
- National NHS Staff Survey Co-ordination Centre. (2017). NHS staff survey for England.

- National Institute for Health and Clinical Excellence. (2015). *Violence and aggression: short-term management in mental health, health and community settings 10*, London: NICE.
- Naylor, C., Alderwick, H., & Honeyman, M. (2015). *Acute hospitals and integrated care: From hospitals to health systems*. London: The King's Fund.
- Needham, H., & Sands, N. (2010). Post-Seclusion Debriefing: A Core Nursing Intervention. *Perspectives in Psychiatric Care*. 46 (3), 221-233.
- Neimeyer, R. A., Kazantzis, N., Kassler, D. M., Baker, K. D., & Fletcher, R. (2008). Group cognitive behavioural therapy for depression outcomes predicted by willingness to engage in homework, compliance with homework, and cognitive restructuring skill acquisition. *Cognitive Behaviour Therapy*, 37(4), 199-215.
- Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. *Journal of abnormal psychology*, 100(4), 569.
- Ott, M., & French, R. (2009). Hand hygiene compliance among health care staff and student nurses in a mental health setting. *Issues in mental health nursing*, 30(11), 702-704.
- Pasillas, R. M., Follette, V. M., & Perumean-Chaney, S. E. (2006). Occupational stress and psychological functioning in law enforcement officers. *Journal of Police and Criminal Psychology*, 21(1), 41-53.
- Paterson, B., Bradley, P., Cameron, S., Sadler, D., Leadbetter, D., & Allen, D. (2003). Restraint related deaths in health and social care in the UK: learning the lessons. *Mental Health Practice*. 6(9),10–17.

- Peterson, U., Bergström, G., Samuelsson, M., Åsberg, M., & Nygren, Å. (2008). Reflecting peer-support groups in the prevention of stress and burnout: Randomized controlled trial. *Journal of advanced nursing*, *63*(5), 506-516.
- Pestka, E. L., Hatteberg, D. A., Larson, L. A., Zwycart, A. M., Cox, D. L., & Borgen Jr, E. E. (2012). Enhancing safety in behavioral emergenciesituations. *Medsurg nursing*, *21*(6), 335.
- Pianta, R. C. (2001). STRS Student-Teacher Relationship Scale (professional manual). Florida: Psychological Assessment Resources, Inc.
- Piazza, J. R., Almeida, D. M., Dmitrieva, N. O., & Klein, L. C. (2010). Frontiers in the use of biomarkers of health in research on stress and aging. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *65*(5), 513-525.
- Pulsford, D., Duxbury, J. A., & Hadi, M. (2011). A survey of staff attitudes and responses to people with dementia who are aggressive in residential care settings. *Journal of Psychiatric and Mental Health Nursing*, *18*(2), 97-104.
- Querstret, D., & Cropley, M. (2012). Exploring the relationship between work-related rumination, sleep quality, and work-related fatigue. *Journal of Occupational Health Psychology*, *17*(3), 341-353.
- Raber, J. (1998). Detrimental effects of chronic hypothalamic—pituitary—adrenal axis activation. *Molecular neurobiology*, *18*(1), 1-22.
- Rector, N. A., Beck, A. T., & Stolar, N. (2005). The negative symptoms of schizophrenia: a cognitive perspective. *The Canadian Journal of Psychiatry*, *50*(5), 247-257.

- Robinson, V. (1993). The purpose and function of humour in nursing. *Today's nurse*, 15(6), 7-12.
- Rodney, V. (2000). Nurse stress associated with aggression in people with dementia: its relationship to hardiness, cognitive appraisal and coping. *Journal of Advanced nursing*, 31(1), 172-180.
- Roemer, L., & Borkovec, T. D. (1993). *Worry: Unwanted cognitive activity that controls unwanted somatic experience*. New Jersey: Prentice Hall.
- Rogers, C. R. (1958). The characteristics of a helping relationship. *The Personnel and Guidance Journal*, 37(1), 6-16.
- Rohleder, N., Nater, U. M., Wolf, J. M., Ehlert, U., & Kirschbaum, C. (2004). Psychosocial stress-induced activation of salivary alpha-amylase: an indicator of sympathetic activity?. *Annals of the New York Academy of Sciences*, 1032(1), 258-263.
- Rose, D., Horne, S., Rose, J. L., & Hastings, R. P. (2004). Negative emotional reactions to challenging behaviour and staff burnout: Two replication studies. *Journal of Applied Research in Intellectual Disabilities*, 17(3), 219-223.
- Royal College of Psychiatrists. (2007). *Challenging Behaviour: A unified approach (College report CR 144)*. London: Royal College of Psychiatrists.
- Rozin, P., & Fallon, A. E. (1987). A perspective on disgust. *Psychological review*, 94(1), 23-41.

- Russell, E., Koren, G., Rieder, M., & Van Uum, S. (2012). Hair cortisol as a biological marker of chronic stress: current status, future directions and unanswered questions. *Psychoneuroendocrinology*, *37*(5), 589-601.
- Samson, A. C., & Gross, J. J. (2012). Humour as emotion regulation: The differential consequences of negative versus positive humour. *Cognition & emotion*, *26*(2), 375-384.
- Schablon, A., Zeh, A., Wendeler, D., Peters, C., Wohlert, C., Harling, M., & Nienhaus, A. (2012). Frequency and consequences of violence and aggression towards employees in the German healthcare and welfare system: a cross-sectional study. *BMJ open*, *2*(5), e001420.
- Schaufeli, W. B., & Bakker, A. B. (2003). Utrecht work engagement scale: Preliminary manual. Utrecht: *University of Utrecht*.
- Schmidt, S. G., Dichter, M. N., Palm, R., & Hasselhorn, H. M. (2012). Distress experienced by nurses in response to the challenging behaviour of residents—evidence from German nursing homes. *Journal of clinical nursing*, *21*(21-22), 3134-3142.
- Schore, A. N. (2001). The effects of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant mental health journal*, *22*(1-2), 201-269.
- Schuengel, C., Kef, S., Damen, S., & Worm, M. (2010). 'People who need people': attachment and professional caregiving. *Journal of Intellectual Disability Research*, *54*(1), 38-47.

- Segerstrom, S. C., Tsao, J. C., Alden, L. E., & Craske, M. G. (2000). Worry and rumination: Repetitive thought as a concomitant and predictor of negative mood. *Cognitive therapy and Research*, 24(6), 671-688.
- Shah, S. K., & Corley, K. G. (2006). Building better theory by bridging the quantitative–qualitative divide. *Journal of management studies*, 43(8), 1821-1835.
- Sheu, S., Lin, H. S., & Hwang, S. L. (2002). Perceived stress and physio-psycho-social status of nursing students during their initial period of clinical practice: the effect of coping behaviors. *International journal of nursing studies*, 39(2), 165-175.
- Sjögren, J. M. (2017). Anorexia Nervosa and Motivation for Behavioral Change-Can it be Enhanced?. *Journal of Psychology and Clinical Psychiatry*, 8(4), 2-5.
- Skinner, B. F. (1953). *Science and human behavior*. New York: Macmillan.
- Skoluda, N., Dettenborn, L., Stalder, T., & Kirschbaum, C. (2012). Elevated hair cortisol concentrations in endurance athletes. *Psychoneuroendocrinology*, 37(5), 611-617.
- Sobral, D. T. (2000). An appraisal of medical students' reflection-in-learning. *Medical Education*, 34(3), 182-187.
- Sofronoff, K., & Farbotko, M. (2002). The effectiveness of parent management training to increase self-efficacy in parents of children with Asperger syndrome. *Autism*, 6(3), 271-286.
- South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust. (2010). *Recovery is for All. Hope, Agency*

and Opportunity in Psychiatry. A Position Statement by Consultant Psychiatrists. London: SLAM/SWLSTG.

Sowney, M., & Barr, O. G. (2006). Caring for adults with intellectual disabilities: perceived challenges for nurses in accident and emergency units. *Journal of Advanced Nursing*, 55(1), 36-45.

Spector, P. E., Coulter, M. L., Stockwell, H. G., & Matz, M. W. (2007). Perceived violence climate: A new construct and its relationship to workplace physical violence and verbal aggression, and their potential consequences. *Work & Stress*, 21(2), 117-130.

Stalder, T., Kirschbaum, C., Heinze, K., Steudte, S., Foley, P., Tietze, A., & Dettenborn, L. (2010). Use of hair cortisol analysis to detect hypercortisolism during active drinking phases in alcohol-dependent individuals. *Biological Psychology*, 85(3), 357-360.

Stalder, T., Steudte, S., Alexander, N., Miller, R., Gao, W., Dettenborn, L., & Kirschbaum, C. (2012). Cortisol in hair, body mass index and stress-related measures. *Biological psychology*, 90(3), 218-223.

Stalder, T., Tietze, A., Steudte, S., Alexander, N., Dettenborn, L., & Kirschbaum, C. (2014). Elevated hair cortisol levels in chronically stressed dementia caregivers. *Psychoneuroendocrinology*, 47, 26-30.

Stalder, T., Steudte-Schmiedgen, S., Alexander, N., Klucken, T., Vater, A., Wichmann, S., Kirschbaum, C., & Miller, R. (2017). Stress-related and basic determinants of hair cortisol in humans: a meta-analysis. *Psychoneuroendocrinology*, 77, 261-274.

- Stanley, B., & Standen, P. J. (2000). Carers' attributions for challenging behaviour. *British Journal of Clinical Psychology, 39*(2), 157-168.
- Stewart, M. W., Wilson, M., Bergquist, K., & Thorburn, J. (2012). Care coordinators: A controlled evaluation of an inpatient mental health service innovation. *International journal of mental health nursing, 21*(1), 82-91.
- Stuart, E. H., Jarvis, A., & Daniel, K. (2008). A ward without walls? District nurses' perceptions of their workload management priorities and job satisfaction. *Journal of Clinical Nursing, 17*(22), 3012-3020.
- Sutton, D., Webster, S., & Wilson, M. (2014). *Debriefing following seclusion and restraint: a summary of relevant literature*. Auckland: Te Pou o Te Whakaaro Nui.
- Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. *The social psychology of intergroup relations, 33*(47), 74.
- Thase, M. E., & Callan, J. A. (2006). The role of homework in cognitive behavior therapy of depression. *Journal of Psychotherapy Integration, 16*(2), 162-177.
- Tobin, D. L. (1995). Coping strategies inventory: Short form. *Unpublished scale*.
- Topper, M., Emmelkamp, P. M., & Ehring, T. (2010). Improving prevention of depression and anxiety disorders: Repetitive negative thinking as a promising target. *Applied and Preventive Psychology, 14*(1-4), 57-71.
- Townsley, R., Watson, D., & Abbott, D. (2004). Working partnerships? A critique of the process of multi-agency working in services to disabled children with complex health care needs. *Journal of integrated care, 12*(2), 24-34.

- Tsigos, C., & Chrousos, G. P. (2002). Hypothalamic–pituitary–adrenal axis, neuroendocrine factors and stress. *Journal of psychosomatic research*, 53(4), 865-871.
- Vakola, M., & Nikolaou, I. (2005). Attitudes towards organizational change: What is the role of employees' stress and commitment?. *Employee relations*, 27(2), 160-174.
- Valli, L. (1997). Listening to other voices: A description of teacher reflection in the United States. *Peabody journal of Education*, 72(1), 67-88.
- Van de Vliert, E., Nauta, A., Euwema, M. C., & Janssen, O. (1997). *The effectiveness of mixing problem solving and forcing. Using conflict in organizations*, London:Sage.
- Van Uum, S. H. M., Sauv e, B., Fraser, L. A., Morley-Forster, P., Paul, T. L., & Koren, G. (2008). Elevated content of cortisol in hair of patients with severe chronic pain: a novel biomarker for stress. *Stress*, 11(6), 483-488.
- Vedhara, K., Shanks, N., Wilcock, G., & Lightman, S. L. (2001). Correlates and predictors of self-reported psychological and physical morbidity in chronic caregiver stress. *Journal of Health Psychology*, 6(1), 101-119.
- Walker, D., & Myrick, F. (2006). Grounded theory: An exploration of process and procedure. *Qualitative health research*, 16(4), 547-559.
- Webber, L. S., McVilly, K. R., & Chan, J. (2011). Restrictive interventions for people with a disability exhibiting challenging behaviours: Analysis of a population database. *Journal of Applied Research in Intellectual Disabilities*, 24(6), 495-507.

- Weinberg, A., & Creed, F. (2000). Stress and psychiatric disorder in healthcare professionals and hospital staff. *The Lancet*, 355(9203), 533-537.
- West, M. A., & Lyubovnikova, J. (2013). Illusions of team working in health care. *Journal of health organization and management*, 27(1), 134-142.
- Wetherell, M. A., Lovell, B., & Smith, M. A. (2015). The effects of an anticipated challenge on diurnal cortisol secretion. *Stress*, 18(1), 42-48.
- Winning, F. J. (2010). Counselling in organisations: What is the experience of the lone counsellor?. *Counselling and Psychotherapy Research*, 10(4), 249-257.
- Winstanley, S., & Whittington, R. (2004). Aggressive encounters between patients and general hospital staff: Staff perceptions of the context and assailants' levels of cognitive processing. *Aggressive Behavior*, 30(6), 534-543.
- Wright, A., Jorm, A. F., & Mackinnon, A. J. (2011). Labeling of mental disorders and stigma in young people. *Social Science & Medicine*, 73(4), 498-506.
- Zeisel, J., Silverstein, N. M., Hyde, J., Levkoff, S., Lawton, M. P., & Holmes, W. (2003). Environmental correlates to behavioral health outcomes in Alzheimer's special care units. *The Gerontologist*, 43(5), 697-711.
- Zheng, M. (2015). Conceptualization of cross-sectional mixed methods studies in health science: a methodological review. *International Journal of Quantitative and Qualitative Research Methods*, 3(2), 66-87.

**APPENDIX A: Initial Interview Schedule – Focus Group –
26/04/2016**

Could someone please provide an overview of the service here?

How would you describe your work setting?

- Is there anything in your work setting that causes difficulties for you in completing work related tasks?
- What are the positive aspects of your working environment?

What type of behaviours, displayed by care recipients, do you perceive to be challenging?

- What are the impacts on you when exposed to the stipulated behaviours?
- What would help you to manage or prevent the stipulated behaviours?

Not naming any people in particular, but are there any other behaviours that you find problematic that may be exhibited by people other than care recipients?

- Do these behaviours have an effect on wellbeing, if so how?
- Have you experienced anything that has helped you to deal with the situations described?

Have you ever experienced any difficulties in meeting the healthcare needs of service users?

How do you feel when you know you have done a good job when providing care to a service user?

What are the potential challenges or stressors that people in your line of work can experience during a busy day?

During a busy day at work, what coping strategies do you use to help you to get through the day?

Is there anything that you think that health care organisations could do to help people who work in your profession to cope with potential stressors?

APPENDIX B: Modified version of the Student Teacher Relationship Scale (Pianta, 2001)

Please think about a service user, patient or resident who has exhibited a behaviour that you have found to be challenging within the past month. Now reflect on the degree to which each of the following statements currently applies to that person. Using the point scale below, please CIRCLE the appropriate number for each item

1	2	3	4	5
Definitely does not apply	Does not really apply	Neutral, not sure	Applies somewhat	Definitely applies

I share a warm relationship with this service user.	1	2	3	4	5
This service user and I always seem to be struggling with each other.	1	2	3	4	5
If upset, this service user will seek comfort from me.	1	2	3	4	5
This service user is uncomfortable with physical contact from me.	1	2	3	4	5
This service user values his/her relationship with me.	1	2	3	4	5
The service user appears hurt or embarrassed when I correct him/her	1	2	3	4	5
When I praise this service user, he/she beams with pride.	1	2	3	4	5
This service user reacts strongly to separation from me.	1	2	3	4	5
This service user spontaneously shares information about himself/herself.	1	2	3	4	5
This service user is overly dependent on me.	1	2	3	4	5
The service user easily becomes angry with me	1	2	3	4	5
The service user tries to please me.	1	2	3	4	5
This service user feels that I treat him/her unfairly	1	2	3	4	5
This service user asks for my help when he/she really does not need help	1	2	3	4	5
It is easy to be in tune with what this service user is feeling	1	2	3	4	5
This service user sees me as a source of punishment and criticism	1	2	3	4	5
This service user expresses hurt or jealousy when I spend time with other service users	1	2	3	4	5
This service user is resistant to my input as a professional.	1	2	3	4	5
When this service user exhibits behaviours that challenge, they appear to calm when I use verbal de-escalation techniques.	1	2	3	4	5
Dealing with this service user drains my energy.	1	2	3	4	5
I have noticed this service user copying my behaviour or ways of doing things	1	2	3	4	5
When this service user is in a bad mood, I know I am in for a long and difficult day	1	2	3	4	5
This service user's feelings towards me can be unpredictable or can change suddenly.	1	2	3	4	5
Despite my best efforts, I'm uncomfortable with how this service user and I get along	1	2	3	4	5

This service user cries when he/she wants something from me	1	2	3	4	5
This service user tries to manipulate me.	1	2	3	4	5
This service user openly shares his/her feelings and experiences with me.	1	2	3	4	5
My interactions with this service user makes me feel effective and confident	1	2	3	4	5

APPENDIX C: Perceived Stress Scale (Cohen, Karmarck & Mermelstein, 1983)

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling how often you felt or thought a certain way.

Name _____ Date _____

Age _____ Gender (Circle): M F Other _____

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly?..... 0 1 2 3 4

2. In the last month, how often have you felt that you were unable to control the important things in your life? 0 1 2 3 4

3. In the last month, how often have you felt nervous and "stressed"? 0 1 2 3 4

4. In the last month, how often have you felt confident about your ability to handle your personal problems? 0 1 2 3 4

5. In the last month, how often have you felt that things were going your way?..... 0 1 2 3 4

6. In the last month, how often have you found that you could not cope with all the things that you had to do? 0 1 2 3 4

7. In the last month, how often have you been able to control irritations in your life?..... 0 1 2 3 4

8. In the last month, how often have you felt that you were on top of things?.. 0 1 2 3 4

9. In the last month, how often have you been angered because of things that were outside of your control?..... 0 1 2 3 4

10. In the last month, how often have you felt difficulties
were piling up so high that you could not overcome them? 0 1 2 3 4

This questionnaire is composed of 30 statements regarding your confidence with other people. Circle YES if you consider that the statement is true of your feelings most of the time. Circle NO if you consider that the statement is rarely true of you. Remember that this information is completely **confidential**

	Please circle	
I rarely worry about seeming foolish to others	YES	NO
I worry about what people will think of me even when I know it doesn't make any difference	YES	NO
I become tense and jittery if I know that someone is sizing me up	YES	NO
I am unconcerned even if I know that people are forming an unfavourable impression of me	YES	NO
I feel very upset when I commit some social error	YES	NO
The opinions that people have of me cause me little concern	YES	NO
I am often afraid that I may look ridiculous or make a fool of myself	YES	NO
I react very little when other people disapprove of me	YES	NO
I am frequently afraid of other people noticing my shortcomings	YES	NO
The disapproval of others would have little effect on me	YES	NO
If someone is evaluating me I expect the worst	YES	NO
I rarely worry about what kind of impression I am making on someone	YES	NO
I am afraid that others will not approve of me	YES	NO
I am afraid that others will find fault with me	YES	NO
Other people's opinions of me do not bother me	YES	NO
I am not necessarily upset if I do not please someone	YES	NO
When I am talking to someone, I worry about what they may be thinking of me	YES	NO
I feel that you can't help making social errors sometimes, so why worry about it	YES	NO
I am usually worried about what kind of impression I make	YES	NO
I worry a lot about what my superiors think of me	YES	NO
If I know someone is judging me, it has little effect on me	YES	NO
I worry that others will think I am not worthwhile	YES	NO
I worry very little about what others may think of me	YES	NO

Continues.....

	Please circle	
Sometimes I am too concerned with what other people may think of me	YES	NO
I often worry that I will say or do the wrong things	YES	NO
I am often indifferent to the opinions others have of me	YES	NO
I am usually confident that others will have a favourable impression of me	YES	NO
I often worry that people who are important to me won't think very much of me	YES	NO
I brood about the opinions my friends have about me	YES	NO
I become tense and jittery if I know I am being judged by my superiors	YES	NO

Format for the 36-item Survey of Perceived Organizational Support

© University of Delaware, 1984

Listed below and on the next several pages are statements that represent possible opinions that YOU may have about working at _____. Please indicate the degree of your agreement or disagreement with each statement by filling in the circle on your answer sheet that best represents your point of view about _____. Please choose from the following answers:

0	1	2	3	4	5	6
Strongly Disagree	Moderately Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Moderately Agree	Strongly Agree

- *1. _____ values my contribution to its well-being.
- *2. If _____ could hire someone to replace me at a lower salary it would do so.
- *3. _____ fails to appreciate any extra effort from me. (R)
- *4. _____ strongly considers my goals and values.
5. _____ would understand a long absence due to my illness.
- *6. _____ would ignore any complaint from me. (R)
- *7. _____ disregards my best interests when it makes decisions that affect me. (R)
- *8. Help is available from _____ when I have a problem.
- *9. _____ really cares about my well-being.
10. _____ is willing to extend itself in order to help me perform my job to the best of my ability.
11. _____ would fail to understand my absence due to a personal problem. (R)
12. If _____ found a more efficient way to get my job done they would replace me. (R)
13. _____ would forgive an honest mistake on my part.
14. It would take only a small decrease in my performance for _____ to want to replace me. (R)
15. _____ feels there is little to be gained by employing me for the rest of my career. (R)
16. _____ provides me little opportunity to move up the ranks. (R)
- *17. Even if I did the best job possible, _____ would fail to notice. (R)
18. _____ would grant a reasonable request for a change in my working conditions.
19. If I were laid off, _____ would prefer to hire someone new rather than take me back. (R)
- *20. _____ is willing to help me when I need a special favor.
- *21. _____ cares about my general satisfaction at work.
- *22. If given the opportunity, _____ would take advantage of me. (R)

- *23. _____ shows very little concern for me. (R)
- 24. If I decided to quit, _____ would try to persuade me to stay.
- *25. _____ cares about my opinions.
- 26. _____ feels that hiring me was a definite mistake. (R)
- *27. _____ takes pride in my accomplishments at work.
- 28. _____ cares more about making a profit than about me. (R)
- 29. _____ would understand if I were unable to finish a task on time.
- 30. If _____ earned a greater profit, it would consider increasing my salary.
- 31. _____ feels that anyone could perform my job as well as I do. (R)
- 32. _____ is unconcerned about paying me what I deserve. (R)
- 33. _____ wishes to give me the best possible job for which I am qualified.
- 34. If my job were eliminated, _____ would prefer to lay me off rather than transfer me to a new job. (R)
- *35. _____ tries to make my job as interesting as possible.
- 36. My supervisors are proud that I am a part of this organization.

(R) indicates the item is reverse scored.

* indicates the item was retained for the short version of the survey.