An investigation of multidisciplinary community mental health staff members' causal attributions for non-engagement amongst clients with psychosis

and Research Portfolio

Part One (Part Two Bound Separately)

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August 2006

Submitted in partial fulfilment of the requirements for the degree of Doctorate in Clinical Psychology, University of Glasgow

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An audit of the psychological needs of individuals experiencing first-episode psychosis within Ayrshire and Arran NHS

Chapter 1

Small Scale Service Related Project

An audit of the psychological needs of individuals experiencing first-episode psychosis within Ayrshire and Arran NHS

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SUMMARY

This audit is part of a larger audit of psychological need for all individuals with a diagnosis of psychosis in Ayrshire and Arran and examines the recorded psychological need of individuals experiencing first-episode psychosis in relation to national clinical standards.

INTRODUCTION

There is evidence that psychological needs are more pronounced during the early stages of psychosis (Mason et al., 1995). Many of the disabilities often associated with psychosis are thought to develop within the first three years, which has become known as the 'critical period' (Birchwood et al., 1998) and relapses are common during the five years after a first-episode (Robinson et al., 1999). Co-morbid problems such as substance misuse, depression, suicidal thinking, social avoidance and phenomena similar to post traumatic stress disorder (PTSD) are common at the first-episode and need assessment and treatment both in their own right and because of their potential to act as stressors provoking relapse (Birchwood et al., 1998). Adverse reactions to the experience of psychosis and its treatment are well established and can lead to non-compliance with treatment, loss of self-efficacy and self-esteem and absorption of negative stereotypes of mental illness (Birchwood et al., 1998).

Special emphasis has recently been given to implementing 'early intervention' services for people showing the first signs of psychotic experiences (British Psychological Society: BPS, 2000). It has been suggested that the early years after onset may be a

critical time for psychological and other interventions and that interventions at this time are *'likely to have a disproportionate impact relative to interventions later in the course'* (Birchwood et al., 1998). Developmental and transitional needs are important at this time and psychological interventions aimed at supporting individuals' developmental needs and adjustment to psychosis may have an impact on longer-term outcome in terms of reducing negative symptoms and disabilities (Jackson et al., 1996).

There is an increasing evidence base that psychological and psychosocial interventions are effective in targeting many aspects of psychosis (Baguley et al., 1999). Specific psychological therapies shown to be effective include Cognitive Behaviour Therapy (CBT) (Drury et al., 1996) and Family Interventions (Pharoah et al., 2006). In addition, psycho-education (Fowler et al., 1995), assessment (Kingdon et al., 1994), and specific psychosocial techniques such as social (Liberman et al., 1986), cognitive (Wykes et al., 1999) and occupational rehabilitation (Chadwick,1997) have also proved useful. Despite the proven efficacy of these treatments, availability is patchy since there are too few suitably trained mental health practitioners to deliver them, especially in Scotland (CAPISH/ SCPMDE Review, 1999).

The relevance and importance of such interventions is reflected in national clinical standards such as the NICE (National Institute for Clinical Evidence) Guidelines for Schizophrenia (2002), SIGN (Scottish Intercollegiate Guidelines Network) Guidelines for Psychosocial Interventions (1998), the BPS document outlining psychological approaches to the understanding and treatment of psychosis (2000) and the NHS QIS

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(Quality Improvement Scotland, previously Clinical Standards Board Scotland) Clinical Standards for Schizophrenia (2001).

Service Context

The implementation of these evidence-based psychological and psychosocial interventions for schizophrenia into routine practice is a branch of the Ayrshire and Arran NHS overall strategy for clinical effectiveness in line with QIS Schizophrenia Standards.

These standards were introduced to NHS Scotland in 2001 and relate to standards of care for all individuals with a diagnosis of Schizophrenia. There are 11 standards in total; Standard 10 refers to social and psychological care.

Standard 10

"Every person who has a diagnosis of schizophrenia has their need for life skills and social skills training assessed regularly, along with their need and where appropriate, their carer's need for psychological therapies "

Within Ayrshire and Arran NHS, service provision of psychological therapies for individuals with a diagnosis of schizophrenia and their carers is currently available within Community Mental Health Teams (CMHTs), Psychiatric Rehabilitation and within the Area Psychology Service (CCPS). While the Trust does have clinical psychologists specialising in this area they are a scarce resource. Other clinicians providing psychological interventions include CBT therapists, and mental health professionals who

have undergone training in psychosocial interventions (PSIs) for psychosis. However, there remain too few skilled clinicians to meet the criteria of Standard 10.

To enable identification of need for psychological therapies for psychosis and to provide a guideline for referral to the appropriately skilled clinicians, the Ayrshire and Arran working group for CSBS Standard 10 have produced a proforma, Psychological Therapies for Psychosis Record of Identification of Need (PSYRIN, Appendix 1.ii). This document has now been completed for the majority of patients with a diagnosis of psychosis and the data have been recorded on the ICP (Integrated Care Pathway) database: FACE (Functional Analysis of Care Environment) (Clifford, 2000).

The Clinical Psychology Service is completing an audit of identified need for all patients with a diagnosis within the schizophrenia spectrum according to ICD-10 (International Statistical Classification of Diseases and Related Health Problems, WHO, 1992). It was decided to begin with an audit of psychological need for individuals experiencing first-episode psychosis.

AUDIT QUESTIONS

What are the identified psychological needs of individuals experiencing a first-episode of psychosis?

What are the range and number of problems across individuals?

Which problems have the greatest frequency and severity?

What is the impact of the identified problems on individuals' functioning?

METHOD

This audit follows the procedure employed in the larger service audit of identified psychological need for all individuals with a diagnosis of psychosis. The audit was based on the initial roll out of PSYRIN forms to CMHTs over a period of 6 months from February 2003. The forms were completed by the key-worker or consultant, where necessary in collaboration with the patient (see Guidelines, Appendix 1.iii). Data were entered onto the FACE database by ICP staff or by clinicians directly.

This audit examines the identified psychological need for individuals experiencing a first-episode of psychosis.

The proposal for this project was approved by the Local Clinical Governance Forum within Ayrshire and Arran NHS (Appendix 1.iv).

Audit Tool

PSYRIN: Psychological Therapies for Psychosis Record of Identification of Need (Appendix 1.ii)

Section A of the PSYRIN identifies those patients where assessment by a clinical psychologist is required:

First-episode psychosis

Early psychosis (duration of illness less than 3 years)

Trauma or PTSD-like symptoms associated with the psychosis

Query over cognitive deficits.

Section B of the PSYRIN identifies factors indicating high risk of relapse and includes

information about the level of severity and impact on functioning of the following:

Difficulty engaging in services

Treatment adherence problems

Family relationship problems

Section C identifies level of severity and impact on functioning of the following:

Persisting positive and negative symptoms

Co-existing psychological disorders/problems such as anxiety, depression, low self

esteem

Problem behaviours

Difficulty adjusting to psychosis

Section D asks whether or not the carer has expressed having their own psychological

difficulties and if so, then whether this is related to their experience of being a carer.

Procedure

The data for those individuals recorded as experiencing first-episode psychosis were

selected from the FACE database, which is doubly password protected and fully

monitored.

In addition, team leaders from each CMHT were contacted and visits to each of the teams were set up to explain the project to the staff and to get the details of any further patients with first-episode psychosis identified since the initial roll out of PSYRIN. Key-workers were then sent an explanatory letter (Appendix 1.v) along with copies of PSYRIN for newly identified first-episode patients. Phone contact liaison was used to maximize data collection.

Data were exported to SPSS for analysis.

RESULTS

Data Collection

Initially PSYRIN forms indicating first-episode psychosis were available for 18 individuals on the FACE database. Following visits to each of the teams it was highlighted that one of these individuals had since been given an alternative diagnosis and so their data were not included in the audit. In addition, names were given for a further 31 individuals whose data had not yet been entered onto the database.

In total, 48 individuals were identified as having first-episode psychosis.

Poor return rates of PSYRIN forms issued meant that data were available for 27 individuals: 15 males (mean age = 30.5 years, SD = 13.7) and 12 females (mean age = 31.5, SD = 11.2). Of these 16 were from North Ayrshire, 6 from East Ayrshire and 5 from South Ayrshire. The following results are for these 27 individuals.

Frequency and Severity of Problems

PTSD-like symptoms related to the psychosis, treatment or past trauma were identified as a problem for 3 (11.1%) individuals, cognitive deficits were identified in 4 (14.8%) individuals and 3 (11.1%) individuals were reported as having both trauma and cognitive deficits.

Frequency and severity of the problems in Section C of PSYRIN, i.e. ongoing symptoms and co-existing disorders are displayed in Figure 1.

INSERT FIGURE 1 ABOUT HERE.

Co-existing Disorders

Twenty-one individuals were identified as having co-existing disorders. Four were reported as having a co-existing anxiety disorder, 3 as having co-existing depression, 11 as having both anxiety and depression and 3 as having anxiety, depression and a further co-existing psychological disorder. Table 1 shows the type and frequency of each specific co-existing disorder. While 3 individuals were reported as having another co-existing psychological disorder, only 1 specified which disorder: this was "extremely shy and withdrawn".

INSERT TABLE 1 ABOUT HERE.

Problem Behaviours

Twelve individuals were identified as having specific problem behaviours. Table 2 displays the range and frequency of these behaviours.

INSERT TABLE 2 ABOUT HERE.

Not Otherwise Stated Psychological Difficulties

Four individuals were identified as having not otherwise stated psychological difficulties and these were reported as being:

1 prior diagnosis of ADHD

1 previous trauma

1 difficulty accepting help

1 relationship issues (sexuality, abuse, bereavements)

Impact on Functioning

Figure 2 shows the impact on functioning of each of the problems identified in Section C of PSYRIN.

INSERT FIGURE 2 ABOUT HERE.

Range of Psychological Need Identified

All 27 individuals reported some symptoms or co-existing disorders in Section C of PSYRIN and all reported more than one problem of at least mild severity.

The number of people experiencing multiple problems of moderate or severe impact on functioning are displayed in Figure 3.

INSERT FIGURE 3 ABOUT HERE.

Risk of Relapse

Eight (29.6%) of the 27 individuals were identified as having a high risk of relapse in Section B of PSYRIN. However, problems which indicate high risk of relapse were recorded for 19 individuals (70.4%). Difficulty engaging in services was reported to be a problem for 3 (11.1%) individuals and family relationship problems were identified as a problem for 3 (11.1%) individuals. A combination of engagement and family problems was recorded for 4 (14.8%) individuals, treatment adherence and family problems for 3 (11.1%) individuals and treatment adherence, engagement and family problems were all reported to be a problem for 6 (22.2%) individuals.

Figure 4 shows the frequency and severity of these problems. The reported impact on functioning is displayed in Figure 5.

INSERT FIGURE 4 ABOUT HERE.

INSERT FIGURE 5 ABOUT HERE

DISCUSSION

Psychological Need

This audit highlights the complex and multiple psychological needs of many individuals experiencing a first-episode of psychosis. For example all individuals reported some symptoms or co-existing problems in addition to their psychosis however, most were rated as only mild severity and having only a mild impact on functioning.

Over one-third of the individuals identified were reported to be suffering from PTSD-like symptoms, cognitive deficits or both. This is in line with expected rates of trauma in this population from previous studies which suggest that over one-third of individuals with psychosis may experience PTSD symptoms often related to images regarding the psychosis or treatment (McGorry et al., 1991). Furthermore, individuals with chronic schizophrenia have shown deficits in several areas of cognitive functioning including abstract reasoning, word fluency, sequential memory, cognitive set-shifting and attention (Gold et al., 1994). Other research has also suggested that these individuals perform poorly on tasks requiring working memory (Gold, et al., 1997).

Around two-thirds of the individuals identified in the audit were reported to be suffering from co-existing anxiety and depression. These rates are high but are not unexpected in

this population (Birchwood et al., 1998). A range of anxiety disorders was found within this group, however many failed to report a particular disorder and so it is unclear whether they would meet diagnostic criteria.

The most commonly reported problems in this group were low self-esteem and difficulty adjusting to psychosis. This is in line with recent ideas that the appraisal of a diagnosis of psychosis can involve feelings of loss, humiliation and entrapment or defeat, which can lead to loss of valued roles or goals and the individual being unable to assert an identity (Rooke and Birchwood, 1998). The prevalence of additional complicating problems such as suicidality, problem behaviours (especially substance abuse) and problems with persisting positive and negative symptoms are also high. It is of interest however that the impact on functioning of many of these problems is rated as mild. For example, it was reported that for all of the individuals identified as having problems with suicidality it had only a mild impact on functioning. One possible explanation for this is that because all individuals involved in the study were in contact with services and since suicide risk may be one of the first things tackled it may be more under control.

Around 70% of these individuals were identified as having problems with engagement, treatment adherence and family relationships, which are known risk factors for relapse in psychosis (Bebbington et al., 1995). Furthermore a high proportion of these individuals were reported to have problems in more than one of these areas. However, despite this only 30% of individuals were actually identified as being at high risk of relapse by the key-worker or consultant who completed the PSYRIN. This implies that there may be

other factors influencing the clinicians' judgment of risk of relapse and suggests a possible area for future research.

Implications for Treatment

The above findings have implications for the range of psychological and psychosocial interventions required by these individuals. For example, psychological approaches aimed at enhancing cognitive functioning in psychosis have been developed in recent years with variable success (Pilling et al., 2002a), and may prove useful when working with those individuals with cognitive deficits. In addition, evidence-based psychological techniques such as CBT could be used to tackle the co-existing depression, anxiety and PTSD symptoms (Jackson et al., 2000) and may be especially important for preserving a stable sense of self and in maintaining self-esteem in these individuals (Fennel, 1997). Furthermore, evidence is now accumulating for the effectiveness of CBT in the treatment of positive and negative symptoms (Haddock et al., 1998). However, Turkington et al. (2003) state that evidence to date is not yet sufficient to warrant its general use in treating the negative symptoms associated with first-episode schizophrenia. Falzer et al. (2004) suggest using novel psychosocial strategies capable of diminishing the burden and disruption that can occur as a result of negative symptoms in early psychosis. These strategies are based on improving quality of life and social functioning and could aid adjustment to psychosis.

Co-morbid substance abuse can contribute to relapse (Linszen et al., 1994) and problems surrounding engagement with services, treatment adherence and family relationships also

highlight the potentially high risk of relapse for these individuals (Bebbington, et al. 1995). This suggests the importance of spending time engaging with first-episode patients and their families where appropriate and the use of psycho-education can help to improve both understanding of the disorder and engagement in treatment, especially at this early stage (McGorry, 1995). CBT techniques and the use of motivational interviewing may be important for improving treatment adherence and for tackling co-morbid substance abuse (Barrowclough et al., 2001). In addition, family interventions have been shown to reduce relapse in this group (Pilling et al., 2002b).

Problems with Data Collection

The total number of people identified with first-episode psychosis is lower than would be expected, with the population of Ayrshire and Arran being 376,800 and with an incidence rate of 20 new cases of schizophrenia expected each year per 100,000 of the population (NHS QIS, 2004). According to these figures around 75 individuals would be expected with first-episode psychosis over the period of one year in Ayrshire and Arran. The lower figure of 48 individuals identified in this audit could be a result of clinicians' reluctance to make an early diagnosis of psychosis, or there could in fact be lower numbers of individuals experiencing first-episode psychosis in Ayrshire and Arran.

A lack of PSYRIN data on the FACE database could be linked to problems with the introduction of the database in some areas. For this reason, electronic records may not have been kept up-to-date. In addition, the many pressures on staff time in completing multiple electronic and paper records regarding their patients may have influenced the

poor rates of completion. Due to the poor return rates of PSYRIN forms, data were only available for 27 of the 48 individuals identified with first-episode psychosis. Demographic information was not available for the other 21 individuals, so it is unclear whether the sample included in this audit are representative of the larger population.

Further problems include missing data from the PSYRIN forms that were completed. For example, some people indicated that a patient was suffering from a co-existing anxiety disorder but did not specify which one, so it is unclear whether they would meet diagnostic criteria for a specific disorder. It is therefore possible that the rates of co-existing disorders in this audit may be inflated.

This audit highlights the possibility that further training in the use of the FACE database and more detailed guidelines regarding the completion of PSYRIN may be of use in optimizing the effectiveness of the needs assessment in line with QIS (CSBS) Standard 10.

Summary and Implications for Service

The above results highlight the multiple and complex nature of the problems experienced by many individuals with first-episode psychosis. This appears to justify the existing service guidelines that all individuals experiencing first-episode psychosis should be prioritised for assessment by a clinical psychologist and has implications for workforce planning.

Within Ayrshire and Arran NHS training in PSI for psychosis, including family interventions for psychosis is currently underway. This audit highlights the importance of such training to ensure that suitably trained mental health practitioners are available to offer appropriate and timely interventions in line with prioritization of need.

Wider implications

Other NHS Trusts could consider using a similar proforma to identify need for psychological assessment and intervention. Ensuring clarity about guidelines for completion and appropriate training in the use of an electronic database such as FACE may help to minimize some of the problems experienced in Ayrshire and Arran NHS.

Dissemination of Results

These results will be disseminated throughout Ayrshire and Arran NHS in conjunction with the results from the larger audit and will be used in relation to service planning for people with psychosis.

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List of Tables and Figures

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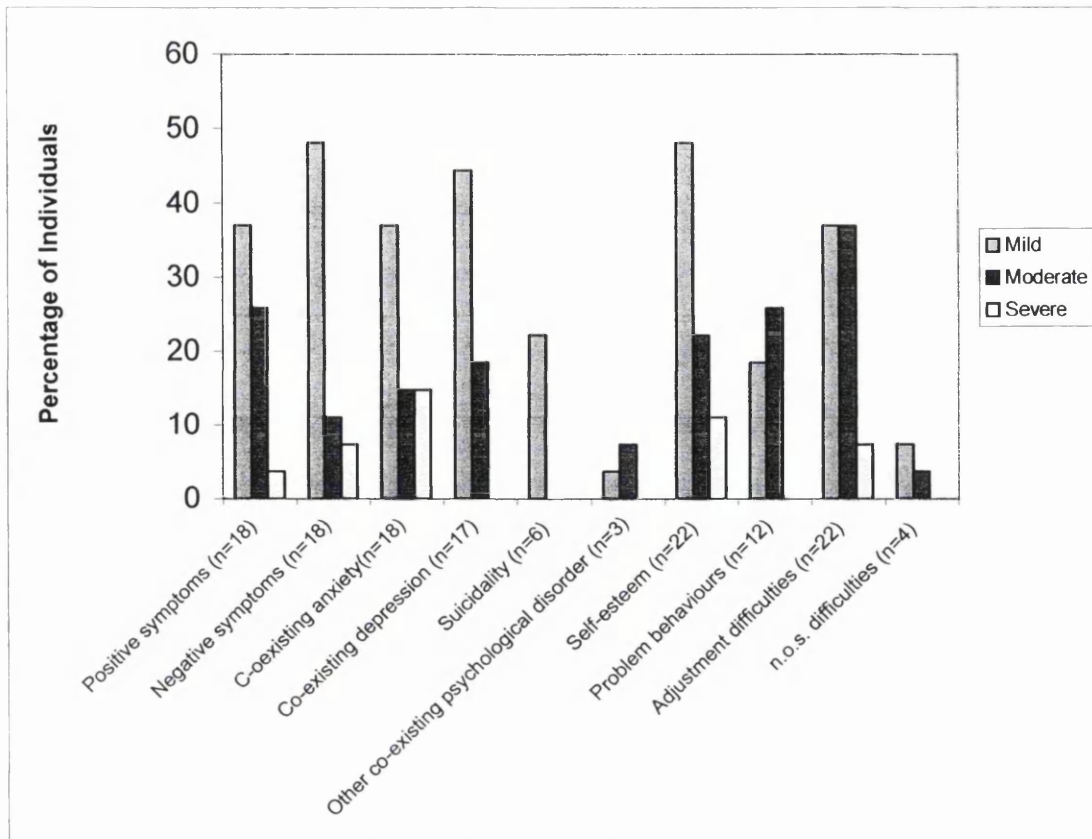
Figure 2: Impact on Functioning of Symptoms and Co-existing Disorders
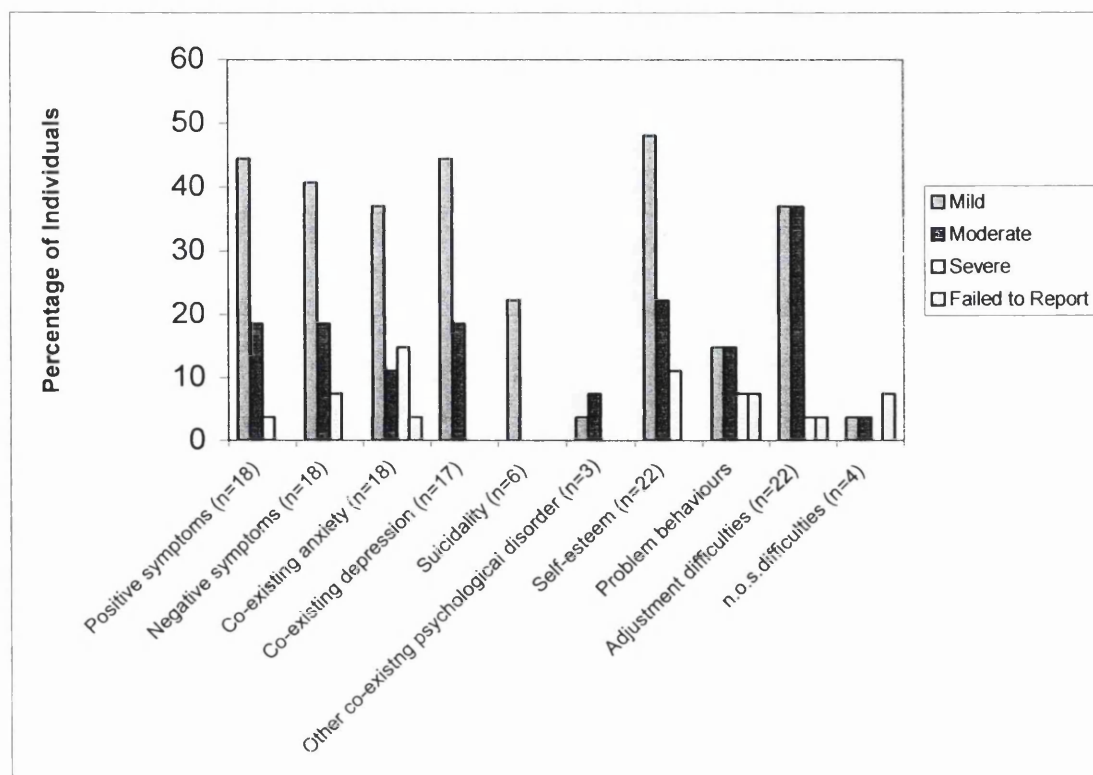
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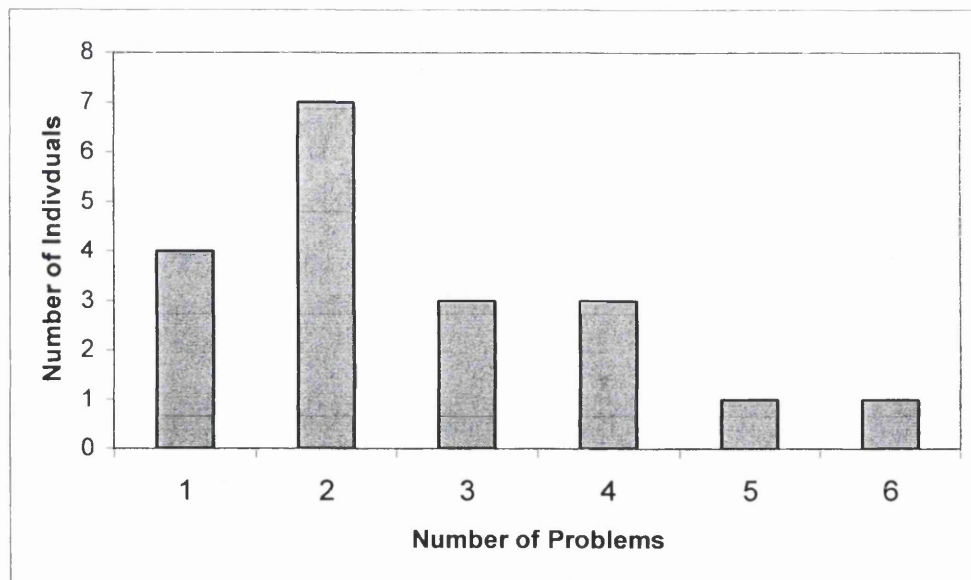
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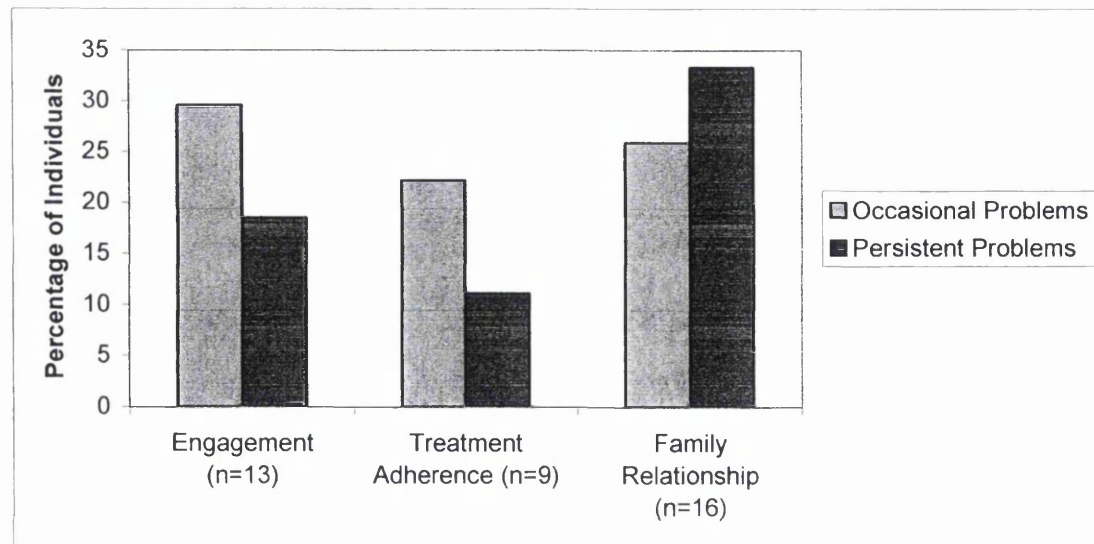
Figure 5: Impact on Functioning of Problems Related to Relapse
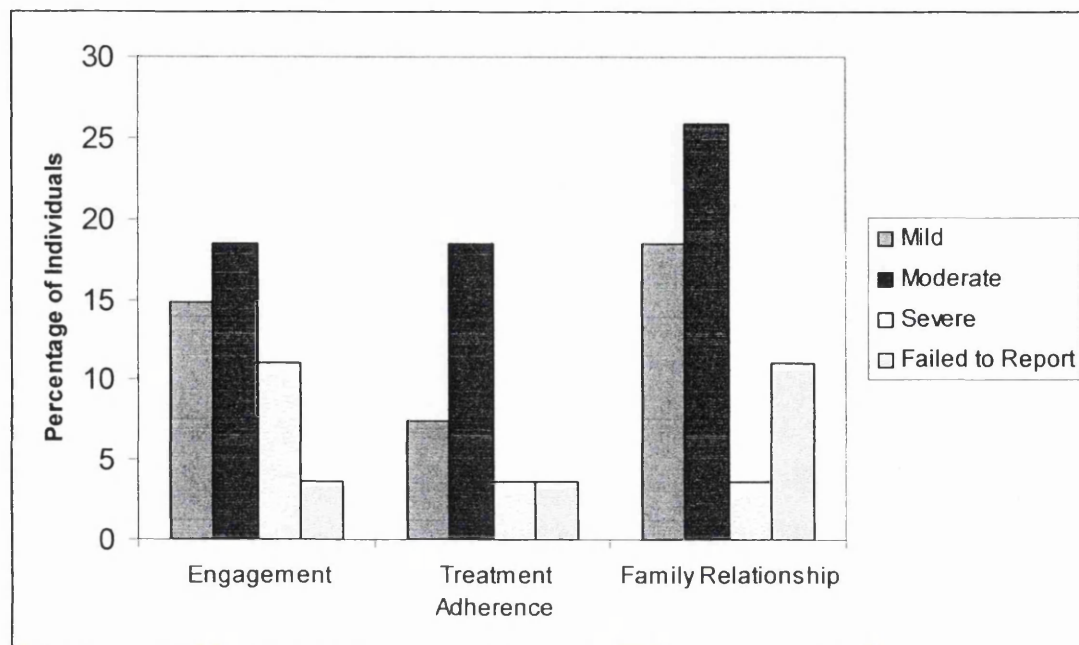
Table 1: Range and Frequency of Coexisting Psychological Disorders

Coexisting Psychological Disorder	Number (%) of Individuals
GAD	1 (3.7)
Social Anxiety	2 (7.4)
OCD-type Symptoms (frequent washing/changing clothes)	1 (3.7)
Panic Disorder	1 (3.7)
Anxiety Disorder - Not Specified	13 (48.1)
Depression	17 (63)
Other Co-existing Psychological Disorder	3 (11.1)

Table 2: Range and Frequency of Problem Behaviours

Problem Behaviour	Number (%) of Individuals
Substance abuse not specified	3 (11.1)
Cannabis and alcohol abuse	1 (3.7)
Cannabis abuse	1 (3.7)
Alcohol abuse	1 (3.7)
Amphetamine abuse	1 (3.7)
Self/home-care deficit	1 (3.7)
Not specified behaviour	4 (14.8)

Chapter Two

Systematic Literature Review

Care staff causal attributions about clients with severe mental health problems – a systematic review

Chapter 2

Systematic Literature Review

Care staff causal attributions about clients with severe mental health problems – a systematic review

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Prepared in accordance with requirements for submission to *Clinical Psychology Review*

ABSTRACT

Background: Recent research suggests that there is a link between the causal attributions made by care staff to explain their clients' mental health problems and their emotional response towards their clients and that this could in turn influence their helping behaviour.

Objectives: To explore the nature, reliability and validity of causal attributions made by staff about their clients and the clinical correlates of these attributions. In addition to investigate the range of methods employed to elicit and measure causal attributions.

Methods: An electronic database search found thirteen eligible studies which examined care staff attributions towards clients with severe mental health problems.

Results: There was substantial methodological variance throughout. Staff tended to make causal attributions for clients' problems which were predominantly internal to the client and there was some evidence that they made attributions which were controllable by the client. This contrasted with the results for clients' who tended to rate causes as uncontrollable. Results for clients' attributions of internality were mixed.

Conclusions: Further research is needed to explore the potential discrepancy between client and staff attributions and to examine the relationship between causal attributions and objective measures of staff-client relationships. Methodological implications are also discussed.

INTRODUCTION

Expressed emotion (EE) is a term widely used to describe a critical, hostile or emotionally over-involved interpersonal environment. EE has been demonstrated to be a reliable and robust predictor of outcome in clients with a broad range of mental health problems and physical illnesses (Wearden, et al., 2000). In particular in the field of psychosis studies have consistently shown that clients living in a high EE environment have a greater likelihood of relapse than clients living in low EE environments (e.g. Butzlaff and Hooley, 1998). Subsequently, interventions to reduce relapse in individuals living in high EE families have been shown to be effective (Barbato and D'Avanzo, 2000). Evidence suggests that criticism from relatives with high EE results from their tendency to attribute symptoms as being internal to and within the control of the family member (Hooley and Campbell, 2002; Bolton et al., 2003) and that the causal attributions which underpin critical or emotionally over-involved attitudes may be more powerful predictors of relapse than EE itself (Barrowclough et al., 1994; Barrowclough and Parle, 1997; Hooley and Campbell, 2002).

While most of this research has focused on the EE of relatives, recently a number of studies have revealed that EE may also be found among care staff working with people with long-term mental health problems or learning disabilities (e.g. Van Audenhove and Van Humbeeck, 2003). In the field of learning disabilities, care staff causal attributions have been shown to be correlated with their responses towards individuals whose behaviours are challenging for services (e.g. Hastings et al., 1995; Morgan and Hastings,

1998). For example, Dagnan et al. (1998) found that staff who reported that a challenging behaviour was under the control of the client were more likely express negative emotions, be less optimistic about the outcome for that client and be less willing to offer help.

The theoretical basis for this research stems from Weiner's attributional model of helping behaviour (Weiner, 1980; 1985). This model proposes that attributions of internality (the cause of a behaviour is viewed as arising from factors within an individual) and attributions of controllability (the cause of a behaviour is seen as under the voluntary control of an individual) are the primary determinants of the emotional reactions of sympathy and anger. If the individual's need for help is attributed to uncontrollable factors then the potential helper would experience sympathy which would promote the tendency to help. Conversely attributions to controllable and internal factors are thought to give rise to emotions such as anger, which would reduce the tendency to help. In the more recent version of Weiner's (1986) theory of achievement motivation, attributional stability is regarded as an important determinant of expectations of success and failure. Thus, in the context of helping it may be predicted that if a problem behaviour is attributed to a stable cause, help is less likely to be elicited, since expectations of that help being successful are low. Conversely, unstable attributions for a client's negative behaviour may be associated with greater optimism. Therefore attribution theory, applied to staff behaviour, has an underlying hypothesis that the attributions which staff make about the causes of behaviour will influence their emotional and behavioral response to it.

There is no clear consensus about the best way to elicit and measure causal attributions. Existing methods include examining attributions towards case vignettes or towards actual clients. Some studies provide participants with possible causes, while others ask participants to give a cause. Participants are often asked to rate these causes along attributional dimensions provided by the experimenter (e.g. Meddings and Levey, 2000; Markham and Trower 2003). Other methods include asking open-ended questions, using a semi-structured interview format or analysing spontaneous causal thinking. The causal attributions generated are then identified and coded by the experimenter (e.g. Barrowclough, et al., 2001). The fact that there is not one clear method for eliciting attributions suggests a need to review the literature.

There has been no previous systematic review of the literature exploring care staff attributions towards clients with severe mental health problems such as psychosis. Such a review would be especially timely in the context of recent policy developments from the National Institute for Clinical Evidence (NICE, December 2002), Scottish Intercollegiate Guidelines Network (SIGN, October 1998) and Clinical Standards Board for Scotland (CSBS, NQIS, January 2001). These guidelines highlight the challenge for mental health services in engaging service users and their carers in a therapeutic relationship and stress the importance of delivering evidence-based psychosocial interventions for psychosis. The application of an attributional model of care staff responses to their clients' problems or behaviours could have important implications for the development of such approaches.

OBJECTIVES

This review sought to explore the nature, reliability and validity of care staff causal attributions towards clients with severe and enduring mental health problems and the clinical correlates of those attributions. In addition, methods for eliciting and measuring causal attributions were investigated.

METHODOLOGY

Search Strategy

A computerized search of electronic databases accessed through the OVID gateway (EMBASE (1988 to week 1 September 2005), OVIDMedline(R) (1966 to week 1 September 2005), PSYCHINFO (1985 to week 1 September 2005) and CINAHL (1982 to week 1 September 2005) was performed using the key words: "Staff" or "Mental Health Personnel" or "Carer" and "Expressed Emotion" or "Attributions" or "Causal Attributions". The search was limited to studies written in the English language and published between 1990 and September 2005. Study eligibility was determined by reading the titles and where necessary the abstracts of identified papers using the following inclusion and exclusion criteria:

Inclusion Criteria

Empirical studies relating to paid care staff attributions towards their adult clients with severe mental health problems.

Exclusion Criteria

Articles relating only to: child clients, individuals with a learning disability or individuals with dementia. Unpublished dissertations, qualitative studies, narrative reviews and articles relating only to non-paid carers, such as family members.

Search Process

Appendix 2.ii shows a flow-chart diagram of the search results. A total of 278 articles were identified during the initial electronic database search. When duplicates, those articles which clearly did not fit inclusion criteria from their title, review articles, book chapters and unpublished dissertations were excluded this left 45 potential articles. These articles were screened according to the inclusion and exclusion criteria and this revealed 13 eligible articles for inclusion. As there are no established search criteria for such a review the reference sections of selected articles were also searched for further relevant articles. No further articles were found. Therefore 13 articles, comprising 13 studies were included.

Critical Appraisal of Methodological Quality

Criteria for assessing the quality of the literature were adapted from the guidelines provided by SIGN (2004). The author and one other independent rater assessed the methodological quality of selected articles. A critical appraisal checklist was developed for this purpose (see Appendix 2.iii). Although generic methodological factors were considered when reviewing studies, also of interest was the attribution theory on which

the studies were based, the attribution measures used in the studies and the method of eliciting attributions - for example using case vignettes or actual clients.

Each paper was rated and a simple categorical rating of "excellent" (80% - 100%), "good" (60% - 79%), "adequate" (40% - 59%) or "poor" (below 40%) was allocated on the basis of the score. Inter-rater agreement for overall category was 100% and for item-by-item scoring K = 0.881. Items for which there was disagreement were discussed and an agreement was reached – these are the reported values in Appendix 2.iv.

Data Analysis and Synthesis

Details of the studies were placed in a table to facilitate cross-referencing of study design and outcomes.

Although all of the included studies addressed staff attributions towards clients with severe mental health problems, there was substantial methodological variance in the attribution measures employed, methodological design, coding of attributions and statistical analyses. Therefore meta-analytic techniques were considered inappropriate. Instead the results are organized as a narrative synthesis where the results of the studies are organized according to the domains providing a basis for eliciting attributions. Methodologically strong studies are given precedence in the description of results.

RESULTS

Characteristics of Studies

Of the 13 studies included in the review, 6 examined staff attributions towards actual clients (Whittle, 1996; Sharrock, et al., 1990, Barrowclough et al., 2001; Leggett and Silvester, 2003; Ilkiw-Lavalle and Grenyer, 2003; Outlaw and Lowery, 1994), 3 investigated attributions towards case vignettes (Apel and Bar-Tal, 1996; Meddings and Levey, 2000; Boisvert and Faust, 1999), 1 investigated attributions towards a 'typical client' (Nathan et al., 2001), 1 investigated attributions towards readmitted clients with schizophrenia in general (Fetter and Lowery, 1992), 1 investigated attributions towards 'imaginary clients' (Markham and Trower, 2003), and the final study investigated causal attributions for physical aggression in the psychiatric unit in general (Gillig et al., 1998).

Seven of the studies investigated staff attributions only (Boisvert and Faust, 1999; Sharrock et al., 1990; Markham and Trower, 2003; Leggett and Silvester, 2003; Meddings and Levey, 2000; Apel and Bar-Tal, 1996; Barrowclough et al., 2001), 4 investigated staff and client attributions (Gillig et al., 1998; Ilkiw-Lavalle and Grenyer, 2003; Outlaw and Lowery, 1994; Fetter and Lowery, 1992) and 2 investigated staff, clients' and relatives' attributions (Whittle, 1996; Nathan et al., 2001).

Appendix 2.iv shows the quality ratings of each of the included studies. None of the studies were rated "excellent", 7 studies were rated "good" (Whittle, 1996; Barrowclough et al., 2001; Leggett and Silvester, 2003; Fetter and Lowery, 1992; Markham and Trower, 2003; Boisvert and Faust, 1999 and Apel and Bar-Tal, 1996), 5 studies were rated

"adequate" (Sharrock et al., 1990; Ilkiw-Lavalle and Grenyer, 2003; Outlaw and Lowery, 1994; Nathan et al., 2001; Meddings and Levey, 2000) and 1 study was rated "poor" (Gillig et al., 1998).

Characteristics of Staff Participants

In the 13 studies reported in the review the total number of staff participants was 813. The staff participants (from those studies where demographics were clearly reported) were predominantly female (N = 435 out of 668, 65%) and predominantly from the nursing profession (N = 398 out of 622, 64%). However, there were smaller numbers of other professional groups reported including psychologists, unqualified care staff, social workers, counsellors and psychiatrists. The median age of staff participants was estimated to be 36 years (range 31 – 51.2 years).

A full breakdown of the participants included in each study is shown in Table 1.

NATURE OF CAUSAL ATTRIBUTIONS

The research questions of each of the studies and their key findings are shown in Table 1. Due to the heterogeneity of research questions the findings are organised according to the specific attributional domains which were focused on in the studies.

INSERT TABLE 1 ABOUT HERE.

Causal Attributions for Challenging Behaviour or Aggression

Of the 5 studies examining staff attributions towards clients' with challenging behaviour or aggression, studies by Barrowclough et al. (2001) and Apel and Bar-Tal (1996) were rated as good. Studies by Sharrock et al. (1990) and Ilkiw-Lavalle and Grenyer (2003) were rated adequate and the study by Gillig et al. (1998) was rated poor.

Barrowclough et al. (2001) examined the causal attributions of 20 psychiatric nursing staff from inpatient wards towards their clients with challenging behaviour. Strengths of this study included that it was based on attribution theory, that they used a previously published attribution measure and that inter-rater reliability was reported. They utilised the Camberwell Family Interview (CFI, Vaughn and Leff, 1976; modified by Barrowclough, 2001) to elicit spontaneous staff causal attributions. Attributional statements were extracted and coded using the Leeds Attributional Coding System (LACS, Munton et al., 1999). Inter-rater agreement for extraction and coding of attributional statements was high. Staff attributions for client causality were predominantly internal and personal. Attributions tended to be rated as unstable and results for controllability were mixed. The events for which attributions were made could be allocated to 5 categories: illness symptoms (e.g. illness onset, exacerbation, positive symptoms, affective symptoms); negative symptoms; interpersonal problems; behavioural excesses and aggression. Most staff attributions concerned illness symptoms and aggression followed by interpersonal problems, behavioural excesses and negative symptoms.

They also explored the concept of EE in relation to attributions and found that while no staff interviews were rated high in EE, critical comments were associated with giving more stable causes for clients' problems. When borderline critical comments were also included, criticism was associated with staff giving more internal causes. No other EE/attributional associations reached statistical significance.

Barrowclough et al. (2001) also assessed staff and clients' perceptions of relationship quality using two 5-point scales to assess their current feelings towards the client or key-worker respectively and their perception of the client or key-worker's feelings towards them (1 = mostly very strong positive feelings and thoughts and 5 = mostly very strong negative feelings and thoughts). Greater negative expressed feelings by staff about their clients were associated with increased tendency for staff to attribute client problems to being within the clients' voluntary control. The more negative clients' expressed feelings were, the greater the tendency for staff to make attributions which were internal to the client. Staff participants' perceived negativity from clients was related to seeing client problems as more personal to and more controllable by the client.

Apel and Bar-Tal (1996) employed a within-subjects design to examine the behavioural and attributional responses of 133 nursing staff from closed wards in psychiatric hospitals towards a hypothetical scenario of a client displaying challenging behaviour under 'arbitrary' and 'non-arbitrary' conditions. Strengths of this study included that they presented detailed information regarding their sample and that the study was based on attribution theory. Results were stated clearly and they discussed the clinical

implications and limitations of their study. However, they used an attribution measure which had not been previously published and did not report reliability for this measure. Apel and Bar-Tal (1996) defined an arbitrary (or uncontrollable) violent event as an occurrence which was not prompted by any action on the part of the staff member. In the non-arbitrary (or controllable) vignette the client had a reason to attack the nurse (the nurse had tried to prevent the client from leaving the ward). The scenarios were constructed on the basis of the nursing experience of the author and were judged by 7 psychiatric nurses as to the extent to which they represented real life situations. They were also judged regarding the extent to which the client's behaviour was more arbitrary and less controllable by either the client or the nurse. The questionnaire was designed by the experimenters. They asked only one question to measure attributions which concerned the extent to which participants thought the client's mental illness had caused the violent behaviour. The response was measured on a 5-point scale from 'absolutely disagree' to absolutely agree'. Apel and Bar-Tal (1996) found that staff participants were more likely to attribute a client's violent behaviour to mental illness in an arbitrary (uncontrollable) scenario compared with a non-arbitrary (controllable) scenario.

Apel and Bar-Tal (1996) also investigated the participant's behavioural response to the incident. The panel of experts indicated all possible nursing responses to the vignettes. These were then divided into three response categories on the basis of content analysis defined as either violent response, vigilant response or therapeutic response. For each category the response most frequently given by the experts was chosen as representative. For each event participants were asked to indicate how nursing staff on their ward usually

responded to such a behaviour. The authors state that they asked about the responses of others to prevent a social desirability effect. The most frequently selected behaviour with regards to the arbitrary (uncontrollable) scenario was therapeutic, while for the non-arbitrary (controllable) scenario the most frequent response was violent behaviour. Participants therefore seemed to find it easier to respond therapeutically to a situation in which a client's behaviour seemed arbitrary (or uncontrollable) than when a client's behaviour seemed more predictable or controllable. They also examined the impact of staff seniority and level of education on their responses. Participants who had taken a course in psychiatry were more likely to respond therapeutically to the non-arbitrary (controllable) vignette, while those who had not were more likely to choose the violent response. Furthermore those participants who chose the therapeutic response in the non-arbitrary scenario had worked longer and had more seniority in their roles.

Ilkiw-Lavalle and Grenyer (2003) examined the causal beliefs of staff and clients for aggressive incidents which had taken place while they were in the psychiatric inpatient unit. They provided detailed information about their sample but the study did not appear to be based on attribution theory. They used an attribution measure which had not been published and failed to report the reliability of this measure. Ilkiw-Lavalle and Grenyer (2003) used their own questionnaire designed for the study. They found that 3 main causes were cited for challenging behaviour: client illness factors, interpersonal conflicts and limit setting. Client and staff perceptions of the causes of aggression were significantly different when compared across these 3 factors. Staff viewed illness factors as the main cause of aggression, followed by limit setting then interpersonal conflicts.

Clients viewed interpersonal conflicts as the main cause of aggression, they viewed illness factors as the cause less often than staff and both clients and staff almost equally reported limit setting as a cause of aggression.

Sharrock et al. (1990) examined staff attributions regarding one particular client who had been resident on a medium secure unit for mentally disordered offenders for 14 months and was diagnosed as 'personality disordered with borderline intelligence'. Weaknesses of this study included that they failed to provide detailed information about their sample and they only examined staff attributions towards one particular client which limits generalisability. Strengths included the use of a previously published attribution measure and that the study was based on attribution theory. They used the modified Attributional Style Questionnaire (Peterson et al., 1982, modified by Dagnan et al., 1998). This involved staff writing down the major cause of each of 14 negative behaviours commonly associated with clients with mental health problems (for example acting with hostility to another client or absconding) and rating each cause along four 7-point bipolar scales labeled internal-external (to the client), stable-unstable (over time), global-specific and controllable-uncontrollable (by the client). Reliability for the 4 subscales was found to be high. Staff tended to make internal, controllable, stable and global attributions for problem behaviour. This contrasts with the results of Barrowclough et al. (2001) who found that staff attributions for challenging behaviour tended to be unstable and neither consistently controllable nor uncontrollable. This discrepancy may be due to the fact that Sharrock et al. (1990) only examined attributions in response to one particular target

client and therefore it seems possible that their results are influenced by staff participants' relationship and knowledge of this particular client.

Sharrock et al. (1990) also examined staff optimism. They used a scale similar to that used by previous researchers (Garety and Morris, 1984; Moores and Grant, 1976). They found that staff ratings towards the target client fell towards the mid-point on the optimism scale. Optimism was associated with helping behaviour, which had high and significant negative correlations with stable, internal and controllable attributions. There was no effect of staff age, experience, professional qualifications or seniority on any of the dependent variables. They also found no effect of degree of knowledge of the client.

Gillig et al. (1998) examined staff and client causal attributions about the causes of physical aggression on a psychiatric inpatient unit. This study had several weaknesses, detailed information about the sample was not provided, the study did not appear to be based on attribution theory, they used an attribution measure which had not been previously published and failed to report the reliability of this measure. They also did not discuss the limitations of their study. Gillig et al. (1998) asked for attributions about physical aggression on the unit in general and used their own questionnaire designed for the study. They found that both clients and staff viewed verbal abuse directed by clients at staff or at other clients to be the most important interpersonal contributor to physical aggression on the unit. Staff also listed the impact of client substance abuse, intoxification and violent lifestyle as major causative factors. Although many clients agreed that these factors were important, there was a significant difference in the

percentage of staff versus clients endorsing these issues. Clients tended to attribute physical aggression to the use of forced medication, restraint and seclusion to a greater extent than staff.

Effect of Psychiatric Label

Of the 3 studies examining staff attributions about clients with various diagnostic labels the studies by Markham and Trower (2003) and Boisvert and Faust (1999) were rated good and the study by Meddings and Levey (2000) was rated adequate.

Markham and Trower (2003) used a within-participants design to examine the causal attributions of 48 staff from inpatient psychiatric facilities towards clients with specific diagnostic labels. This study had clear aims, was based on attribution theory and used a previously published attribution measure. They asked participants to imagine a client with a specific diagnosis (borderline personality disorder (BPD), depression and schizophrenia) and utilised the modified Attributional Style Questionnaire (ASQ, Peterson et al., 1982, modified by Dagnan et al., 1998) to measure causal attributions. They did not report the reliability of this measure in their own sample. Staff scores for stability and controllability were higher for clients with a diagnostic label of BPD than for those with a label of depression or schizophrenia. In addition, the more control the client was perceived to have, the less sympathetic staff were - they actually reported a tendency to feel unsympathetic towards clients with a diagnosis of BPD. In contrast, staff tended to report that they would feel sympathetic towards clients with a label of depression or schizophrenia.

Boisvert and Faust (1999) used a randomized 2 x 2 factor design to examine the attributions of 58 mental health professionals from a community mental health centre towards a fictional scenario of an employee with and without a label of schizophrenia. Strengths of this study included that it had clear aims and the attribution measure had been previously published. However, detailed information about the sample was not presented and the study did not appear to be based on one clear attribution theory. Half of the participants evaluated an employee who had no psychiatric label and half evaluated the same employee with a label of schizophrenia. Within each of these groups they varied the level of environmental stress along 2 conditions: negligible or moderate. They used the Causal Dimension Scale - Version II (CDS-II, McAuley et al., 1992) to measure causal attributions. This is a 12-item self-report scale designed to measure how individuals perceive causes along four factors: internality, stability, external control and personal control. There were three questions per factor, each rated on a scale of 1 – 9. They did not examine the reliability of this measure in their own sample. They also used a questionnaire designed for the study to explore perceptions of the severity of the behaviour, the degree to which the behaviour was justified, the cause of the behaviour, the degree to which the behaviour was characteristic of the person and the likelihood that the behaviour had occurred previously. The reliability of this measure was not reported. They found that regardless of diagnostic label (schizophrenia versus no diagnostic label), with increasing environmental stress, staff were more likely to rate the person as justified in acting violently and the cause of the behaviour as more situational.

Meddings and Levey (2000) employed a between-groups design to examine the impact of the label schizophrenia on the attributions and preferred management strategies of hostel staff in relation to a violent incident. Strengths of this study included the provision of detailed information about their sample. However, the study did not appear to be based on one clear attribution theory and they used an attribution measure which had not been previously published. Participants responded to a hypothetical vignette of a violent incident, half of the participants were informed the client had schizophrenia and half were not. They used their own questionnaire designed for the study which they demonstrated to be valid and reliable. There were few significant differences between attributions made by staff informed that a client had schizophrenia and those who were not. However participants were more likely to attribute a violent incident to the client not understanding a request in the schizophrenia vignette than in the non-schizophrenia vignette and as less due to him being angry. In terms of individual items the most important causes rated by hostel staff for a violent act were: 'he is angry', 'his argument with his girlfriend' and 'he is a violent man'. They also rated 'he's been drinking' and 'he's been using drugs' as quite important, despite them not being mentioned in the vignette. Staff used a wide range of explanations for violent behaviour and attributed violent behaviour to all 3 factors examined: internal enduring, internal temporary and external.

Meddings and Levey (2000) also examined general attitudes towards homelessness using Guzewicz and Takooshian's (1992) scale of public attitudes towards homelessness (PATH). Reliability for this measure was not reported. Staff showed generally positive attitudes towards homeless people and neither positive nor negative attitudes towards

people with schizophrenia. More positive attitudes as measured by the PATH were correlated with making more external attributions for the incident.

They also included questions relating to management strategies. These could be grouped into six factors: medical, punitive, tough/caring, talking/caring, ignore and understanding. Staff rated the most useful ways of managing violent behaviour as being to 'feedback he's angry', 'look after him' and 'calmly ask him to leave'. Staff reported they would be likely to manage the behaviour differently if the man had schizophrenia, i.e. they would be more likely to use psychiatric or medical strategies (e.g. phoning a mental health professional, using time out and admitting to a psychiatric hospital). External attributions were associated with more talking/caring strategies. They also found some evidence that trained hostel staff made less internal attributions for violent behaviour compared to untrained staff and that they preferred less punitive management strategies. More experienced hostel staff rated the management strategies of being understanding and phoning a health professional as more useful. There were few gender or age differences.

Causal Attributions for Clients' Mental Health Problems

Of the 2 studies examining staff attributions for clients' mental health problems the study by Whittle (1996) was rated good and the study by Nathan et al. (2001) was rated adequate.

Whittle (1996) examined causal attributions regarding the onset of psychiatric disorder in 53 psychiatric inpatients, their relatives and key-worker staff. Strengths of this study

included clear aims and the use of a previously published attribution measure, however reliability data for this measure were not presented. Causal attributions for the onset of psychiatric disorder for each client were measured using the Causal Belief Questionnaire (CBQ, Whittle, 1996) which yields scores on four factors: psychosocial, biological, structural (beliefs regarding the effects of large social processes) and stress. Results indicated that belief in psychosocial factors were highest for all groups, followed by stress, biological and then structural factors. Clients and relatives had significantly higher scores compared to the views of staff for biological and structural causal beliefs. Causal beliefs relating to psychosocial factors and stress were not significantly different from those of staff. On average, clients who had been re-admitted held stronger biological causal beliefs than those admitted for the first time; whereas the beliefs of staff and relatives were no different on the basis of previous admission.

Whittle (1996) also examined the treatment beliefs of clients and relatives using the Treatment Beliefs Questionnaire (TBQ) developed for the study. Reliability for this measure was not reported. They found no significant differences between clients' and relatives' treatment beliefs and found that psychosocial causal beliefs were associated with belief in psychosocial treatment approaches and biological causal beliefs were associated with belief in biological treatment. They omitted to administer this measure to the staff participants included in their study.

Nathan et al. (2001) examined the causal attributions of staff from community mental health services, clients from these services and their relatives. Strengths of this study

included clear aims, the provision of detailed information about the sample and statistical analysis which was clearly related to the hypotheses. However, they used an attribution measure which had not been previously published and failed to report the reliability of this measure. Nathan et al. (2001) used an attribution interview schedule designed for the study. Staff participants were asked to make attributions regarding their 'typical client'; clients and their relatives were asked to respond in relation to the client's own mental health problems. They also examined the role of clients' ethnicity by splitting the clients into 4 ethno-cultural groups for analysis (European-Americano, Filipino-American, Hawaiian/Part-Hawaiian and Japanese-American). Clients, family members and staff all acknowledged the importance of stress as a causal factor in mental illness. Staff rated the causes poor health, drugs and alcohol significantly higher than clients and family members. In terms of ethnic origin Japanese-American clients rated religious or spiritual concerns and evil spirits/curses/black magic significantly higher than European-American clients.

Seclusion and Restraint

Of the 2 studies examining staff attributions about seclusion and restraint the study by Leggett and Silvester (2003) was rated good and the study by Outlaw and Lowery (1994) was rated adequate.

Leggett and Silvester (2003) employed content analysis of restraint forms which had been completed over a four year period by nurses in a medium secure psychiatric hospital in relation to actual clients. Strengths of this study included that it had clear aims, was

based on attribution theory and used a previously published attribution measure. They used the Leeds Attributional Coding System (LACS, Munton et al., 1999) in conjunction with Brewin et al.'s (1991) guidelines on its' use in schizophrenia studies to rate the attributional statements from physical restraint forms. A rating was made for the entire passage of text based on the frequency of controllable (to staff and to clients) and uncontrollable (to staff and to clients) causes. Inter-rater reliability was high. Staff perceived the majority of incidents of restraint as uncontrollable by staff. However a quarter of restraint forms were rated controllable by the client and half of the forms as neither controllable nor uncontrollable by the client. When staff stated they had no explanation for a violent incident they were more likely to make uncontrollable attributions for themselves and attributions which were 'neither controllable nor uncontrollable' by the client. They also found that incidents rated as controllable for the client and 'neither controllable nor uncontrollable' for staff had resulted in seclusion more frequently.

Outlaw and Lowery (1994) interviewed staff and clients from psychiatric inpatient units about an incident of seclusion or restraint which had taken place while they were in the unit. Strengths of this study included that the statistical analysis and results were clearly presented. However, the hypotheses were unclear, detailed demographic information about the sample was not provided and the study did not appear to be based on one clear attribution theory. The authors state that their attributional questions were adapted from a format used by several other attribution researchers. Participants were asked if they had thought about why a client had been placed in seclusion or restraint and to give a reason.

Answers were recorded verbatim and a nominal category system was developed which allowed all of the responses to be categorised. Each response was coded from 1 to 3 along the dimensions internality (to the client), controllability (by the client) and stability. Inter-rater reliability for the nominal coding scheme and the three dimensional scores was found to be adequate. Staff unanimously made internal causal attributions for clients' restraint. Clients on the other-hand were evenly split between attributions of internal and external causality. There was a tendency for both staff and clients to say that the causes for the clients' restraint were unstable. Staff gave causal responses that indicated the reasons for the clients' seclusion or restraint were controllable by the clients themselves, whereas clients gave causes that implied the seclusion or restraint was not under their control.

Re-hospitalisation

Only one study examined staff and clients' attributions for re-hospitalisation and this study was rated good.

Fetter and Lowery (1992) examined the causal attributions of staff and clients with a diagnosis of schizophrenia from psychiatric inpatient wards regarding re-hospitalisation. Strengths of this study included that it was based on attribution theory and inter-rater reliability for the measure was examined. Staff participants were asked to think about re-admitted clients with schizophrenia in general, why they were readmitted into hospital and the causes. Clients' attributions about their own re-hospitalisation were examined. They used their own semi-structured interview designed for the study. A panel of

'experts in attributions' coded the causal replies and each reason was given three ratings - one for each attributional dimension: internality, stability and controllability. Inter-rater reliability was high for all dimensions. Clients' reasons for readmission tended to be internal, unstable and uncontrollable. Staff attributions were significantly more unstable than clients and significantly more controllable than those of clients. Attributions did not differ significantly with regards to internality. Fetter and Lowery (1992) also examined the ability of setting and client and staff demographic variables to predict re-hospitalisation attributions along the three attributional dimensions. None of these variables significantly predicted attributions for either clients or staff.

Responses were also categorised into nominal categories: client illness, someone else, environment and treatment problems. Approximately half of the clients attributed their re-hospitalisation to something about their illness, while only 17% of staff posited illness as the cause. Only 8% of clients blamed non-compliance with their regimen, while half of the staff said non-compliance was the cause. While 34% of clients blamed someone else, none of the staff did.

DISCUSSION

This review explored the nature, reliability and validity of care staff causal attributions towards clients with severe and enduring mental health problems and the clinical correlates of those attributions. The methods used to elicit and measure causal attributions were also of interest.

Staff Causal Attributions and Concordance with Clients' Attributions

A common topic of studies was staff attributions for problem behaviour or aggression (Barrowclough et al. 2001; Apel and Bar-Tal 1996; Sharrock et al.1990; Ilkiw-Lavalle and Grenyer, 2003; Gillig et al. 1998). Barrowclough et al. (2001) and Sharrock et al. (1990) found staff attributions for challenging behaviour to be predominantly internal to the client. Results for controllability and stability were more mixed (Barrowclough, et al. 2001) but there was some evidence that staff tend to view challenging behaviour as under the voluntary control of the client (Sharrock et al., 1990). This relates to Weiner's (1980; 1985) theory that judgments of internality and controllability may lead to increased likelihood of carers experiencing negative emotions towards clients and decreased tendency to help. Only two of the studies (Markham and Trower, 2003; Sharrock et al., 1990) included in this review directly explored Weiner's model in relation to staff attributions and both found support for the model. In a clinical setting, separating the evaluation of a client's behaviour from the evaluation of the client themselves is likely to be important in forming a positive therapeutic relationship (Dryden, 1990).

Two studies examined causal attributions about the onset of mental health problems (Whittle, 1996; Nathan et al., 2001). Clients and relatives rated biological causes for mental health problems higher than staff (Whittle, 1996). Nathan et al. (2001) found that while clients, family members and staff all acknowledged the importance of stress as a causal factor in mental illness, staff rated poor health, drugs and alcohol significantly higher than clients and family members. If clients and staff hold different views about the cause of mental health problems this may adversely affect the therapeutic relationship

and could influence views about treatment. For example, Whittle (1996) found that clients and relatives with psychosocial causal beliefs for mental illness tended to believe in psychosocial treatment approaches, whereas biological causal beliefs were associated with belief in biological treatment. Although they did not examine treatment engagement or outcome it seems possible that clients may be more likely to engage with treatments which fit with their causal beliefs and this may act as a barrier to them receiving the best evidence-based interventions.

Two studies examined causal attributions for seclusion and restraint (Leggett and Silvester, 2003; Outlaw and Lowery, 2004). Staff felt the causes of restraint were largely uncontrollable on their part but were more likely to make attributions which were controllable by (Leggett and Silvester, 2003; Outlaw and Lowery), and internal to, the client. Clients tended to give uncontrollable causes and responses were mixed regarding internality. Both clients and staff tended to give unstable causes for restraint (Outlaw and Lowery, 2004).

One study examined beliefs about re-hospitalisation (Fetter and Lowery, 1992) and found that while both clients' and staff causal attributions tended to be internal and unstable, client's attributions tended to be uncontrollable and staff attributions tended to be controllable. The majority of clients attributed their re-hospitalisation to their illness while fewer staff posited illness as the cause. This suggests that clients may have been rating illness attributions as internal in the sense that illness is not due to other people or circumstances. The internal-external distinction has been criticised as problematic

(Kruglanski, 1979; Markham and Trower, 2003) as it is recognised that some causes may be considered to be ambiguous. This raises a question about the usefulness of the attributional dimension internality. Half of the staff attributed re-hospitalisation to non-compliance while few clients blamed this. Again this potential discrepancy in causal attributions could prove problematic when trying to build a positive therapeutic relationship with clients.

Methodological Issues

Many of the studies contained substantial methodological limitations. The predominant use of correlational analyses limits the extent to which causal links can be made between attributions and other variables. Also many studies did not use published attributional measures (Ilkiw-Lavalle and Grenyer, 2003; Gillig et al., 1998; Nathan et al., 2001; Fetter and Lowery, 1992; Meddings and Levey, 2000; Apel and Bar-Tal, 1991) and some did not appear to be based on attribution theory (Ilkiw-Lavalle and Grenyer, 2003; Gillig et al., 1998).

Six of the studies examined attributions towards actual clients (Whittle, 1996; Sharrock, et al., 1990, Barrowclough et al., 2001; Leggett and Silvester, 2003; Ilkiw-Lavalle and Grenyer, 2003; Outlaw and Lowery, 1994). This method may be preferential, since it might be expected that stronger emotional reactions and more realistic attributions would be generated in response to actual clients rather than fictional ones. The second most popular method was to use case vignettes of clients to elicit attributions. Some advantages of this method are that it allows the experimenter to control for possible

confounding factors and to manipulate various aspects (for example diagnostic label) in a standardized way that allows direct comparison between responses. However, this method has been criticised since vignettes often provide scant information about an individual's behaviour and fail to take account of contextual factors (Grey et al., 2002). None of the studies reviewed employed more than one method to elicit attributions and so a direct comparison of these methods was not possible. Future studies that allow a direct comparison of staff attributions towards actual clients and case vignettes would help to shed light on this issue.

Included studies varied widely in their research questions. The most common questions surrounded staff attributions towards clients with challenging behaviour and aggression (Barrowclough et al. 2001; Apel and Bar-Tal 1996; Sharrock et al.1990; Ilkiw-Lavalle and Grenyer, 2003; Gillig et al. 1998). This may be because challenging behaviour is a clearly definable variable and it would also be expected that strong emotional reactions would be evoked by such behaviour. In other studies the focus for attributions was less clear and the definition of mental health problems varied widely – even within studies. For example Fetter and Lowery (1992) and Nathan et al. (2000) asked staff participants to respond in relation to clients in general or their 'typical client', whereas the clients in these studies responded in relation to their own mental health problems. It seems possible that this could account for any difference between staff and client attributions in these studies.

Several studies did not report the reliability of their attribution measure (Ilkiw-Lavalle and Grenyer, 2003; Gillig et al., 1998; Nathan et al., 2000; Markham and Trower, 2003) and the measures varied widely in the way they were administered. The validity of causal attributions obtained from questionnaires and by asking specific questions has been questioned because the respondent may not have made any attributions if they were not prompted by the experimenter (Weiner, 1985). Only two studies (Barrowclough et al., 1991 and Leggett and Silvester, 2003) analysed spontaneously occurring causal attributions. Barrowclough and Hooley (2003) suggest that this is the preferred method of measurement, since attributions obtained in this way are not constrained by the questioning of the experimenter. The results from these studies suggest that like family members, formal caregivers also make a considerable number of spontaneous causal attributions for clients' behaviour.

Further difficulties with this type of attributional research include that staff may wish to present themselves in a professional manner and therefore be prone to give socially desirable responses. In addition, clients may be influenced by what they feel the researcher wants to hear or may be concerned that their responses will be divulged to staff and therefore affect their care in some way. Some of the studies (Apel and Bar-Tal, 1996; Whittle, 1996 and Gillig et al., 1998) did not appear to assure anonymity of participants which may have affected their results.

Clinical Implications

The findings reported in this review have clinical implications in terms of the management strategies which staff select to work with clients. For example, Meddings and Levey (2000) found that external (or situational) attributions for a violent incident were associated with more talking/caring strategies. They also found evidence that trained hostel staff made less internal attributions for violent behaviour and preferred less punitive strategies compared with untrained staff. Leggett and Silvester (2003) found that incidents were more likely to result in seclusion when staff rated them as controllable for the client and Sharrock et al. (1990) found that stable, internal and controllable attributions for challenging behaviour were negatively correlated with optimism and helping behaviour.

It is possible that staff attributions may impact on the therapeutic relationship. Barrowclough et al. (2001) investigated the relationship between staff-client relationships and causal attributions and found evidence that more 'blaming' (internal, personal and controllable) attributions were associated with a poorer staff-client relationship. Specifically greater negative expressed feelings by staff about their clients were associated with increased tendency for staff to attribute client problems to being within the clients' voluntary control. The more negative clients' expressed feelings were, the greater the tendency for staff to make attributions which were internal to the client. Staff participants' perceived negativity from clients was related to seeing client problems as more personal to the client and more controllable by the client.

Markham and Trower (2003) found that staff scores for stability and controllability were higher for clients with a diagnosis of BPD rather than depression or schizophrenia. There was less sympathy for those perceived to have more control and staff were least optimistic about change for clients with a label of BPD. The quality of the staff-client relationship is known to be an important factor in determining client outcome (Martin et al., 2000; Svensson and Hansson, 1999; Hewitt and Coffey, 2005). Furthermore there is evidence to suggest that a lack of optimism about treatment outcomes can negatively impact on the relationship between client and clinician (Woodside et al., 1994). These findings have important implications for developing interventions and training programs which focus on staff attributions towards their clients. Training and supervision may encourage staff to expand their causal analysis to include new elements and address attributions of internality and controllability, thus helping to modify staff emotional and behavioural responses towards clients. Helping staff to reattribute client problems to factors less within the client's control may be one way of improving relationship quality.

This review also contains evidence that clients' and relatives' views about the causation and best treatment of their problems sometimes differ from health professionals. This may be important since there is some evidence that mutual understanding between the client and therapist is needed to ensure a satisfactory therapeutic relationship and to aid compliance with treatment (Hewitt and Coffey, 2005). Staff training aimed at encouraging staff to examine their beliefs about the causes of mental health problems and

challenging behaviours and to take into account clients' and relatives' perspectives may therefore be helpful.

Recommendations for Future Research

Future research in this area would benefit from having a clear theoretical basis and a clear focus for causal attributions. Multiple methods could be used to elicit causal attributions to allow a direct comparison between attributions generated for example in response to actual clients and case vignettes. Future studies should assess the reliability of the attribution measures used. There is a need for the development of new measures of staff attributional, emotional and behavioural responses to clients which are based on recognised attribution theory. The use of attributional measures which result in 'forced' attributional ratings may not be ideal and other alternatives such as analysing spontaneous causal attributions are needed.

In addition a more thorough investigation of the interpersonal relationship between clients and staff and their causal attributions is needed. Future studies should report any correlations between causal attributions and other variables such as therapeutic alliance, intervention strategies and client outcome. It would also be of interest to further investigate the impact of staff characteristics such as level of training as possible predictors of causal attributions. The negative impact of psychiatric labels such as BPD and their relationship to attributions of control should also be explored further and it may be that training specifically in relation to this disorder would be helpful.

Conclusions

There are many methodological issues inherent in the reviewed studies which makes coherent synthesis of the findings a challenge. However, in general the findings suggest that, like relatives, paid care staff also make causal attributions for clients' problems which may affect their relationship with these clients and which could influence their tendency to help.

Attributional differences between mental health practitioners and their clients about the nature and cause of their problems such as those identified in this review could set up an environment conducive to tension and treatment non-compliance. Mental health practitioners should be conscious of these differences and make an effort to understand the clients' perspective.

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List of Tables and Figures

Table 1: Research Questions, Findings and Limitations of Studies

Study	Participants	Study Question	Method of Eliciting Attributions	Attribution Measure	Main Limitations	Main Findings
Apel et al. (1996) Quality Rating 64.3% (good)	Nursing staff (N = 133) from closed wards in psychiatric hospitals. Mean age 36 years, 42% male, 58% female.	What are the behavioural and attributional responses of nursing staff to arbitrary and non-arbitrary challenging behaviour in a client?	Case vignettes depicting a female client, diagnosis not specified in an arbitrary (uncontrollable) and non-arbitrary scenario.	Used their own questionnaire designed for the study.	The attribution measure was not published. Participants' causal attributions were assessed using only one question which concerned the extent to which they thought the client's mental illness had caused the challenging behaviour. Diagnosis was not specified.	Participants were more likely to attribute a client's violent behaviour to mental illness in an arbitrary scenario compared with a non-arbitrary scenario. When violent behaviour is viewed as arbitrary (uncontrollable) it mobilises staff willingness to take a therapeutic role.
Barrowclough et al. (2001) Quality Rating 78.6% (good)	Psychiatric inpatients (N = 20) and their staff key-workers (N = 20). Staff were qualified mental health nurses, 38% male, 62% female, mean age 31 years. Clients' mean age 32.7 years, 85% male. Diagnoses were primarily psychotic disorders.	What is the relationship between staff EE and their causal attributions for challenging behaviour?	Each staff member was interviewed regarding a specific client for whom they were key-worker.	Camberwell Family Interview (CFI, Vaughn and Leff, 1976, modified by Barrowclough 2001) and Leeds Attributional Coding System (LACS, Munton et al., 1999). Also measured clients' and staff perceptions of their relationship.	Relatively small sample. They did not account for socially desirable responding.	Attributions for client causality were predominantly internal and personal. Staff tended to view the behaviour of clients they felt less positively disposed to as more controllable. No interviews were rated as high in EE. Critical comments were associated with giving more stable causes for clients' problems.

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Study	Participants	Study Question	Method of Eliciting Attributions	Attribution Measure	Main Limitations	Main Findings
Boisvert et al. (1999) Quality Rating 67.9% (good)	Mental health professionals from a community mental health centre (N = 58). Four psychiatrists, 10 registered nurses, 41 clinicians of various levels of education, 1 case manager and 2 other.	What is the relationship between the label schizophrenia and causal attributions of violence?	Half evaluated a case vignette of an employee with no psychiatric label and half evaluated a case vignette of an employee with a label of schizophrenia. Within these groups the level of stress was varied (negligible or moderate).	Causal Dimension Scale – version II (CDS-II, McAuley et al., 1992)	Detailed demographic information was not presented. The study was not based on one clear attribution theory. Reliability for the attribution measure was not reported.	Regardless of diagnostic label there was a significant trend towards increasing situational attributions with increasing environmental stress.
Fetter et al. (1992) Quality Rating 60.7% (good)	Clients (N = 120) and staff (N = 162) from psychiatric inpatient wards, >70% of staff were female, median age 37.6 years, 50% psychiatrists, psychologists, social workers, OTs or non-professionals and 50% nurses, 61.7% were white. Clients with schizophrenia, median age 32.3 years, 43% white, 56% black and 1% Hispanic.	What causes do clients with a diagnosis of schizophrenia and their staff give for re-hospitalisation?	Asked staff participants about readmitted clients with schizophrenia in general. Clients were asked about their own re-hospitalization.	Used their own semi-structured interview designed for the study.	Demographic data were not clearly reported. The attribution measure was not published. Staff were asked about clients with schizophrenia in general while clients responded about their own re-hospitalization.	Staff attributions for readmission tended to be internal, marginally unstable and controllable. Clients' attributions tended to be internal, stable and uncontrollable. Fifty-one percent of clients attributed the cause of re-hospitalisation to their illness whereas only 17% of staff did. More staff than clients blamed non-compliance, more clients than staff blamed someone else.

Study	Participants	Study Question	Method of Eliciting Attributions	Attribution Measure	Main Limitations	Main Findings
Gillig et al. (1998) Quality Rating 32% (poor)	Clients (N = 54) and staff (N = 32) from an inpatient psychiatric unit. All clients were male, all staff female. Twenty-two clients with schizophrenia, 11 major depression, 5 bipolar disorder, 8 adjustment disorder, 8 substance-induced mental disorders.	What are perceptions of the causes of verbal and physical aggression and what corrective measures would they endorse?	Asked about physical aggression in the unit in general.	Used their own questionnaire designed for the study.	Did not account for socially desirable responding. Was not based on attribution theory, attribution measure unpublished and no reliability data presented. Data analysis, results and clinical implications not clearly presented and limitations not discussed.	Verbal abuse was viewed as an important contributor to physical aggression by both clients and staff. Staff stressed client substance abuse, intoxification and violent life-styles. Clients tended to focus on involuntary procedures such as forced medication, restraint and seclusion to a greater extent than staff.
Ilkiw-Lavalle (2003) Quality Rating 42.9% (adequate)	Staff (N = 29) and clients (N = 29) from psychiatric inpatient units. Staff 52% male, 48% female, mean age 33.02 years, 27 nursing staff of varying levels and 2 ward security staff. Clients 66% male, 34% female, mean age 30.51 years. Diagnoses 45% bipolar disorder, 41% schizophrenia, 10% another psychotic disorder, 4% adjustment disorder.	What are the emotions experiences, perceptions of cause and recommendations for reducing frequency of aggression given by those involved in incidents of aggression?	Staff and clients were asked about specific aggressive incidents which they had been involved in.	Used their own semi-structured interview designed for the study.	Not based on attribution theory. The attribution measure had not been published and no reliability data were presented. Results, clinical implications and limitations were not clearly discussed.	Staff emphasized medical management as both a cause of aggression and a way to manage aggression. Clients emphasised equally the roles of interpersonal conflict, limit setting and their illness as the cause and the need for better communication as a way to reduce aggression.

Study	Participants	Study Question	Method of Eliciting Attributions	Attribution Measure	Main Limitations	Main Findings
Leggett et al. (2003) Quality Rating 71.4% (good)	Staff (N = 58) and clients (N = 114) in a medium secure psychiatric hospital. 55.2% of staff were male, 44.8% female. Clients were 77.2% male, 22.8% female, mean age 31 years.	What is the relationship between attributions of control for the client, control for the staff and behavioural outcomes following challenging behaviour?	Physical restraint forms completed about actual clients.	Content analysis of physical restraint forms using LACS.	Detailed demographic information was not reported. Clinical implications and limitations were only briefly discussed.	Seclusion was more likely to be used when staff perceived the cause of an aggressive incident as neither controllable nor uncontrollable by themselves and controllable by the client.
Markham et al. (2003) Quality Rating 75% (good)	Staff from inpatient facilities (N = 48), 69% were female, 25% male, mean age 38 years.	How does psychiatric label affect perceptions and causal attributions about clients with challenging behaviour?	Staff were asked to imagine a client with a specific diagnosis.	Attributional Style Questionnaire (ASQ, Peterson et al., 1982, modified by Dagnan et al., 1998).	Although the attribution measure had been previously published the authors did not report reliability.	Staff scores for stability and controllability were higher for clients with a diagnosis of BPD rather than depression or schizophrenia. The more control a client was perceived to have the less sympathetic staff were.

Study	Participants	Study Question	Method of Eliciting Attributions	Attribution Measure	Main Limitations	Main Findings
Meddings et al. (2000) Quality Rating 53.6% (adequate)	Hostel staff (N = 59), 51.8% were female, 48.2% male, mean age 35.8 years, 58.9% had no relevant qualifications, 7.3% had nursing qualifications, 3 had social work training and 3 had NVQ qualifications.	What are the attitudes, attributions and preferred management strategies of staff in relation to a violent incident and what is the impact of the label schizophrenia?	Hypothetical vignette of a violent incident. Half of the participants were told the man had schizophrenia, half were not.	Used their own questionnaire designed for the study.	The study was not based on one clear attribution theory and the attribution measure used had not been previously published. However, reliability data for the measure were presented. The results section was not particularly clear and limitations were not discussed.	External attributions were related to more talking/caring strategies. Behaviour of the person with schizophrenia was attributed to less internal and enduring factor and more to lack of understanding.
Nathan et al. (2001) Quality Rating 57.1% (adequate)	Staff from community mental health services (N = 43), clients (N = 563) and relatives (N = 185). Staff were 44.2%male, 55.8% female, mean age 51.2 years, 8 psychiatrists, 7 psychologists, 9 social workers, 9 nurses, 10 other. Clients were 48.8% male; 51.2% female, mean age 43.3 years. Relatives were 29.2% male, 70.8% female, mean age 50.9 years.	What are attributions about the nature, cause and best treatment of mental health problems? Is there a role of ethnicity?	Staff were asked about their 'typical client'. Clients were asked about their own mental health problems and relatives were asked about the individual with mental illness.	Used their own semi-structured interview designed for the study.	The study was not based on one clear attribution theory. The attribution measure had not been published and reliability data for the measure were not presented. Results, clinical implications and limitations were not clearly stated. Staff were asked about their typical client whereas clients responded about their own mental health problems.	All groups acknowledged stress as a causal factor in mental illness. Staff rated poor health, drugs and alcohol higher than clients and family members. In terms of ethnic origin the four client groups compared (European-Americano, Filipino-American, Hawaiian/Part-Hawaiian and Japanese-American) differed in their ratings of causes with Japanese-Americans rating religious or spiritual concerns and evil spirits/curses/black magic significantly higher than European-Americans.

Study	Participants	Study Question	Method of Eliciting Attributions	Attribution Measure	Main Limitations	Main Findings
Outlaw et al. (1994) Quality Rating 50% (adequate)	Staff (N = 84) and clients (N = 84) from psychiatric inpatient units. Staff were nurses, mean age 37 years, 86.9% female, 13.1% male. Clients' mean age 39 years. 94% male, 6% female. Diagnoses schizophrenia, agitated psychosis and manic depression.	What are the causes given for clients' seclusion and restraint?	Staff and clients were asked about a specific incident of seclusion and restraint which they had been involved in.	Used their own semi-structured interview designed for the study.	Participation rate was unclear. The study was not based on one clear attribution theory. The limitations were not discussed.	Clients gave more situational causes while staff ascribed dispositional factors. Nurses tended to attribute cause of seclusion to internal, controllable, unstable factors and clients to external, uncontrollable and unstable factors.
Sharrock et al. (1990) Quality Rating 53.6% (adequate)	Staff from a medium secure unit for mentally disordered offenders (N = 34), 30 nurses, 4 from paramedical professions. Mean age 33 years.	Are attributions for challenging behaviour related to optimism and helping behaviour?	Staff were asked about one particular client who had been resident on the ward for 14 months and was diagnosed as 'personality disordered with borderline intelligence'.	Modified Attributional Style Questionnaire (Peterson et al., 1982, modified by Dagnan et al., 1998)	Participation rate was not reported. Staff all responded about the same client therefore results may lack generalisability. Aspects of statistical analysis were weak and the clinical implications were only briefly discussed.	The tendency of staff to make attributions of problem behaviour to unstable factors was associated with higher staff optimism and in turn to increased helping behaviour.

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Study	Participants	Study Question	Method of Eliciting Attributions	Attribution Measure	Main Limitations	Main Findings
Whittle (1996) Quality Rating 67.9% (good)	Psychiatric inpatients (N = 53), relatives (N = 53) and key-worker staff (N = 53) for each client. 54.7% of clients were male, 45.3% female. Diagnoses were 10 psychotic disorders, 12 mood disorders, 6 personality disorders and 25 other. All clients were white Caucasian apart from 1 of Afro-caribbean origin. Relatives were 50% male, 50% female.	What are causal beliefs regarding the onset of psychiatric disorder and treatment expectations?	Staff, clients and their relatives were asked about the client's mental health problems.	Causal Belief Questionnaire (CBQ, Whittle, 1996)	Staff demographics were not clearly presented. The study was not based on one clear attribution theory. Although the attribution measure had been previously published reliability data were not presented.	Belief in psychosocial factors were highest for all groups, followed by stress, biological and then structural factors. Both clients' and relatives' mean biological views were significantly greater than staff biological views. Beliefs of staff were no different for clients who had been readmitted and those who were being admitted for the first time.

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Chapter Three

Major Research Project Proposal

An investigation of multidisciplinary community mental health staff members' causal attributions for non-engagement amongst clients with psychosis

Chapter 3

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SUMMARY OF PROJECT

It is a major challenge for community-based mental health services to engage a significant number of people with psychosis (Mueser et al., 1998, Sainsbury Centre, 1998) and non-engagement can lead to increased risk of relapse and poorer clinical outcome (Song et al., 1998). There are a range of potential reasons for non-engagement with services amongst clients with psychosis. For example, difficulty engaging may be due to individual experience or characteristics, or due to the inappropriate nature of services (Sainsbury Centre, 1998). Psychosocial factors have been implicated in the engagement process, but their role in the engagement of clients with psychosis with community mental health services remains poorly understood (Levy, 1998). Identification of these processes may be important in guiding the development of interventions to aid engagement with clients.

This study will use attribution theory to explore the causal attributions made by multi-disciplinary community mental health staff to explain non-engagement behaviour. Specifically this study will be based on Weiner's (1980; 1985) model of helping behaviour, which proposes that helping behaviour is caused primarily by the emotional reactions of sympathy and anger which, respectively, promote or reduce the tendency to help. Furthermore, attributions of controllability and internality are regarded as the primary determinants of these emotional reactions.

The current study aims to investigate whether Weiner's model of helping behaviour is useful to explore multidisciplinary community mental health staff members' causal

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attributions towards non-engagement behaviour amongst clients with psychosis. The study will examine the validity of those attributions generated in response to vignettes of hypothetical clients displaying non-engagement by comparing them with the attributions generated in response to non-engagement amongst real clients with psychosis using a diary methodology. Furthermore the study will allow a comparison of the attributions made by staff who are trained and untrained in psychosocial interventions (PSI) for psychosis.

Results will have implications for understanding the causal attributions made by community mental health staff to explain non-engagement amongst clients with psychosis. In addition, the results will help determine the validity of using vignette methodology to investigate causal attributions as opposed to real incidents of non-engagement amongst clients with psychosis. The study will also allow a comparison of the attributions made by staff members who have received training in PSI with a similar group of staff who have not received this training.

INTRODUCTION

Engagement

The process of engaging clients with mental health services is a complex one and over the years researchers have defined non-engagement in different ways. The majority of studies have looked at medication non-adherence amongst clients with psychosis as a measure of non-engagement. A recent systematic review by Lacro et al. (2002) using this definition found a mean rate of 41.2% non-adherence amongst clients with schizophrenia.

Alternatively non-engagement could be defined as either failure to adhere to medication or failure to attend scheduled appointments. Nosé et al. (2003) used this wider definition in their recent systematic review and found that a mean of 25.8% of clients with psychosis had problems with engagement. It seems likely that engagement is multi-factorial, for example Tait et al. (2002) developed the Service Engagement Scale (SES, Appendix 3.i) to measure engagement with community mental health services according to four factors: availability, collaboration, help-seeking and treatment adherence.

Non-engagement with services is a major block to delivering treatment and support in the community and may be a risk factor for relapse and re-hospitalization (Song et al., 1998). Failure to engage is often attributed to lack of insight on the part of the client, however, evidence for a relationship between insight and treatment adherence is inconclusive (Trauer and Sacks, 2000). The attitudes and characteristics of mental health professionals as well as clients contribute to the creation and maintenance of a trusting relationship between clients and professionals and it is important that strategies aimed at improving this relationship are developed. Further understanding of non-engagement with services or treatment may assist the development of interventions to enhance engagement and treatment adherence.

It seems possible that psychological adjustment to psychosis might underlie some of the difficulties with engagement. Tait et al. (2003) carried out a study to investigate the impact of clients' coping or recovery style, insight and symptoms on engagement with services for psychosis. The recovery style 'sealing over' can be defined as a way of

coping that involves minimizing the significance and impact of symptoms and showing a lack of curiosity about the experience of psychosis, whereas the recovery style 'integration' can be defined as an acknowledgement of and curiosity about and active attempts to manage their psychosis on the part of the client (McGlashan et al., 1977). The Tait et al. (2003) study explored whether there was a relationship between recovery style and service engagement, whether integration and sealing over were stable over time and whether recovery style was related to insight. Results showed that having a sealing over recovery style was associated with consistently lower service engagement (according to the SES) than integration. Furthermore, recovery style at 3 months predicted service engagement at 6 months and there was no relationship between service engagement and either psychotic symptoms or insight. Results also showed that recovery style can change over time, suggesting that at least for some individuals with psychosis changes in recovery style may reflect psychological adjustment to psychosis and could influence how clients interact with statutory services. Understanding the relationship between recovery style and engagement may be important when designing interventions or training to enhance engagement, since clinicians could tailor their interventions with clients according to their current recovery style.

Attribution Theory

Current research into the belief systems employed by staff to understand non-engagement behaviour and the nature and extent of emotional reactions to such behaviour is lacking. This study will therefore focus on the attributions made by multidisciplinary CMHT staff to explain non-engagement amongst clients with psychosis and specifically will examine

the reliability and validity of using vignettes of hypothetical clients who do not engage to elicit causal attributions. Previous research investigating staff attributions towards challenging behaviour in mentally disordered offenders (Sharrock et al., 1990) and individuals with a learning disability (Dagnan et al., 1998; Wanless et al., 2002) have applied Weiner's model of helping behaviour (Weiner, 1980; 1985) to care staff responses to problem behaviours. The current study will use a similar approach to explore community mental health staff responses to non-engagement behaviour amongst hypothetical and real clients with psychosis.

Weiner's (1980; 1985) model of helping behaviour has two central components. First, that helping behaviour is regarded as being caused primarily by the emotional reactions of sympathy and anger which, respectively, promote or reduce the tendency to help. Second, that attributions of internality and controllability are regarded as the primary determinants of the emotional reactions. While Weiner's research has been useful in specifying the role of attributions in helping behaviour, studies in this area have largely ignored the behaviour of helping professionals. Although it might be argued that professional staff have a moral obligation to help clients in need, they may often face difficult choices about whom to help given limited time and resources. In the more recent version of Weiner's (1986) theory of achievement motivation, attributional stability is regarded as the most important determinant of expectations of success and failure. Thus, in the context of helping it may be predicted that if a problem behaviour is attributed to a stable cause, help is less likely to be elicited, since expectations of that help being successful are low. It could therefore be predicted that unstable attributions of

a client's negative behaviour would be associated with greater staff optimism. Conversely, attributions of behaviour problems to stable factors suggest that the causes are less likely to be amenable to change and would be associated with reduced staff optimism.

Attribution theory, applied to staff behaviour, has an underlying hypothesis that the attributions which staff make about the causes of behaviour will influence their emotional and behavioral response to it. Munton et al. (1999) identified four attributional dimensions following a review of the literature:

- Stable vs. unstable (i.e. will the cause operate reliably in the future?)

- Global vs. specific (i.e. has it a range of important outcomes?)

- Internal vs. external (i.e. does it originate within that person?)

- Controllable vs. uncontrollable (i.e. does it indicate that the person could influence the outcome?)

These dimensions have allowed the model to suggest a role for staff emotional responses, predicting that behaviour which is seen as deliberate, i.e. internal and controllable, is likely to result in a negative emotional response in staff and a reduced likelihood of offering support (Stanley and Standen, 2000).

Methodological Issues

Previous research has tended to use two different approaches to examine the reaction of staff to problem behaviours. One method is to ask staff to generate causal attributions relating to a known client (Bromley and Emerson, 1995), while the other approach is to ask staff to generate causal attributions in response to a fictional client displaying problem behaviour depicted in a vignette (e.g. Hastings et al., 1997). A recent study by Wanless et al. (2002) used a combination of both of these methodologies to examine whether there was any difference in staff responses to individuals with learning disabilities displaying challenging behaviour depicted in vignettes and in relation to a known client with learning disabilities who engages in challenging behaviour. Results showed significant differences between staff responses to hypothetical and real scenarios of challenging behaviour. Stronger emotional responses were evoked and more negative evaluations of clients and their behaviour were found in relation to real incidents of challenging behaviour compared with vignette examples. These results suggest that responses to real incidents of problem behaviour may be influenced by the actual relationship with the client in question, whereas more general beliefs which staff hold about the causes of problem behaviours may be evoked in response to hypothetical clients or problem behaviours. This is important because such general beliefs have been found to have little correspondence with how people actually behave in a given situation (Ajzen, 1982). This methodology could have important implications for examining the reliability and validity of using hypothetical vignettes to explore staff attributions.

This study is based on the methodology of Wanless et al. (2002) but will be carried out in relation to multi-disciplinary staff working in CMHTs and specifically with regard to the problem of non-engagement behaviour amongst clients with psychosis. This study will use vignettes of hypothetical clients who do not engage. In addition, a diary questionnaire will be used to try and access staff members' immediate responses following real-life examples of non-engagement behaviour rather than doing this in retrospect. This is to reduce any effects of recall bias and to attempt to tap into spontaneous attributions, affect and behaviour.

Implications for Staff Training

This study will have an added component, which is to examine the difference between responses made by staff members who are trained and untrained in PSI. A range of PSI now have proven effectiveness with psychosis including family-based behavioural interventions, cognitive behaviour therapy (CBT) for psychotic symptoms and early intervention (Tarrier et al., 1998). Skills gaps in areas such as PSI for severe mental illness have been identified as a 'critical challenge' in the UK (Milne et al., 2002) and this includes treatment adherence, where research has identified that many nurses in the UK have poor skills and knowledge (Gournay, 2001).

Research studies evaluating the staff training which does exist have been variable in quality and in the outcome measures used and few have adopted a comprehensive approach to evaluation. Most studies in this area have used changes in skill or knowledge

gain after training as the key outcome and few studies have measured attitude change after training or the impact of the training upon clients (Milne et al., 2000). Most of the evidence suggests that knowledge and skill gains are typically found following training and this could therefore be expected to affect staff attitudes and practice. Leff and Gamble (1995) trained nurses to tackle high expressed emotion in families containing a person with schizophrenia. They developed a 40-item multiple choice questionnaire to assess knowledge gain and a 13-item 'Attitude and Assumptions Questionnaire' and found that attendance at the 72-hour long training programme was associated with statistically significant improvements on both measures.

Recently Gray et al. (2003) reported a 10-day 'Medication Management' training programme aimed at enhancing the medication adherence skills of mental health nurses. Training topics included assessment of medication adherence issues, cognitive and compliance therapy skills, psychopharmacology and ongoing (weekly) clinical supervision of the trainees' implementation. Improvements in both cognitive therapy skills and knowledge were found after the training however, Gray et al. did not measure staff attitudinal variables. Given the possibility that staff attitudes towards medication adherence may influence the way they respond to adherence issues (Coombs et al., 2003) this is a significant omission.

Another recent study in Australia (Byrne et al., 2004) examined the effectiveness of a 3-day training workshop on developing mental health workers' strategies to enhance client adherence to medication. Pre and post training measures were taken of clinician

knowledge about adherence strategies, ability to identify predictors of non-adherence, attitudes towards working with non-adherent clients and optimism about treatment outcomes for clients. Their 'Medication Alliance' programme emphasizes the need to carefully evaluate the specific causal variables surrounding medication-taking behaviour and to use that information to derive a clinical formulation of non-adherence. In their sample, consisting mostly of community mental health nurses, Byrne et al. found significant improvements in participants' knowledge of individualised assessment techniques and ability to apply that knowledge to specific case material after training, with participants showing significant improvement in their ability to identify potential causal variables for non-adherence. There were also significant changes in participants' attitudes following the training. Results showed that participants felt their knowledge was more adequate for working with people who do not adhere to treatment and that they expected to derive more satisfaction from engaging with people who have medication non-adherence issues following the training. It has been suggested that clinicians can unwittingly transmit their treatment expectations to clients and that the expectations of the clinician may therefore have an important impact on the outcome of treatment (van Dulmen et al., 2002), a lack of optimism about treatment outcomes can negatively impact on the relationship between client and clinician (Woodside et al., 1994). Byrne et al. (2004) found that clinician optimism about treatment outcomes for their clients was also significantly improved after training.

The above research suggests that staff who have received PSI training may feel more positively about engaging clients who are difficult to engage and may feel more

optimistic about the potential treatment outcomes for these clients. In addition, it might be expected that staff who have received training in PSI will have increased knowledge and skills and show a better understanding of the potential causes of non-engagement amongst clients with psychosis, as reflected in the type of causal attributions they generate to explain this behaviour.

PROPOSED AIMS

This study has three main aims which are:

1/ To explore the nature and characteristics of multi-disciplinary CMHT staff members' causal attributions for non-engagement behaviour amongst clients with psychosis and their relationship with self-reported affect, helping behaviour and optimism.

2/ To investigate the validity and reliability of using vignette methodology for eliciting multi-disciplinary CMHT staff members' causal attributions for non-engagement behaviour amongst clients with psychosis.

3/ To compare responses of multi-disciplinary CMHT staff members who are trained and untrained in psychosocial interventions (PSI).

HYPOTHESES

There are three main hypotheses:

Hypothesis 1

The primary hypothesis is that causal attributions for non-engagement will be related to participants' self reported affect, helping behaviour and optimism in line with Weiner's model of helping behaviour. In particular:

i)   Internal, controllable and stable attributions for non-engagement will be positively correlated with negative emotions and reduced optimism

ii)   Negative emotions and reduced optimism will be related to reduced self-reported willingness to provide extra help to that client

Secondary hypotheses include:

Hypothesis 2

There will be a positive correlation between the causal attributions generated by participants to explain non-engagement behaviour depicted in vignettes of hypothetical clients and in response to real clients with psychosis.

Hypothesis 3

Participants who are trained in PSI will make different responses compared with participants who are untrained in PSI:

i) They will show greater positive affect in response to non-engagement behaviour

ii) They will show greater optimism in response to non-engagement behaviour

PLAN OF INVESTIGATION

Measures/Materials

The measures used to assess the cognitive and emotional responses of staff towards non-engagement are based on those used by Sharrock et al. (1990), Dagnan et al. (1998) and Wanless et al. (2002).

Demographic Questionnaire (Appendix 3.ii)

Demographic measure asking staff to report name, age, gender, profession, grade, place of work, length of time working there and to specify any post-qualification formal clinical training undertaken.

Vignettes (Appendix 3.iii)

Four brief vignettes depicting a client with a diagnosis of schizophrenia will be presented, each vignette describing one of the four types of non-engagement behaviour defined by Tait et al. (2002).

The types of non-engagement behaviour displayed in each of the four vignettes are therefore:

1/ Vignette 1 (availability): client seems to make it difficult to arrange appointments or avoid making appointments

2/ Vignette 2 (collaboration): client usually resists advice or does not take an active part in the setting of goals or treatment plans

3/ Vignette 3 (help-seeking): client finds it difficult to ask for help or does not actively seek help even at times of crisis

4/ Vignette 4 (treatment adherence): client refuses to co-operate with treatment or has difficulty in adhering to the prescribed medication.

The vignettes will be examined by a panel of experts (to be determined) to examine face validity. Vignettes will be counter-balanced in presentation to each participant to minimize order effects.

Vignette Questionnaire (Appendix 3.iv)

Attributions will be recorded using a questionnaire method based on a modified version of Peterson et al's (1982) Attributional Style Questionnaire.

Section A: Participants will be asked for their main emotional response to each vignette and then to rate this emotion on a 7-point bipolar scale from 'not at all' to 'extremely'. Higher scores indicate greater levels of emotion (Dagnan et al., 1998).

Section B: Participants will be asked to write down what they think the possible cause(s) of the behaviour depicted in the vignette are and to underline the most probable cause.

Section C: Participants will be required to rate the most probable cause of the client's behaviour along four 7-point bipolar scales. These scales will be anchored by the relevant attributional constructs: internal vs. external (to the client), stable vs. unstable (over time), global vs. specific and controllable vs. uncontrollable (by the client). Russell et al. (1987) carried out a comparison of the reliability and validity of three different attribution methodologies used to assess causal dimensions: open-ended attributions; importance ratings of different causes and the attributor's perception of his or her own causal attributions as assessed by the causal attribution scale. They found support for the use of the causal attribution scale (which uses the controllability, stability and locus of

causality dimensions as described by Weiner, 1980) over the other methods and thus recommend the use of this type of self-rating measure.

Section D: Participants will be asked to rate their willingness to provide extra effort to help the client depicted in each vignette (e.g. Wanless et al., 2002; Dagnan et al., 1998, Sharrock et al., 1990, Weiner, 1980). This will be scored on a 7-point bipolar scale. Higher scores indicate a greater willingness to put extra effort into helping. Staff will also be asked what action they would take in this situation.

Section E: Participants will be asked to indicate their agreement or disagreement with two statements concerning the potential for changing the non-engagement behaviour depicted in each vignette scored on a 7-point bipolar scale, a measure derived from the optimism-pessimism scale used by Sharrock et al., (1990) (originally from work by Garety et al. (1984)). This measure was adapted to be more specific to non-engagement. Higher scores indicate greater optimism.

Diary Questionnaire (Appendix 3.v)

All participating staff will also be asked to complete an adapted version of this questionnaire, recording their spontaneous causal attributions each time they note the occurrence of non-engagement (as defined by Tait et al., 2002) by their own clients with psychosis over a two-week period. They will be asked to complete the same questions detailed above in relation to these clients. No identifying information about these clients will be collected.

Procedure

Participants

After obtaining local ethical and managerial approval, multidisciplinary staff from the 6 CMHTs within NHS Ayrshire and Arran will be invited to participate in the study. The project will be described as an exploration of staff attributions towards non-engagement amongst clients with psychosis. Following provision of information (Appendix 3.vi) and obtaining informed consent (Appendix 3.vii), staff will be approached to complete the study measures.

Participants in the study will be assessed using a questionnaire format. There will be two formats; one regarding the hypothetical clients depicted in the vignettes (Appendix 3.iv) and one relating to real incidents of non-engagement (Appendix 3.v). The second format aims to gather information regarding incidents of non-engagement as they occur. Staff members who have consented will be posted out copies of the vignette questionnaire and multiple copies of the diary questionnaire, which they will be asked to complete each time a client they see with a diagnosis of psychosis displays difficulty engaging over a 2-week period. They will be asked to return these by internal mail once the 2-week period is over. Follow-up telephone contact liaison will be used to maximize data collection.

After all of the questionnaires have been returned and the data have been analysed participants will be debriefed about the nature of the study.

Design

The dependent measures will be the causal attributions generated and rated by participants along the dimensions of internal vs. external, stable vs. unstable, global vs. specific and controllable vs. uncontrollable. Further dependent variables include the ratings of affect, helping behaviour and optimism generated by participants.

Data Analysis

Prior to formal data analysis, data will be checked to ensure that they meet the assumptions for parametric analysis using the Kolmogorov-Smirmov test.

Data will be analysed in three stages. The first stage of analysis will test the applicability of Weiner's model by examining relationships between attributions, affect, helping behaviour and optimism. The second stage will examine the relationship between participants' causal attributions towards non-engagement amongst real and hypothetical clients (vignettes). The third stage will examine the differences between causal attributions for non-engagement made by PSI-trained and PSI-untrained staff.

Hypothesis one: that causal attributions for non-engagement will be related to participants' self reported affect, helping behaviour and optimism, will be examined using Spearman's correlations to explore the relationship between causal attributions and reported affect, optimism and helping behaviour. Hypothesis two: that there will be a positive correlation between the causal attributions generated by participants to explain

non-engagement behaviour depicted in vignettes of hypothetical clients and in response to real clients with psychosis, will be examined using Spearman's correlations to investigate the relationship between attributions towards non-engagement behaviour amongst hypothetical (vignettes) and real clients with psychosis. Prior to examining hypothesis three: that participants who are trained in PSI will make different causal attributions compared with participants who are untrained in PSI, basic demographic characteristics of community mental health staff in the PSI-trained and PSI-untrained groups will be compared for differences using the appropriate statistical analyses. If the data display a non-normal distribution data will be transformed using square root or log 10 transformation methodology. Hypothesis three will then be examined using one-way repeated measure ANOVAs to investigate significant differences between staff who are trained and untrained in PSI for psychosis and will be corrected for multiple comparisons using Bonferroni correction.

Power Calculation

An investigation of staff members' causal attributions towards non-engagement in clients with psychosis has not been carried out previously so it is difficult to identify a suitable number of participants.

To test hypothesis one, assuming 80% power with an alpha set at 0.05 a sample size of 17 would be needed to detect a correlation of 0.6. To test hypothesis two, assuming 80%

power with an alpha set at 0.05 a sample size of 9 would be needed to detect a correlation of 0.8.

For hypothesis three the aim will be to determine the magnitude of the effect size. See Figure 1 for estimates of the sample size needed per group to detect a significant difference at varying levels of alpha and power (Cohen, 1969):

INSERT FIGURE 1 ABOUT HERE.

Due to the limited number of CMHT staff members who are trained in PSI in NHS Ayrshire and Arran this study will aim to recruit around 30 participants per group. This sample size means that assuming 80% power, with alpha set at 0.05 it would be possible to detect a significant difference between the two groups (PSI-trained vs. PSI-untrained) if the effect size is large.

PRACTICAL AND ETHICAL ISSUES

Following approval by the Local Clinical Governance Forum within NHS Ayrshire and Arran the project proposal will be submitted to NHS Ayrshire and Arran for ethical approval.

Permission for the study to take place will be obtained from clinical managers and the rationale and usefulness of the project will be explained to both managers and staff. Informed consent will be obtained from all staff involved in the study.

No client-identifying information will be requested from staff completing the diary questionnaire.

Staff will be blind to the hypothesis comparing the attributions made by PSI-trained and PSI-untrained staff (to reduce demand characteristics). All participants will be debriefed about this aspect of the study afterwards.

There are no health and safety risks involved in the study.

PRACTICAL AND CLINICAL APPLICATIONS

This study will help to develop our understanding of staff members' causal attributions and responses to non-engagement with services amongst clients with psychosis. The study will investigate the reliability and validity of using hypothetical clients depicted in vignettes in attributional research as opposed to exploring attributions towards real clients.

The study will also examine the applicability of Weiner's theory of helping behaviour and will provide evidence as to whether this may be a useful theory to base future research in this area.

In addition, the study will allow a comparison of the attributions made by staff who have received training in PSI with a similar group of staff who have not received this training. Such an understanding of staff responses to non-engagement will help provide information which could guide the development of future PSI training in order to work with staff on their interpretations and feelings towards such behaviour. This is of clinical relevance since to date there has been a lack of research in this area yet the problem of engaging clients with psychosis is one of great importance.

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Figure 1. Sensitivity Analysis
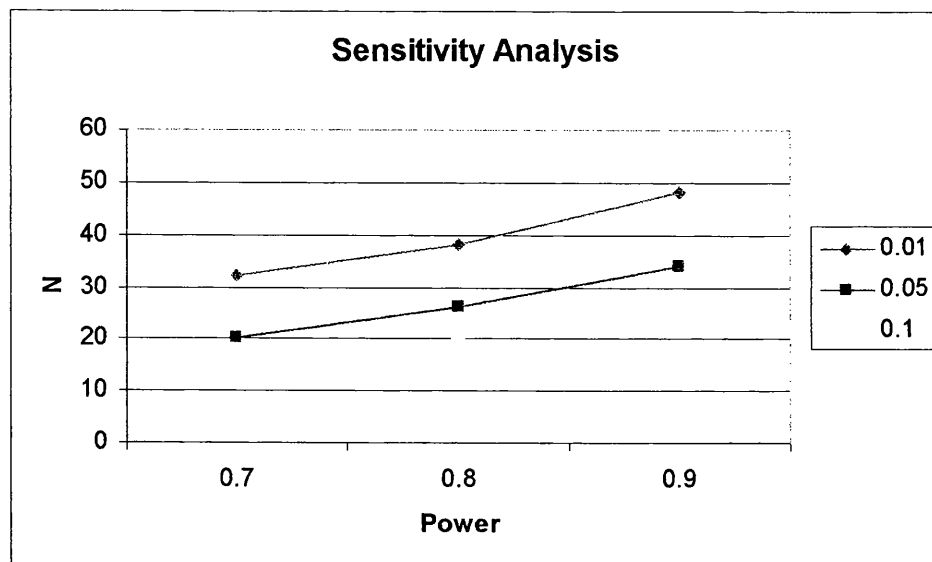
ADDENDUM: Changes to Major Research Project Proposal

Following submission of the major research project proposal some minor changes were made. Following feedback from the Local Research Ethics Committee and Research and Development Department some minor changes were made to the wording of the Participant Information Sheet. The revised version is presented in Appendix 4 iv.

There were also some changes to the proposed data analysis following submission of the proposal. Due to the fact that the data were not normally distributed it was decided to use non-parametric statistical analysis for the comparison of PSI-trained versus non-PSI-trained groups.

Chapter Four

Major Research Project

An investigation of multidisciplinary community mental health staff members' causal attributions for non-engagement amongst clients with psychosis

Chapter 4

Major Research Project

**An investigation of multidisciplinary community mental health staff members'
causal attributions for non-engagement amongst clients with psychosis**

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ABSTRACT

Objectives: This study applied Weiner's (1980; 1985) attributional model of helping behaviour to multidisciplinary community mental health staff attributions about non-engagement in psychosis.

Design: A within-subjects design was used. Questionnaires were administered to assess staff causal attributions towards case vignettes and towards actual clients with psychosis.

Method: Participants were asked to generate causes for non-engagement and to rate what they perceived to be the most likely cause along the dimensions: internal vs. external (to the client), stable vs. unstable (over time), global vs. specific and controllable vs. uncontrollable (by the client). Further dependent variables included ratings of affect, helping behaviour and optimism.

Results: Partial support for Weiner's model was found in relation to case vignettes but not in relation to actual clients. There was some evidence in relation to vignette data that staff training in psychosocial interventions (PSI) may influence attributional responses and optimism in a positive direction.

Conclusion: Future studies examining staff responses towards actual clients are needed to explore whether Weiner's model is applicable in real clinical settings. The ecological validity of using case vignettes to elicit causal attributions is questionable and further research is needed to clarify the best method for eliciting causal attributions. The impact of staff training in PSI also warrants further investigation.

BACKGROUND

Engagement

The process of engaging clients with mental health services is a complex one and over the years researchers have defined non-engagement in different ways. The majority of studies have used medication non-adherence amongst clients with psychosis as a measure of non-engagement. A recent systematic review by Lacro et al. (2002) using this definition found a mean rate of 41.2% non-adherence amongst clients with schizophrenia. A wider definition of non-engagement also includes failure to attend scheduled appointments. Nosé et al. (2003) used this definition in their recent systematic review and found that a mean of 25.8% of clients with psychosis had problems with engagement. Tait et al. (2002) used a multi-factorial definition of non-engagement and developed the Service Engagement Scale (SES, Appendix 3.i) to measure engagement with community mental health services according to four factors: availability, collaboration, help-seeking and treatment adherence. They found this scale could discriminate between groups of clients based on their level of engagement with services.

Non-engagement with services is a major block to delivering treatment and support in the community and may be a risk factor for relapse and re-hospitalization (Song et al., 1998). Failure to engage is often attributed to lack of insight on the part of the client, however, evidence for a relationship between insight and treatment adherence has been inconclusive (Trauer & Sacks, 2000). The attitudes and characteristics of mental health professionals and their clients also contribute to the creation and maintenance of a

trusting relationship and it is important that strategies aimed at improving this relationship are developed (Hewitt and Coffey, 2005). Further understanding of reasons for non-engagement with services or treatment may assist the development of interventions to enhance engagement and treatment adherence.

Attribution Theory

Current research into the belief systems of staff to understand non-engagement behaviour and the nature and extent of emotional reactions to such behaviour is lacking. Previous research investigating staff attributions towards challenging behaviour in mentally disordered offenders (Sharrock et al., 1990) and individuals with a learning disability (Dagnan et al., 1998; Wanless & Jahoda, 2002) have applied Weiner's model of helping behaviour (Weiner, 1980; 1985) to care staff responses to problem behaviours.

Weiner's (1980; 1985) model of helping behaviour proposes that attributions of internality (i.e. that the cause of a behaviour arises from factors internal to an individual) and attributions of controllability (i.e. that the cause of a behaviour is under the voluntary control of an individual) are the primary determinants of the emotional reactions sympathy and anger. If an individual's need for help is attributed to uncontrollable factors then it is proposed that the potential helper would experience sympathy which would promote the tendency to help. Conversely, attributions to controllable and internal factors are thought to give rise to emotions such as anger, which would reduce the tendency to help. In the more recent version of Weiner's (1986) theory of achievement motivation, attributional stability is regarded as an important determinant of expectations

of success and failure. Thus, in the context of helping it may be predicted that if a problem behaviour is attributed to a stable cause, help is less likely to be elicited, since expectations of that help being successful are low. Conversely, attributions to unstable factors suggest that the causes are more likely to be amenable to change and would be associated with increased optimism. Global attributions for the cause of a problem or behaviour suggest a belief that the same cause will apply in many different situations and across many aspects of the person's life. There is some evidence that ratings of globality are associated with decreased optimism and hopelessness (Peterson et al., 1993; Sharrock et al., 1990; Weiner, 1980). Attribution theory, applied to staff behaviour, has an underlying hypothesis that the attributions which staff make about the cause of a behaviour will influence their emotional and behavioral response to it.

A recent systematic review of studies investigating staff causal attributions towards clients with severe and enduring mental health problems (Dafters, 2006, Chapter 2) found that staff tended to make causal attributions for clients' problems that were predominantly internal to the client and there was some evidence that they made attributions that were controllable by the client. This contrasted with the results for clients, who tended to rate causes as uncontrollable and whose attributions of internality were mixed. There have been no studies to date specifically examining staff attributions about non-engagement in psychosis.

Methodological Issues

Previous research has tended to use two different approaches to examine the reaction of staff to problem behaviours. One method is to ask staff to generate causal attributions in relation to a known client (Bromley & Emerson, 1995) and the other is to ask staff to generate causal attributions in response to a case vignette (e.g. Hastings et al., 1997). In the field of learning disabilities a recent study by Wanless & Jahoda (2002) used a combination of both of these methodologies to examine whether there was any difference in staff responses to the challenging behaviour of a known client and a hypothetical scenario of a client. They found stronger emotional responses and more negative evaluations of clients and their behaviour in relation to real incidents of challenging behaviour compared with vignette examples. Their results suggest that responses to real incidents of problem behaviour may be influenced by the actual relationship with the client in question, whereas more general beliefs which staff hold about the causes of problem behaviours may be evoked in response to hypothetical clients. This is important because such general beliefs have been found to have little correspondence with how people actually behave in a given situation (Ajzen, 1982). This methodology could have important implications for examining the reliability and validity of using case vignettes to explore staff attributions.

Implications for Staff Training

A range of PSI including cognitive behaviour therapy (CBT) and behavioural family therapy (BFT) now have proven effectiveness for psychotic symptoms. Skills gaps in PSI for psychosis have been identified as a 'critical challenge' in the UK (Milne et al.,

2002). Research suggests that staff who have received PSI training may feel more positively about working with clients who are difficult to engage and may feel more optimistic about the potential treatment outcomes for these clients (Leff & Gamble, 1995; Byrne et al., 2004). In addition, it might be expected that staff who have received training in PSI will have increased knowledge and skills and show a better understanding of the potential causes of non-engagement amongst clients with psychosis, as reflected in the type of causal attributions they generate to explain this behaviour (Byrne et al., 2004).

AIMS

This study had three main aims which were:

1. To explore the nature and characteristics of staff causal attributions for non-engagement behaviour amongst clients with psychosis and their relationship with self-reported affect, helping behaviour and optimism.

2. To investigate the validity and reliability of using vignette methodology to elicit staff responses towards non-engagement behaviour amongst clients with psychosis.

3. To compare responses of staff who were trained and untrained in psychosocial interventions (PSI).

HYPOTHESES

There were three main hypotheses:

Hypothesis 1

The primary hypothesis was that causal attributions for non-engagement would be related to participants' self reported affect, helping behaviour and optimism in line with Weiner's model of helping behaviour.

Hypothesis 2

There would be a positive correlation between the responses of staff towards case vignettes and actual clients with psychosis.

Hypothesis 3

Participants who were trained in PSI would make different responses compared to participants who were untrained in PSI.

METHOD

Recruitment

After obtaining local ethical (Appendix 4.ii) and managerial approval (Appendix 4.iii), multidisciplinary staff from the 6 community mental health teams (CMHTs) and 2 Day Services within NHS Ayrshire and Arran were approached at their team meetings and invited to participate in the study. Of approximately 75 available staff, 40 staff in total consented to take part in the research. Following provision of information (Appendix

4.iv) and obtaining informed consent (Appendix 3.vii) staff were approached to complete the study measures.

Design and Materials

The study had a within-subjects design with a between-subjects component (PSI-trained vs. PSI-untrained). Participants were required to complete two questionnaire formats; one regarding hypothetical clients depicted in vignettes (Appendix 3.iv) and one relating to actual incidents of non-engagement (Appendix 3.v). Staff members who consented to participate were posted copies of the vignette questionnaire and multiple copies of the diary questionnaire, which they were asked to complete each time they noted that one of their clients with psychosis presented with difficulty engaging over a 2-week period. They were asked to return these by internal mail once the 2-week period was over. Follow-up email and telephone contact was used to maximize data collection.

The measures used to assess the cognitive and emotional responses of staff towards non-engagement were based on those used by Sharrock et al. (1990), Dagnan et al. (1998) and Wanless & Jahoda (2002).

Demographic Questionnaire

The demographic questionnaire (Appendix 3.ii) asked staff to report name, age, gender, profession, grade, place of work, length of time working in community mental health services, length of time working in current team and to specify any post-qualification formal clinical training undertaken. For the purpose of the study the definition of training

in PSI was the completion of a formal, post-qualification training course in PSI (for example cognitive behaviour therapy or behavioural family therapy), which had involved teaching, assessment and supervision components.

Vignettes

Four brief vignettes were designed and reviewed by the research supervisors (A.G. & J.H.) to assess face validity. Each vignette depicted a client with a diagnosis of schizophrenia displaying one of the four types of non-engagement behaviour defined by Tait et al. (2002). These can be seen in Appendix 3.iii.

The types of non-engagement behaviour in each of the four vignettes were:

1. Availability - Client seems to make it difficult to arrange appointments or avoids making appointments

2. Collaboration - Client usually resists advice or does not take an active part in the setting of goals or treatment plans

3. Help-seeking - Client finds it difficult to ask for help or does not actively seek help even at times of crisis

4. Treatment Adherence - client refuses to co-operate with treatment or has difficulty adhering to the prescribed medication.

Vignettes were counter-balanced in presentation to each participant to minimize order effects. Background and demographic information was constant in each vignette to control for confounding variables.

Vignette Questionnaire

Responses were recorded using a questionnaire which was based on a modified version of Peterson et al's (1982) Attributional Style Questionnaire (ASQ). This can be seen in Appendix 3.iv.

Section A: Asked participants for their main emotional response to each vignette and then to rate this emotion on a 7-point bipolar scale from 'not at all' to 'extremely'. Higher scores indicated greater levels of emotion.

Section B: Asked participants to write down what they thought the possible cause(s) of the behaviour were and to underline the most probable cause.

Section C: Asked participants to rate this cause along four 7-point bipolar scales anchored by the relevant attributional constructs: internal vs. external (to the client), stable vs. unstable (over time), global vs. specific and controllable vs. uncontrollable (by the client). Higher scores indicated greater internality, stability, globality and controllability.

Section D: Asked participants to rate their willingness to provide extra effort to help the client on a 7-point bipolar scale (e.g. Wanless & Jahoda, 2002; Dagnan et al., 1998, Sharrock et al., 1990, Weiner, 1980). Lower scores indicated greater willingness to put

extra effort into helping. This item was reverse scored for the purpose of analysis. Staff were also asked what action they would take in this situation.

Section E: Asked participants to indicate their agreement or disagreement with two statements concerning the potential for changing the non-engagement behaviour depicted in each vignette rated on a 7-point bipolar scale. This measure was derived from the optimism-pessimism scale used by Sharrock et al., (1990), originally from work by Garety and Morris (1984) and was adapted to be more specific to non-engagement. Higher scores indicated greater optimism.

Diary Questionnaire

Participants were also asked to complete a similar questionnaire, recording their responses each time they noted the occurrence of non-engagement (as defined by Tait et al., 2002) by their own clients with psychosis over a two-week period. No client-identifying information was collected. This can be seen in Appendix 3.v.

Data Entry and Coding

Data were input and analysed using SPSS version 14. Inter-rater reliability for the categorisation and coding of responses was assessed using 2 independent raters, both graduates in psychology, who were blind to the hypotheses of the study. They coded emotions as positive, negative, neutral or uncodable; categorised causal attributions according to themes supplied by the author and coded types of non-engagement cited on the diary questionnaires according to the four factors: availability, collaboration, help-

seeking and treatment adherence. Inter-rater reliability for the coding of emotions was K = 0.77, for causal attributions was K= 0.78 and for type of non-engagement was K = 0.78. Items for which there was disagreement were discussed with the researcher and a consensus was reached.

Preparation of Data

Prior to data analysis the distributions of data for continuous variables were checked for normality using One-Sample Kolmogorov-Smirnov Tests. Where distributions were found to be not normal, non-parametric statistics were used and median and mean values are reported.

Data Analysis

Data were analysed in three stages. The first stage of analysis tested the applicability of Weiner's model by examining relationships between attributions, affect, helping behaviour and optimism. This was carried out first in relation to case vignettes and then in relation to actual clients. The second stage investigated the relationship between participants' responses towards non-engagement amongst actual clients and case vignettes. The third stage examined the differences between the responses of staff who were trained in PSI and those who were not. Given the exploratory nature of the study, data were not corrected for multiple comparisons. Although this increases the chance of Type 1 error it was felt that this was an acceptable risk.

RESULTS

Participants

A total of 40 questionnaires were distributed of which 37 were returned, a response rate of 92.5%. The reasons given for drop-out were leaving post (N = 1) and going on long-term leave (N = 2). No further details of those who consented but failed to return their questionnaires were available.

Thirty-seven staff returned completed vignette questionnaires. Twenty-four staff additionally returned completed diary questionnaires (10 returned one diary questionnaire and 14 returned 2). The reason given for non-return of diary questionnaires was that participants reported they had not seen any clients with psychosis who did not engage during the course of the 2-week observation period.

Demographics of the participating group as a whole and of the PSI-trained versus non-PSI-trained groups are displayed in Table 1.

INSERT TABLE 1 ABOUT HERE.

The variables age, length of time working in community mental health services and length of time working in the current team were normally distributed. Therefore t-tests for independent samples were carried out to assess for differences in these variables between the 2 groups (PSI-trained vs. non-PSI-trained). There were no significant differences. Pearson's Chi Square tests were carried out to assess for differences in the

proportion of each gender and profession in the 2 groups. Results showed a significant difference for gender, with a higher proportion of males in the PSI-trained group (p<0.01).

Causal Attributions, Emotional Responses, Optimism and Helping Behaviour – Vignette Data

Descriptive statistics showing categorical data for cause and emotional response in relation to the vignettes are displayed in Table 2.

INSERT TABLE 2 ABOUT HERE.

Results show that the causes given for non-engagement appeared to differ depending on the type of non-engagement. For problems with *availability* the most common cause given was the therapeutic relationship/other relationships (27%) followed by client's mental state and beliefs/attitudes towards services (both 16.2%). For problems with *collaboration* the most common cause given was client's mental state (51.5%), followed by beliefs about/insight into illness and client's skills and competencies (both 10.8%). For difficulty *help-seeking* the most common cause given was stress (18.9%) followed by fear, trauma and demoralization resulting from illness, client's mental state and attitudes towards treatment (including medication) (all 16.2%). For *treatment non-adherence* the most common cause given was attitudes towards treatment (including medication) (43.2%) followed by side-effects (24.3%) and beliefs about/insight into illness (21.6%). A higher proportion of negative emotions were reported in response to the vignettes

which described treatment non-adherence (70.3%) and collaboration (81.1%) compared to those which described problems with availability (59.5%) and help-seeking (24.3%).

Table 3 displays descriptive statistics for the continuous variables: attributions, optimism, helping and strength of emotion by type of non-engagement. The distributions for the variables globality, controllability, internality, stability, optimism and helping were significantly not normal ($p<0.05$). For this reason non-parametric Friedman's Tests for related samples were used to assess for significant differences in these variables across the four types of non-engagement.

INSERT TABLE 3 ABOUT HERE.

The only significant differences were for the globality dimension ($p<0.05$) and for strength of emotion ($p<0.01$). Follow-up Wilcoxon Signed Ranks Tests showed that ratings for globality were significantly higher for problems with collaboration compared to problems with availability and treatment non-adherence. Reported strength of emotion was higher for difficulty help-seeking compared to problems with collaboration and treatment non-adherence and higher for problems with availability than for problems with collaboration. Median ratings for all attributional dimensions fell past the mid-point of the scale in the direction of higher internality, stability, globality and controllability. Median ratings of helping and optimism for all types of non-engagement fell towards the positive end of the scale (i.e. indicating increased tendency to help and increased optimism).

The median values from the four types of non-engagement overall were used in the correlational analysis. Relationships between causal attributions, strength of emotional response, optimism and helping behaviour were examined using Spearman's Rho correlations. Table 4 shows the Spearman's Rho correlations for the four attributional dimensions, optimism, helping behaviour and strength of emotion.

INSERT TABLE 4 ABOUT HERE.

Higher internality was significantly associated with decreased reported helping ($r = -0.038$, $p<0.05$) and with lower ratings of optimism that the person will be possible to engage ($r = -0.36$, $p<0.05$). Higher stability was significantly associated with lower ratings of optimism that the person will be possible to engage ($r = -0.49$, $p<0.01$). Higher globality was significantly associated with decreased reported helping ($r = -0.36$, $p<0.05$) and with decreased optimism ($r = -0.33$, $p<0.05$).

Variables were also examined by emotional response as shown in Table 5.

INSERT TABLE 5 ABOUT HERE.

Only negative and neutral emotions were included in the analysis since there were too few positive responses ($N = 5$). Data for positive emotions are reported for clarity. Mann-Whitney U Tests for unrelated samples were used to examine where any

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differences lay. The only significant differences were for optimism that future efforts to engage the client would be successful (p<0.01) and for strength of emotion (p<0.05). Items for which there were neutral emotional responses were rated significantly higher for optimism than items for which there were negative emotional responses. Higher ratings of strength of emotion were made when emotions were neutral as opposed to negative.

Causal Attributions, Emotional Responses, Optimism and Helping Behaviour – Actual Clients

Table 6 shows the frequency of causes and emotional responses towards actual clients by type of non-engagement.

INSERT TABLE 6 ABOUT HERE.

Results show that the most frequent types of non-engagement reported for actual clients were problems with treatment adherence (n = 15, 43%) and availability (n = 13, 37%). Only one diary reported the type of non-engagement to be difficulty help-seeking. The causes given for problems with treatment adherence were primarily side-effects and substance use (both 26.7%) followed by attitudes towards treatment (20%). The causes given for problems with availability varied widely with beliefs about/insight into illness, attitudes towards treatment, client's mental state, therapeutic relationship and other relationships and client's skills and competencies all at 15.4%. More participants

reported a negative emotional response towards treatment non-adherence (80%) than towards problems with availability (69.2%).

Table 7 shows ratings for the continuous variables: attributions, helping, optimism and emotional strength for actual clients by type of non-engagement.

INSERT TABLE 7 ABOUT HERE.

Non-parametric Kruskal Wallis Tests for independent samples were carried out to assess for differences in variables across types of non-engagement since data were not normally distributed and many staff had only completed one diary questionnaire. Help-seeking was excluded from this analysis since $n = 1$. No significant differences were found for any of the variables. As with the vignette data median ratings for all attributional dimensions fell past the mid-point of the scale in the direction of higher internality, stability, globality and controllability. Median ratings of helping and optimism for actual clients also fell towards the positive end of the scale.

Spearman's Rho correlations were carried out to assess correlations between attributions, helping, optimism and emotional strength for actual clients. Results are shown in Table 8. All correlations were non-significant apart from globality which was positively correlated with strength of emotion ($r = 0.49$, $p<0.05$).

INSERT TABLE 8 ABOUT HERE.

Variables were also examined by emotional response for actual clients as shown in Table 9.

INSERT TABLE 9 ABOUT HERE.

Only negative and neutral emotions were included in the analysis since there were too few positive responses (N = 3), although these are reported for the purpose of clarity. Mann-Whitney U Tests for unrelated samples were used to examine where any differences lay. The only significant difference was for optimism that future efforts to engage the client would be successful ($p<0.05$), with items for which there were neutral emotional responses rated significantly higher for optimism than items for which there were negative emotional responses.

Validity of Responses towards Case Vignettes vs. Actual Clients

Spearman's Rho correlations were used to investigate the relationship between attributions, emotions, helping, optimism and strength of emotion towards case vignettes and actual clients. The median values for each variable were used for this analysis. Results are shown in Table 10.

INSERT TABLE 10 ABOUT HERE.

Significant positive correlations were found between responses towards vignettes and actual clients for internality ($r = 0.61$, $p<0.01$), controllability ($r = 0.46$, $p<0.05$), helping ($r = 0.42$, $p<0.05$) and optimism ($r = 0.43$, $p<0.05$) but not for stability, globality or strength of emotion.

Effect of Staff Training in PSI

Table 11 shows the comparison of PSI-trained versus non-PSI trained staff responses in relation to median vignette data.

INSERT TABLE 11 ABOUT HERE.

Mann Whitney U Tests for independent samples found significant differences for ratings of internality ($p<0.05$), globality ($p<0.05$) and optimism that the client would not always be difficult to engage ($p<0.05$). Staff trained in PSI made significantly lower ratings for internality and globality and significantly higher ratings for optimism compared with those who were untrained in PSI.

DISCUSSION

This study aimed to explore the nature of staff causal attributions for non-engagement in psychosis and their relationship with emotions, optimism and helping. Further aims were to examine the reliability and validity of using case vignettes versus actual clients to elicit

causal attributions and to examine any differences in the responses of staff who had been trained in psychosocial interventions (PSI) compared to those who had not.

Previous research examining staff causal attributions about clients with severe mental health problems such as psychosis has found that staff tend to make internal attributions for clients' problems and there is some evidence that they make controllable attributions for clients' problems (Dafters, 2006, Chapter 2). The current study found that staff tended to make internal, stable, global and controllable attributions for non-engagement in general. Previous studies have also found some support for Weiner's (1980; 1985) model of helping behaviour in relation to staff responses towards their clients (e.g. Markham and Trower, 2003; Sharrock et al., 1990). Results of the current study showed partial support for Weiner's model in relation to case vignettes. There were significant negative correlations between internality and helping and internality and optimism. That is with increased ratings of internality to the client staff reported decreased tendency to offer extra help and decreased optimism about their efforts to engage the client being successful. Significant negative correlations were also found between stability and optimism, globality and helping, and globality and optimism. This suggests that when the cause of non-engagement was seen as more stable and global staff tended to feel less optimistic.

However, no relationship was found between reported strength of emotion and attributional style or helping. This does not fit with Weiner's proposal that attributions of internality and controllability will be associated with increased negative emotions which

mediate the tendency to offer help. One possible explanation for this is that staff made lower ratings for strength of negative emotions overall compared with neutral or positive emotions. This may have been an effect of social desirability. Although the majority of staff reported negative emotional reactions it seems that they may have down-played the strength of these emotions in comparison to neutral or positive emotions.

No significant correlations were found in the directions predicted by Weiner's model for actual client data. Therefore this study found no support for Weiner's model when examining staff responses towards actual clients. However, there were less data available in relation to actual clients so this may be partly due to lack of power. This does however raise a question about the ecological validity of using case vignettes to elicit real emotional, cognitive and behavioural responses towards clients. Vignette methodology has been criticised since vignettes often provide scant information about an individual's behaviour and fail to take account of contextual factors (Grey et al., 2002). The current study found some evidence for a relationship between responses towards actual clients and case vignettes. Although ratings of internality, controllability, helping and optimism were positively correlated for vignettes and actual clients, these were relatively small correlations and ratings for stability, globality and strength of emotion were not correlated. When staff encounter clients in a clinical setting it is likely that a range of contextual factors will affect their responses. For example features of the client such as severity of their problems, age and gender may be important (Dagnan et al., 1998). The interpersonal relationship between the staff member and the individual client is also likely to be important (Wanless and Jahoda, 2002). It seems possible that this could

account for at least some of the difference in response towards case vignettes versus actual clients in the current study.

Also of interest was whether participants who were trained in PSI would make different causal attributions compared to participants who were untrained in PSI. Significant differences in relation to vignette data were found for ratings of internality, globality and optimism that the client would not always be difficult to engage. Staff who had completed formal post-qualification training in PSI made significantly lower ratings for internality and globality and significantly higher ratings for optimism compared with those who were untrained in PSI. No significant differences were found for ratings of controllability, stability or helping.

There are methodological issues which need to be taken into account with regard to the findings of the current study. While this study takes a valuable first step in determining staff responses to the problem of non-engagement in psychosis the measures used may have been vulnerable to socially desirable responding. In particular staff rated negative emotional reactions significantly lower in strength than positive or neutral emotions. However, attempts were made to counter this by assuring participants that their data would be kept within the bounds of clinical confidentiality. Furthermore the vast majority of emotional responses reported by staff fell into the negative category, which suggests that they were not reluctant to report negative responses.

Measurement of helping in this study was based on the methods used in previous research (Sharrock et al., 1990; Dagnan et al., 1998; Wanless and Jahoda, 2002). This was assessed by asking staff how willing they would be to put extra effort into helping the client. However, there are difficulties with this measure of helping since with-holding help is not an option for paid care staff (Dagnan et al., 1998) and results of the current study were biased towards the positive end of the rating. While data regarding what participants reported they would actually do in a given situation were collected in this study the responses were so varied that it was not possible to group these into themes for the purpose of analysis. Future research is needed to determine the best way to examine helping behaviour in this population and objective measures of actual help given may be useful.

A further problem may have been the type of attributional measure used. The ASQ results in 'forced' attributional ratings, where there is no opportunity for the participant to negotiate the meaning of items with the researcher. Such ratings have been criticised since it has been argued that participants may not have made such attributions if the researcher had not asked specific questions (Weiner, 1985). Barrowclough and Hooley (2003) suggest that analysis of spontaneous causal attributions, for example using the five minute speech sample (Magana, et al., 1986) may be the best way to accurately measure causal attributions, since attributions obtained in this way are not constrained by the questioning of the experimenter. Future studies in this area which allow a direct comparison of methodologies would be helpful.

The fact that support was found for Weiner's model in relation to case vignettes but not in relation to actual clients suggests that this model may be too simplistic to accommodate the dynamic nature of the interaction between staff and client. Since much of the support for Weiner's model has come from studies exploring staff responses towards case vignettes it may be that a move away from the case vignette approach is needed. Further studies exploring Weiner's model in relation to actual clients in real clinical settings would help to shed light on the utility of this model for exploring staff attributional, emotional and behavioural responses towards their clients.

The generalisability of the relationships found here cannot be assumed due to the relatively small sample size. No details of why staff did not participate in the study are available but given the busy and unpredictable workloads of community mental health staff it may be that staff felt they did not have enough time to fill in the questionnaires. However, in the absence of detail about non-participants it is possible that the study sample was biased.

Fewer participants completed diary questionnaires than vignette questionnaires therefore it might be argued that this could account for the failure to detect significant correlations in the data relating to actual clients. However, none of these correlations were approaching significance so it seems unlikely that a larger sample would have significantly influenced the findings.

Weiner's attributional model of helping behaviour has been widely used in attributional research. The results of this study found partial support for this model in relation to fictional case vignettes, however the correlational nature of the data precludes conclusions about direction of causality for attributions, helping and optimism. No support for Weiner's model was found in relation to actual clients. This raises questions about the applicability of Weiner's model to staff-client relationships in real clinical settings and about the ecological validity of using case vignettes to explore staff attributions. Further research examining staff attributions towards actual clients using different methodologies is needed.

The finding that staff who were trained in PSI made significantly different ratings compared to those who were untrained in PSI for internality, globality and optimism in future efforts to engage the client is interesting. Staff trained in PSI made significantly lower ratings for internality and globality and significantly higher ratings for optimism compared with those who were untrained in PSI. Attributions of internality have been found to be linked with negative emotional responses and reduced tendency to offer help (Sharrock et al., 1990; Dagnan et al., 1998). There is also some evidence that global attributions may be linked with decreased optimism and hopelessness (Peterson et al., 1993; Sharrock et al., 1990; Weiner, 1980). These results fit with the limited previous research in this area which suggests that staff who have received training in PSI may feel more positively about working with clients who are difficult to engage and may be more optimistic about the potential treatment outcomes for these clients (Leff & Gamble, 1995; Byrne et al., 2004). This could have important implications for developing training

programmes for community mental health staff in PSI. Further research is needed to clarify whether there is a relationship between training in PSI and staff attributional, emotional and behavioural responses towards their clients. Future studies exploring staff attributions in relation to objective measures of therapeutic alliance and outcome are needed. It would also be of interest to explore clients' causal attributions for non-engagement and their concordance with staff attributions.

In summary the present study found partial support for Weiner's model in relation to case vignettes but not in relation to actual clients. Future studies examining the responses of staff towards actual clients are needed to explore whether this model is useful in explaining staff attributions, emotional responses and helping behaviour in clinical settings. While case vignettes remain a useful method for eliciting staff responses they provide limited insight into the impact of the actual staff-client relationship on staff attributions and their emotional and behavioural responses. This study raises a question about the ecological validity of case vignettes. There was also some evidence that staff training in PSI may influence attributional responses and optimism in a positive direction. This warrants further investigation and could have important implications for the development of staff training to facilitate staff in working positively with clients. This may be especially important when working with clients with psychosis, since engagement in this area is a particular challenge (Lacro et al., 2002; Nosé et al., 2003).

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List of Tables and Figures

Table 1. Demographic characteristics of participants

Variable	Whole Group	PSI-trained	Non-PSI-trained	Difference between PSI and non-PSI trained
Mean age ± SD (years)	40.3 ± 9 (range 24 – 61)	40 ± 8.5 (range 31 – 61)	40.5 ± 9.4 (range 24 – 59)	t = -0.16
Gender (n, %)				
Female	30 (81.1%)	9 (60%)	21 (95.5)	$X^2 = 7.30$**
Male	7 (18.9%)	6 (40%)	1 (4.5%)	
Mean length working in community mental health services ± SD (years)	7.2 ± 5.4 (range 0.25 – 21)	8.2 ± 5.2 (range 0.75 – 18)	6.5 ± 5.5 (range 0.25 – 21)	t = 0.95
Mean time worked in this team ± SD (years)	3.8 ± 3.5 (range 0.25 – 13)	5.1 ± 3.9 (range 0.25 – 13)	2.9 ± 3 (range 0.25 – 10)	t = 0.95
Profession (n, %)				
Nursing	28 (75.7%)	12 (80%)	16 (72.7%)	$X^2 = 1.09$
OT	5 (13.5%)	1 (6.7%)	4 (18.2%)	
Psychology	2 (5.4%)	1 (6.7%)	1 (4.5%)	
Psychiatry	2 (5.4%)	1 (6.7%)	1 (4.5%)	

* significant at p < 0.05 (2-tailed)
** significant at p < 0.01 (2-tailed)

Table 2. Descriptive categorical data for causes and emotional response for vignettes

Variable	Availability	Collaboration	Help-seeking	Treatment Adherence
Cause (n, %)				
Substance Use	1 (2.7%)	0 (0%)	0 (0%)	0 (0%)
Stigma of mental illness	1 (2.7%)	0 (0%)	0 (0%)	0 (0%)
Beliefs about/insight into illness	4 (10.8%)	4 (10.8%)	5 (13.5%)	8 (21.6%)
Beliefs/attitudes towards services	6 (16.2%)	3 (8.1%)	0 (0%)	0 (0%)
Attitudes towards treatment (including medication)	5 (13.5%)	1 (2.7%)	6 (16.2%)	16 (43.2%)
Side effects	0 (0%)	0 (0%)	0 (0%)	9 (24.3%)
Client's mental state	6 (16.2%)	19 (51.4%)	6 (16.2%)	2 (5.4%)
Fear, trauma and demoralisation arising from illness	1 (2.7%)	0 (0%)	6 (16.2%)	0 (0%)
Stress	0 (0%)	1 (2.7%)	7 (18.9%)	1 (2.7%)
Therapeutic relationship /other relationships	10 (27%)	2 (5.4%)	1 (2.7%)	0 (0%)
Client's skills and competencies	1 (2.7%)	4 (10.8%)	3 (8.1%)	0 (0%)
Other	2 (5.4%)	3 (8.1%)	3 (8.1%)	1 (2.7%)
Emotion (n, %)				
Negative	22 (59.5%)	30 (81.1%)	9 (24.3%)	26 (70.3%)
Positive	3 (8.1%)	0 (0%)	0 (0%)	2 (5.4%)
Neutral	11 (29.7%)	6 (16.2%)	27 (73%)	8 (21.6%)
Uncodable	1 (2.7%)	1 (2.7%)	0 (0%)	0 (0%)

Table 3. Continuous data for attributions, optimism, helping and strength of emotion for vignettes

Variable	Availability	Collaboration	Help-seeking	Treatment Adherence	Difference (df = 3)
Attributional dimension (mean ± SD, median)					
Internality	4.05 ± 1.31, 4 (range 1 – 7)	3.68 ± 1.27, 4 (range 2 – 6)	4.03 ± 0.9, 4 (range 1 – 6)	4.38 ± 1.09, 4 (range 2 – 7)	$X^2 = 9.27$
Stability	4.32 ± 1.4, 4 (range 1 – 7)	4.16 ± 1.09, 4 (range 2 – 7)	3.97 ± 1.3, 4 (range 1- 6)	4.50 ± 1.24, 4 (range 2 – 7)	$X^2 = 3.37$
Globality	4.03 ± 1.36, 4[a] (range 1 – 6)	4.57 ± 1.01, 5[b] (range 2 – 6)	4.22 ± 1.4, 4 (range 1 – 6)	3.59 ± 1.67, 4 (range 1 – 7)	$X^2 = 10.50$*
Controllability	4 ± 1.35, 4 (range 1 – 7)	3.63 ± 1.26, 4 (range 2 – 6)	3.81 ± 1.31, 4 (range 1 – 6)	3.97 ± 1.54, 4 (range 1- 7)	$X^2 = 1.10$
Helping (mean ± SD, median)	5.94 ± 1.26, 6 (range 2 – 7)	5.92 ± 1.34, 6 (range 2 – 7)	6.14 ± 1.11, 6 (range 2 – 7)	5.95 ± 1.18, 6 (range 2 – 7)	$X^2 = 1.99$
Optimism 1 - efforts to engage this person will be successful (mean ± SD, median)	4.4 ± 1.17, 5 (range 2 – 6)	4.67 ± 1.2, 5 (range 2 – 7)	5.05 ± 1.22, 5 (range 2 – 7)	4.75 ± 1.13, 5 (range 2 – 6)	$X^2 = 6.42$
Optimism 2 - this person will not always be difficult to engage (mean ± SD, median)	4.16 ± 1.42, 5 (range 1 – 6)	4.58 ± 1.42, 5 (range 2 – 7)	4.89 ± 1.1, 5 (range 2 – 7)	4.61 ± 1.25, 5 (range 2 – 6)	$X^2 = 5.11$
Strength of Emotion (mean ± SD, median)	4.58 ± 1.3, 5[a] (range 1- 7)	4.09 ± 1.29, 4[c] (range 1 – 7)	5.14 ± 1.31, 5[b] (range 2 – 7)	4.33 ± 1.15, 4 (range 2 – 7)	$X^2 = 15.13$**

* significantly different (p<0.05)
** significantly different (p<0.01)
[a] significantly different from collaboration (p<0.05)
[b] significantly different from treatment adherence (p<0.05)
[c] significantly different from help-seeking (p<0.05)

Table 4. Correlations between attributions, optimism, helping behaviour and emotional strength for vignettes

Variable	Helping	Optimism 1	Optimism 2	Emotional Strength
Internality	r = -0.38*	r = -0.18	r = -0.36*	r = -0.046
Stability	r = -0.22	r = -0.20	r = -0.49**	r = 0.08
Globality	r = -0.36*	r = -0.33*	r = -0.44**	r = -0.02
Controllability	r = 0.11	r = 0.07	r = -0.12	r = -0.14
Helping		r = 0.17	r = 0.14	r = 0.13
Optimism 1 – efforts to engage this person will be successful			r = 0.64**	r = -0.06
Optimism 2 – this person will not always be difficult to engage				r = -0.13

* correlation significant at p<0.05 level (two-tailed)
** correlation significant at p<0.01 level (two-tailed)

Table 5. Attributions, optimism, helping and strength of emotion by emotional category for vignettes

Variable	Negative Emotion (n = 87)	Neutral Emotion (n = 52)	Difference Negative vs. Neutral	Positive Emotion (n = 5)
Attributions (mean ± SD, median)				
Internality	3.98 ± 1.21, 4 (range 1 – 7)	4.17 ± 0.98, 4 (range 2 – 6)	Z = -1.00	3.80 ± 1.48, 4 (range 2 – 6)
Stability	4.32 ± 1.30, 4 (range 2 – 7)	4.17 ± 1.15, 4 (range 1 – 6)	Z = -0.53	3.40 ± 1.82, 3 (range 1 – 6)
Globality	4.11 ± 1.31, 4 (range 1 – 6)	4.13 ± 1.51, 4 (range 1 – 7)	Z = -0.45	3 ± 2.35, 2 (range 1 – 6)
Controllability	3.79 ± 1.23, 4 (range 1 – 6)	3.77 ± 1.40, 4 (range 1 – 7)	Z = -0.243	6 ± 1.22, 6 (range 4 – 7)
Helping (mean ± SD, median)	5.92 ± 1.25, 6 (range 2 – 7)	6.06 ± 1.14, 6 (range 2 – 7)	Z = -0.61	6.20 ± 1.79, 7 (range 3 – 7)
Optimism 1- efforts to engage this person will be successful (mean ± SD, median)	4.47 ± 1.3, 5 (range 2 – 7)	5.06 ± 0.96, 5 (range 3 – 7)	Z = -2.62**	5.60 ± 0.55, 6 (range 5 – 6)
Optimism 2 - this person will not always be difficult to engage (mean ± SD, median)	4.46 ± 1.35, 5, (range 1 – 7)	4.71 ± 1.19, 5 (range 2 – 7)	Z = -0.94	4.8 ± 2.17, 6 (range 1 – 6)
Strength of emotion (mean ± SD, median)	4.37 ± 1.23, 4 (range 2 – 7)	4.76 ± 1.27, 5 (range 1- 7)	Z = -2.06*	5.6 ± 1.67, 6 (range 3 – 7)

* significantly different p<0.05
** significantly different p<0.01

Table 6. Descriptive categorical data for causes and emotional category for actual clients

Variable	Availability (n = 13)	Collaboration (n = 6)	Help-seeking (n = 1)	Treatment Adherence (n = 15)
Cause (n, %)				
Substance Use	1 (7.7%)	0	0	4 (26.7%)
Stigma of mental illness	0	0	0	0
Beliefs about/insight into illness	2 (15.4%)	0	1 (100%)	0
Beliefs/attitudes towards services	0	0	0	0
Attitudes towards treatment (including medication)	2 (15.4%)	2 (33.3%)	0	3 (20%)
Side effects	0	0	0	4 (26.7%)
Client's mental state	2 (15.4%)	0	0	2 (13.3%)
Fear, trauma and demoralisation arising from illness	1 (7.7%)	2 (33.3%)	0	0
Stress	0	0	0	1 (6.7%)
Therapeutic relationship /other relationships	2 (15.4%)	0	0	0
Client's skills and competencies	2 (15.4%)	2 (33.3%)	0	0
Other	1 (7.7%)	0	0	1 (6.7%)
Emotion (n, %)				
Negative	9 (69.2%)	3 (50%)	1 (100%)	12 (80%)
Positive	3 (23.1%)	0	0	0
Neutral	1 (7.7%)	3 (50%)	0	3 (20%)
Uncodable	0 (0%)	0	0	0

Table 7. Continuous data for attributions, optimism, helping and strength of emotion for actual clients

Variable	Availability (n = 13)	Collaboration (n = 6)	Treatment Adherence (n = 15)	Difference (df = 2)	Help-seeking (n = 1)
Attributional dimension (mean ± SD, median)					
Internality	4.54 ± 1.45, 4 (range 2 – 7)	3.83 ± 1.6, 4 (range 2 – 6)	4.33 ± 1.8, 5 (range 1 – 6)	$X^2 = 0.66$	5, 5
Stability	4.92 ± 1.51, 5 (range 2 – 7)	5.17 ± 0.75, 5 (range 4 – 6)	5.13 ± 1.06, 5 (range 2 – 6)	$X^2 = 0.05$	5, 5
Globality	4.3 ± 1.25, 5 (range 2 – 6)	5.33 ± 1.03, 6 (range 4 – 6)	4.2 ± 1.61, 5 (range 1 – 6)	$X^2 = 3.29$	2, 2
Controllability	3.62 ± 1.66, 4 (range 1 – 6)	4.17 ± 1.17, 4 (range 3 – 6)	4.33 ± 1.76, 5 (range 1- 7)	$X^2 = 1.57$	4, 4
Helping (mean ± SD, median)	5.77 ± 1.17, 6 (range 4 – 7)	6 ± 1.67, 7 (range 3 – 7)	5.67 ± 1.4, 6 (range 2 – 7)	$X^2 = 0.77$	5, 5
Optimism 1 - efforts to engage this person will be successful (mean ± SD, median)	3.92 ± 1.93, 4 (range 1 – 7)	4 ± 1.26, 4.5 (range 2 – 5)	4.53 ± 1.36, 5 (range 2 – 6)	$X^2 = 1.11$	5, 5
Optimism 2 - this person will not always be difficult to engage (mean ± SD, median)	4.3 ± 1.6, 4 (range 1 – 6)	4 ±1.67, 4 (range 2 – 7)	4.13 ± 1.73, 5 (range 1 – 6)	$X^2 = 0.30$	3, 3
Strength of emotion (mean ± SD, median)	4.69 ± 1.49, 5 (range 2 – 7)	4.83 ± 1.6, 5 (range 3 – 7)	5 ± 1.41, 5 (range 2 – 7)	$X^2 = 0.38$	2, 2

Table 8. Correlations between attributions, optimism and helping behaviour and emotional strength for actual clients

Variable	Helping	Optimism 1	Optimism 2	Emotional Strength
Internality	r = 0.03	r = 0.18	r = 0.04	r = 0.36
Stability	r = -0.01	r = -0.22	r = 0.01	r = 0.26
Globality	r = -0.13	r = -0.097	r = 0.29	r = 0.49*
Controllability	r = -0.24	r = 0.07	r = 0.10	r = 0.13
Helping		r = 0.09	r = 0.21	r = 0.32
Optimism 1 - efforts to engage this person will be successful			r = 0.40	r = -0.26
Optimism 2 - this person will not always be difficult to engage				r = 0.18

* correlation significant at p<0.05 level (two-tailed)
** correlation significant at p<0.01 level (two-tailed)

Table 9. Attributions, optimism, helping and emotional strength by emotional category
for actual clients

Variable	Negative Emotion (n = 28)	Neutral Emotion (n = 7)	Difference Negative vs. Neutral	Positive Emotion (n = 3)
Attributions (mean ± SD, median)				
Internality	4.36 ± 1.59, 4 (range 1 – 7)	4.14 ± 1.68, 4 (range 2 – 6)	Z = -0.30	5.33 ± 1.53, 5 (range 4 – 7)
Stability	5.29 ± 1.05, 5.5 (range 2 – 7)	5 ± 0.58, 5 (range 4 – 6)	Z = -1.31	2.5 ± 0.07, 2.5 (range 2 – 3)
Globality	4.21 ± 1.50, 4.5 (range 1 – 6)	4.57 ± 1.13, 4 (range 3 – 6)	Z = -0.38	5 ± 1, 5 (range 4 – 6)
Controllability	4.15 ± 1.58, 4.5 (range 1 – 7)	4.14 ± 1.57, 4 (range 2 – 6)	Z = -0.06	3 ± 1, 3 (range 2 –4)
Helping (mean ± SD, median)	5.64 ± 1.34, 6 (range 2 – 7)	6.43 ± 1.13, 7 (range 4 – 7)	Z = -1.64	6 ± 1, 6 (range 5 – 7)
Optimism 1 - efforts to engage this person will be successful (mean ± SD, median)	3.79 ± 1.47, 4 (range 1- 6)	5 ± 0.58, 5 (range 4 – 6)	Z = -2.05*	6.33 ± 0.58, 6 (range 6 – 7)
Optimism 2 - this person will not always be difficult to engage (mean ± SD, median)	4 ± 1.52. 4 (range 1 – 6)	4 ± 1.82, 4 (range 1 – 7)	Z = -0.06	5 ± 2, 5 (range 3 – 7)
Strength of emotion (mean ± SD, median)	4.71 ± 1.46, 5 (range 2 – 7)	4.86 ± 1.68, 5 (range 3 – 7)	Z = -0.09	4.33 ± 2.08, 5 (range 2 – 6)

* significant at p<0.05

Table 10. Correlation between vignettes and actual clients

Variable	Correlation vignette vs. diary (n = 23)
Internality	0.61**
Stability	0.19
Globality	0.13
Controllability	0.46*
Helping	0.42*
Optimism 1 - efforts to engage this person will be successful	0.53**
Optimism 2 - this person will not always be difficult to engage	0.43*
Strength of emotion	0.38

*correlation significant at $p < 0.05$ level (two-tailed)
** correlation significant at $p < 0.01$ (two-tailed)

Table 11. Comparison of PSI-trained versus non-PSI-trained

Variable	PSI Trained (n = 15)	PSI Untrained (n = 22)	Difference
Attributional dimension (mean ± SD, median)			
Internality	3.77 ± 0.82, 4 (range 2.5 - 6)	4.2 ± 0.67, 4 (range 3- 5)	Z = -2.11*
Stability	4.2 ± 1.15, 4 (range 2.5 – 6)	4.34 ± 0.93, 4.5 (range 2 – 6)	Z = -0.75
Globality	3.93 ± 0.65, 4 (range 3 – 5)	4.39 ± 1.02, 5 (range 1.5 – 5.5)	Z = -2.05*
Controllability	3.6 ± 1.14, 4 (range 1.5 – 5.5)	4 ± 1, 4 (range 1.5 – 5.5)	Z = -1.15
Helping	6.27 ± 0.86, 6.5 (range 4 – 7)	5.9 ± 1.18, 6 (range 2 – 7)	Z = -0.99
Optimism 1 - efforts to engage this person will be successful	4.97 ± 0.92, 5 (range 3 – 6)	4.57 ± 0.98, 4.75 (range 3 – 6)	Z = -1.21
Optimism 2 - this person will not always be difficult to engage	5.1 ± 0.85, 5 (range 3.5 – 6)	4.43 ± 0.97, 4.5 (range 2.5 – 6)	Z = -2.02*
Strength of emotion	4.93 ± 1.03, 5 (range 3 – 7)	4.3 ± 0.85, 4.25 (range 2.5 – 6)	Z = -1.80

* significant at p<0.05 level

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Chapter Five

Single Case Research Study Abstract

An investigation into the additive effect of in vivo behavioural experiments upon cognitive therapy for OCD in a male with borderline intellectual functioning: a single case experimental design

(bound separately in Part Two)

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Chapter 5

Single Case Research Study

An investigation into the additive effect of in vivo behavioural experiments upon cognitive therapy for OCD in a male with borderline intellectual functioning: a single case experimental design

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ABSTRACT

Background: Exposure and response prevention (ERP) has been widely shown to be an effective intervention for obsessive compulsive disorder (OCD; Franklin and Foa, 2002). Recently researchers such as Rachman (1997; 2003) have outlined cognitive strategies for OCD. Results for the efficacy of cognitive therapy (CT) are mixed in comparison to ERP and some researchers have suggested that it may be the behavioural experiments commonly used in CT which are the most powerful components (Wilson & Chambless, 2005). *Aims:* This single case research study investigates the efficacy of CT for chronic OCD in an individual with borderline intellectual functioning and examines the additive effect of a series of behavioural experiments. *Method:* This study used an ABC single subject design (Kazdin, 1982). An initial baseline phase (A) was followed by a block of cognitive treatment (B) and then by a series of behavioural experiments (C). *Results:* The cognitive phase of treatment resulted in very limited improvement in the variables measured. The behavioural experiments in phase C led to a reduction in conviction in the specific obsessional belief which they set out to test and to a decrease in obsessive compulsive problems. *Conclusions:* This single case study provides preliminary evidence that behavioural experiments may be an important component of CT for OCD. Results also suggest that some aspects of CT for OCD may be effective for individuals with cognitive deficits.

Keywords: OCD; cognitive therapy; behavioural experiments; single case research design

Contents of Appendices

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Appendix 1.i. Requirements for Submission to *Clinical Psychology*

Editorial Collective: Lorraine Bell, Jonathan Calder, Lesley Cohen, Simon Gelsthorpe, Laura Golding, Garfield Harmon, Helen Jones, Craig Newnes, Mark Rapley and Arlene Vetere.

Clinical Psychology is circulated to all members of the Division monthly. It is designed to serve as a discussion forum for any issues of relevance to clinical psychologists. The editorial collective welcomes brief articles, reports of events, correspondence, book reviews and announcements.

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Clinical Psychology is published monthly and mailed on the penultimate Thursday of the month before the month of publication.

Submitting to *Clinical Psychology*

■ Articles of 1000—2000 words are welcomed. Send two hard copies of your contribution.

■ When sending copy, make sure it is double spaced, in a reasonably sized font and that all pages are numbered.

■ Give a 40-word summary at the beginning of the paper.

■ Contributors are asked to use language which is psychologically descriptive rather than medical and to avoid using devaluing terminology; i.e. avoid clustering terminology like 'the elderly' or medical jargon like 'person with schizophrenia'. If you find yourself using quotation marks around words of dubious meaning, please use a different word.

■ Articles submitted to Clinical Psychology will be sent to members of the Editorial Collective for refereeing. They will then communicate directly with authors.

■ We reserve the right to shorten, amend and hold back copy if needed.

■ Include a word count at the end (including references).

■ Spell out all acronyms the first time they appear.

■ Include the first names of all authors and give their employers, and remember to give a full postal address for correspondence.

■ Give references in Clinical Psychology style, and if a reference is cited in the text make sure it is in the list at the end.

■ Don't include tables and figures unless they save space or add to the article.

■ Ask readers to request a copy of your questionnaire from you rather than include the whole of it in the article.

Psychological Therapies for Psychosis
Record of Identified Needs

NHS Ayrshire & Arran

(To be completed by the keyworker or consultant, and where necessary, in collaboration with the patient – see Guidelines)

Completed by: Discipline:	Diagnosis:	Date of completion:

Patient Information	
Name:	Key worker:
D.o.b.	Consultant:
Case reference No. :	G.P. & Surgery
Address:	Other staff involved in case:
Has there been a previous referral to psychology? Yes ☐ No ☐	If Yes please detail outcome if known:

Please _tick_ appropriate boxes

Section A CRITERIA/PROBLEM	STATUS	
	NO	YES
1st Episode Psychosis	☐	☐
Early Psychosis (duration less than 3 years)	☐	☐
Psychosis and Trauma	☐	☐ PTSD like symptoms related to the psychosis or treatment or past traumas
Cognitive Deficits	☐ Mild/low impact on functioning	☐ Moderate/severe impact on functioning. Unexplained cognitive deficits. Query over intellectual ability

Referral criteria: **If yes to any of the above refer to the clinical psychologist in your service**

Section B CRITERIA/PROBLEM	SEVERITY			IMPACT ON FUNCTIONING		
	LEVEL 1	LEVEL 2	LEVEL 3	MILD	MODERATE	SEVERE
Difficulty engaging in services	No problems ☐	Occasional problems ☐	Persistent problems or Over-reliance on services ☐			
Treatment adherence problems	Rare or none ☐	Occasional ☐	On going ☐			
Family relationship problems	Rare or none ☐	Occasional ☐	On going ☐			
High frequency and/or increasing frequency of relapse	No ☐		Yes ☐			

Referral criteria:
If any criteria are at level 3 refer to the clinical psychologist in your service

CSBS Standards for Schizophrenia,   174

Section C CRITERIA/PROBLEM	SEVERITY					IMPACT ON FUNCTIONING		
	NONE	MILD	MODERATE	SEVERE		MILD	MODERATE	SEVERE
Persisting positive psychotic symptoms								
Persisting negative psychotic symptoms								
Coexisting anxiety disorder *e.g. social anxiety, health anxiety, general anxiety disorder, OCD* **Please state:**								
Coexisting depression								
Suicidality								
Other coexisting psychological disorders **Please state:**								
Low self esteem								
Problem behaviour, e.g. substance abuse, aggression, self harm **Please state:**								
Difficulties adjusting to psychosis								
Not otherwise stated psychological difficulties **Please state:**								

Referral criteria: **If one or more criteria are at moderate severity with moderate or severe impact on functioning, refer to the clinical psychologist in your service.**

Section D - CARER'S NEEDS

Has the carer expressed having their own psychological difficulties   Yes ☐   No ☐

If yes, is this related to their experience of being a carer   Yes ☐   No ☐

Please describe the difficulties and **discuss referral with clinical psychologist**

REFERRED FOR PSYCHOLOGICAL THERAPIES

YES ☐   *Pass to Clinical Psychologist*   NO ☐   *Record of identified needs should be filed in the case notes and reviewed at each multidisciplinary review -*

.

Due to be reviewed ....

Outcome of referral	
Date referral received:	Date Allocated for assessment:
Date of assessment:	Assessed by:

Outcome of assessment: Intervention by	
☐ Clinical psychologist	☐ Other (please specify) _____
☐ P.S.I. practitioner	☐ No additional intervention required

Intervention commenced (date) _____   By whom _____

If need for intervention is not met please specify the reason below:

CSBS Standards for Schizophrenia,

Guidelines for Completion of Psychological Therapies for Psychosis Record of Identified Needs (PSYRIN)

The PSYRIN has been developed in response to the CSBS Schizophrenia Standards as a means of identifying those patients with a psychotic illness who may benefit from psychological therapies, and as a referral guideline.

1. The form should be completed for each individual with a diagnosis of schizophrenia, query schizophrenia or other psychosis (excluding bi-polar disorder), with reference to their current presentation.

2. It is intended that the form should be completed as part of the initial assessment and should be reviewed at each multidisciplinary review.

3. The form should be completed by the individuals keyworker or consultant psychiatrist.

4. It is not necessary for the patient to be present on completion, but they should be consulted on any item where more information is required.

5. It should be noted that the PSYRIN is not a rating scale, but a means to identify need and guide referral. Clinicians completing the form should use their own clinical judgement and where there is any doubt over a response should consult a colleague or the clinical psychologist in your service.

6. If on completion it is clear that a referral is required please forward this to the Clinical Psychologist in your service. Outcome of the referral will be recorded on the PSYRIN which will be filed in the case notes.

Notes on Section A
This section identifies those situations where intervention by a clinical psychologist is indicated, i.e.
☐ 1st episode psychosis ; first presentation of psychosis
☐ Early psychosis; where duration of psychosis is less than 3 years,
☐ Psychosis and Trauma;
      1. Individuals with symptoms of trauma related to the experience of psychosis or subsequent treatment for psychosis.
      2. Individuals with past history of trauma predating the onset of psychosis.
☐ Assessment of cognitive deficits

Notes on Sections B and C

For both sections B and C levels of severity and impact on functioning are not defined but left to clinical judgement. If in any doubt consult a colleague or the team clinical psychologist.

Consulting & Clinical Psychology Services
Community Health Division
Strathdoon House
50 Racecourse Road
Ayr KA7 2UZ

NHS
Ayrshire
& Arran

Date:	27th May, 2004
Your Ref:	
Our Ref:	CK/JW
Enquiries to:	Janette White
Telephone:	01292 285607
Direct Line:	01292 267456
Fax:	01292 266940
E-mail:	Janette.White@aapct.scot.nhs.uk

Ms. R. Dafters,
Trainee Clinical Psychologist,
CCPS,
Strathdoon House,
50 Racecourse Road,
AYR.

Dear Becky,

Small Scale Service Evaluation Project
"An Audit of the Psychological Needs of People Diagnosed with
First Episode Psychosis within Ayrshire & Arran Primary Care NHS Trust!

I write to advise you that after review, and discussion at the Clinical Governance Forum meeting on 24th May, 2004, your project has been approved and you may proceed.

I wish you well with your project.

Best wishes.

Yours sincerely,

Catherine Kyle
Director, CCPS

NHS

Ayrshire
& Arran

Strathdoon House
50 Racecourse Road
Ayr
KA7 2UZ

Date
Enquiries to   Rebecca Dafters
Tel   (01292) 285607
Email   rebecca.dafters@aapct.scot.nhs.uk

Dear ....,

Re PSYRIN Audit - First Episode Psychosis
Client's Name:
Case Number:

As you may be aware, as part of the implementation of QIS Schizophrenia Standards the Trust is conducting an audit of the identified needs for psychological therapies for individuals with a diagnosis of Schizophrenia. This audit is well underway and the findings will be published in due course.

As part of the audit I am conducting a specific audit of the psychological needs for individuals experiencing first-episode psychosis. Results will enable service planning in order to provide appropriate evidence-based psychological therapies where required to those individuals identified with first-episode psychosis in line with identification and prioritisation of need.

Further to our recent meeting where it was highlighted that it is the above individual's first-episode of psychosis, I would appreciate if you would complete the following form with regard to the above named.

The audit is due for completion at the end of June, 2004. I would therefore ask if you could complete the form **by June 10th, 2004.**

Please do not hesitate to contact me with any queries you may have or if there are any obstacles in the way of completion of the form.

Please return the form to myself at Strathdoon House. The form will be treated in accordance with the usual protocol for confidentiality of patient records.

Many thanks

Yours sincerely

Rebecca Dafters
Trainee Clinical Psychologist

Clinical Psychology Review

Guide for Authors

SUBMISSION REQUIREMENTS: All manuscripts should be submitted to Alan S. Bellack, Department of Psychiatry, The University of Maryland at Baltimore, 737 W. Lombard St., Suite 551, Baltimore, MD 21201, USA. Submit three (3) high-quality copies of the entire manuscript; the original is not required. Allow ample margins and type double-space throughout. Papers should not exceed 50 pages (including references). One of the paper's authors should enclose a letter to the Editor, requesting review and possible publication; the letter must also state that the manuscript has not been previously published and has not been submitted elsewhere. One author's address (as well as any upcoming address change), telephone and FAX numbers, and E-mail address (if available) should be included; this individual will receive all correspondence from the Editor and Publisher.

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TITLE PAGE: The title page should list (1) the article; (2) the authors' names and affiliations at the time the work was conducted; (3) a concise running title; and (4) an unnumbered footnote giving an address for reprint requests and acknowledgements.

ABSTRACT: An abstract should be submitted that does not exceed 200 words in length. This should be typed on a separate page following the title page.

KEYWORDS: Authors should include up to six keywords with their article. Keywords should be selected from the APA list of index descriptors, unless otherwise agreed with the Editor.

STYLE AND REFERENCES: Manuscripts should be carefully prepared using the *Publication Manual of the American Psychological Association*, 5th ed., 1994, for style. The reference section must be double spaced, and all works cited must be listed. Avoid abbreviations of journal titles and incomplete information.

Reference Style for Journals: Raymond, M.J. (1964). The treatment of addiction by aversion conditioning with apomorphine. *Behaviour Research and Therapy, 3*, 287-290.

For Books: Barlow, D.H., Hayes S.C., & Nelson, R.O. (1984). *The scientist practitioner: Research and accountability in clinical and educational settings.* Elmsford, NY: Pergamon.

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278 articles obtained from computerised search.

183 articles excluded on basis of title and abstract leaving 45 articles.

32 articles excluded once full article obtained.

13 articles remaining from computerised search.

Reference check of those articles found no further eligible studies

13 articles included in systematic review.
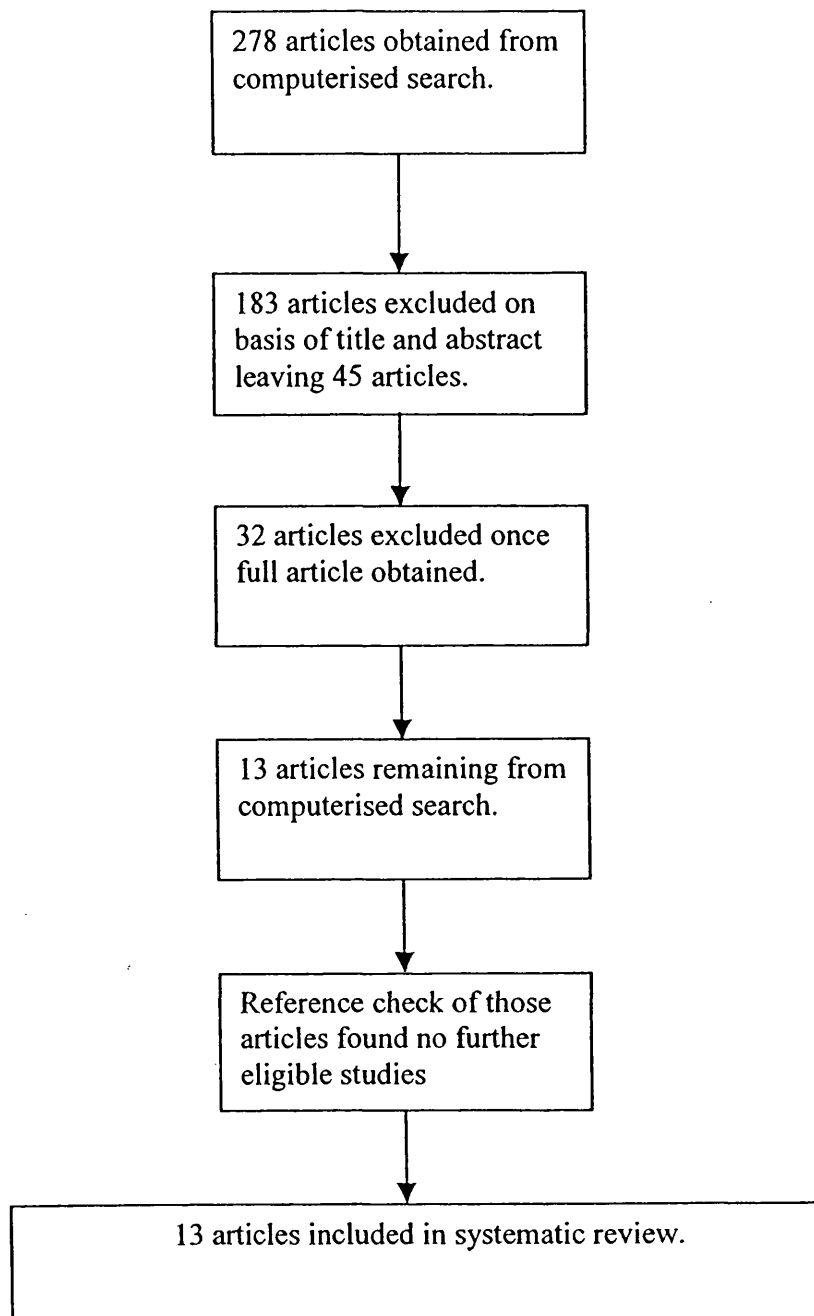
Appendix 2.iii. Quality Criteria for Included Studies

Article Title and Authors:

QUESTIONS	RATINGS	COMMENTS
Section 1: Methodology		
1. Are the aim(s) and hypotheses of the study explicitly stated?	Yes (2) Can't tell/partly (1) No (0)	
2. How was sample size determined?	Power calculation (2) Other method of determining sample size (1) Neither of above (0)	
3. Does the study indicate the rate of participation?	Yes (2) Can't tell/partly (1) No (0)	
4. Does the study indicate how the sample was identified and whether this was representative of the population?	Yes (2) Can't tell/partly (1) No (0)	
5. Is demographic information about the sample provided?	Yes (2) Can't tell/partly (1) No (0)	
Section 2: Measures		
6. Is the assessment of attributions:	Based on attribution theory (e.g. Weiner's model) (2) Can't tell/N/A (1) Not based on attribution theory (0)	State which:
7. Was the attribution measure previously published?	Yes (2) Can't tell (1) No (0)	
8. Are reliability data presented for the attribution measure (inter-rater, test-retest and scale)?	Yes (2) Partly addressed (1) No (0)	
9. Is more than one method used to elicit attributions (e.g. vignette and real life clients)?	Yes (2) No (0)	

Section 3: Results		
10. Are appropriate measures of statistical analysis employed?	Yes (2) Partly/can't tell (1) No (0)	
11. Are statistical analyses clearly related to hypotheses?	Yes (2) Partly/can't tell (1) No (0)	
Section 4: Discussion		
12. Are results clearly stated?	Yes (2) Partly (1) No (0)	
13. Are clinical implications discussed?	Yes (2) Partly (1) No (0)	
14. Are the limitations of studies clearly expressed?	Yes (2) Partly (1) No (0)	

Appendix 2.iv. Quality Criteria Summary

	Whittle (1996)	Sharrock et al (1990)	Barrowclough et al (2001)	Legget et al (2003)	Ilkiw-Lavalle et al (2003)	Outlaw et al (1994)	Gillig et al (1998)	Nathan et al (2001)	Fetter et al (1992)	Markham et al (2003)	Meddings et al (2000)	Boisvert et al (1999)	Apel et al (1996)
1. Clear aim(s)	2	1	2	2	1	1	1	2	1	2	1	2	1
2. Sample size	0	0	0	0	0	0	0	0	0	0	0	0	0
3. Participation rate	2	0	2	2	2	0	2	2	2	2	2	2	2
4. Sample identification	1	0	1	2	2	2	1	2	2	1	2	1	2
5. Demographic data	1	1	2	1	2	1	1	2	1	2	2	1	2
6. Attribution theory	1	2	2	2	0	1	0	1	2	2	1	1	2
7. Published	2	2	1	2	0	1	0	0	0	2	0	2	0
8. Measure reliability	0	1	0	1	0	1	0	0	1	0	2	0	1
9. >1 method	0	0	2	0	0	0	0	0	0	0	0	0	0
10. Statistical analysis	2	1	2	2	1	2	1	2	2	2	1	2	1
11. Related to hypotheses	2	2	2	2	1	1	1	2	1	2	1	2	1
12. Results clearly stated	2	2	2	2	1	2	1	1	2	2	1	2	2
13. Clinical implications	2	1	2	1	1	2	1	1	2	2	2	2	2
14. Limitations	2	2	2	1	1	0	0	1	1	2	0	2	2
Total	19	15	22	20	12	14	9	16	17	21	15	19	18
Percentage	67.9	53.6	78.6	71.4	42.9	50	32	57.1	60.7	75	53.6	67.9	64.3
Rating	Good	Adequate	Good	Good	Adequate	Adequate	Poor	Adequate	Good	Good	Adequate	Good	Good

Appendix 3.i. Service Engagement Scale

Availability	
1	The client seems to make it difficult to arrange appointments
2	When a visit is arranged, the client is available [a]
3	The client seems to avoid making appointments
Collaboration	
4	If you offer advice, does the client usually resist it?
5	The client takes an active part in the setting of goals or treatment plans [a]
6	The client actively participates in managing his/her illness [a]
Help seeking	
7	The client seeks help when assistance is needed [a]
8	The client finds it difficult to ask for help
9	The client seeks help to prevent a crisis [a]
10	The client does not actively seek help
Treatment adherence	
11	The client agrees to take prescribed medication [a]
12	The client is clear about what medications he/she is taking and why [a]
13	The client refuses to co-operate with treatment
14	The client has difficulty in adhering to the prescribed medication

Note: Items are rated 0 (not at all or rarely), 1 (sometimes), 2 (often), 3 (most of the time).
[a] Reverse scored.

Appendix 3.ii. Demographic Questionnaire

A/ Demographics
<u>Name:</u>

<u>Age:</u>

<u>Gender (please circle):</u> M / F

<u>Place of Work:</u>

<u>Profession and Grade:</u>

<u>Have you completed any formal clinical training courses since qualifying that involved teaching, clinical supervision and assessment components? (please provide details in the table below):</u>

Training Course	Duration (hrs)	Type of Assessment	Certificate/Qualification

B/ Work History

<u>In which year did you qualify?</u>

<u>How long have you worked in community mental health services?</u>

<u>How long have you worked in this CMHT?</u>

Thank you for your time.

Appendix 3.iii. Vignettes

Vignette 1 - Availability

Kenny is thirty years old and lives alone, he has a diagnosis of schizophrenia. Kenny has ongoing positive symptoms, poor social functioning and minimal contact with family and friends. Since he was discharged from hospital a year ago Kenny has been offered frequent appointments with you as his key-worker but has failed to attend many scheduled appointments, even when they are at his home. Kenny telephones you today to say he does not want another session with you.

Vignette 2 – Collaboration

Frank is thirty years old and lives alone, he has a diagnosis of schizophrenia. Frank has ongoing positive symptoms, poor social functioning and minimal contact with family and friends. Since he was discharged from hospital a year ago Frank has failed to follow the advice you have given him. At your session today you are trying to include Frank in setting some goals for your contact with him. Frank does not have much to say about this, he is not able to come up with any ideas and seems reluctant to participate.

Vignette 3 – Help-seeking

David is thirty years old and lives alone, he has a diagnosis of schizophrenia. David has ongoing positive symptoms, poor social functioning and minimal contact with family and friends. Since he was discharged from hospital a year ago David has had several periods of difficulty and distress but he has not sought help. Despite constructing a crisis care plan with David, which states that he should contact the team if he has an exacerbation of symptoms, today you receive a call from his neighbour who reports that David has been looking distressed over the past two weeks and has been shouting comments at people in the street due to what appears to be an exacerbation of his symptoms.

Vignette 4 – Treatment Adherence

Grant is thirty years old and lives alone, he has a diagnosis of schizophrenia. Grant has ongoing positive symptoms, poor social functioning and minimal contact with family and friends. Since he was discharged from hospital a year ago Grant has stopped taking his medication on several occasions. As his key-worker you have spent lots of time with Grant discussing the importance of medication. At your session today Grant informs you that he has not been taking his medication for the past fortnight.

Appendix 3.iv. Vignette Questionnaire

A/ Imagine that the client in the vignette is one of your own clients. How would their behaviour make you feel? Write down the main emotion you would experience

Emotion:_____

Please now rate this emotion for strength:

Not at all   Extremely

    1   2   3   4   5   6   7

B/ Write down the possible cause(s) of this client's behaviour

Underline what you think is the most likely reason in your experience

Please do not turn over the page until you have completed questions A and B

Thinking of the reason you have underlined please turn over and complete the rest of the questions

Please do not change your answers to the question on the previous page

C/ Thinking of the reason you gave for X's behaviour, please show your agreement with the following statements by circling one number

i) Is this due to X or due to other people or circumstances?:

It is totally due to others   It is totally due to X
    1   2   3   4   5   6   7

ii) If this behaviour happens over a long period of time will it be for the same reason?:

Never for the same reason   Always for the same reason
    1   2   3   4   5   6   7

iii) Does this reason apply to just this situation or all situations in X's life?:

Just this situation   All situations
    1   2   3   4   5   6   7

iv) Is this reason under X's control?:

Not under X's control   Totally under X's control
    1   2   3   4   5   6   7

D/ Given your experience with this type of behaviour how much extra effort you would be prepared to put in to help X:

As much extra effort as possible   No extra effort at all
    1   2   3   4   5   6   7

What would you do about this behaviour? Please write the first thing(s) you can think of...

E/ Given your experience with this type of problem, please rate the following statements

i) How optimistic are you that any efforts to engage this person will be successful?

Not at all   Extremely

   1   2   3   4   5   6   7

ii) This person will always be difficult to engage

Strongly agree   Strongly disagree

   1   2   3   4   5   6   7

Appendix 3.v. Diary Questionnaire

Please fill in this diary each time one of your own clients with psychosis does not engage in a way defined by one or more of the following four categories:

1/ Availability e.g. the client makes it difficult to arrange appointments, when a visit is arranged the client is unavailable, the client does not attend a scheduled appointment

2/ Collaboration e.g. if you offer advice the client resists it, the client refuses to actively participate in setting goals or treatment plans, the client refuses to actively participate in managing his or her illness

3/ Help-seeking e.g. the client does not seek help when assistance is needed, the client does not seek help to prevent a crisis

4/ Treatment Adherence e.g. the client will not agree to take prescribed medication, the client refuses to co-operate with treatment, the client does not adhere to prescribed medication

A/ Describe the type of non-engagement behaviour displayed

B/ How does X's behaviour make you feel?

Emotion:_____

Please now rate this emotion for strength:

Not at all   Extremely

    1   2   3   4   5   6   7

Write down the possible cause(s) of X's behaviour

Underline what you think is the most likely reason

Please do not turn over the page until you have completed questions A and B

Thinking of the reason you have underlined please turn over and complete the rest of the questions

Please do not change your answers to the questions on the previous page

C/ Thinking of the reason you gave for X's behaviour please show your agreement with the following statements by circling one number

i) Is this due to X or due to other people or circumstances?:

It is totally due to others   It is totally due to X

    1   2   3   4   5   6   7

ii) If this behaviour happens over a long period of time will it be for the same reason?:

Never for the same reason   Always for the same reason

    1   2   3   4   5   6   7

iii) Does this reason apply to just this situation or all situations in X's life?:

Just this situation   All situations

    1   2   3   4   5   6   7

iv) Is this reason under X's control?:

Not under X's control   Totally under X's control

    1   2   3   4   5   6   7

D/ Given your experience with this type of behaviour how much extra effort you would be prepared to put in to help X:

As much extra effort as possible   No extra effort at all

    1   2   3   4   5   6   7

What will you do about this behaviour? Please write the first thing(s) you can think of...

E/ Given your experience with this type of problem, please rate the following statements

i) How optimistic are you that any efforts to engage this person will be successful?

Not at all   Extremely

   1   2   3   4   5   6   7

ii) This person will always be difficult to engage

Strongly agree   Strongly disagree

   1   2   3   4   5   6   7

NHS

Ayrshire & Arran

**TITLE: <u>An investigation of multidisciplinary community mental health staff members'
causal attributions for non-engagement amongst clients with psychosis</u>**

You are being invited to take part in a research study. Before you decide it is important for you
to understand why the research is being done and what it will involve. Please take time to read
the following information carefully and ask if there is anything that is not clear or if you would
like more information. Take your time to decide whether you would like to take part or not.

<u>Purpose of the study</u>

A significant number of people with psychosis are challenging for community-based mental
health services to engage. Non-engagement can lead to increased risk of relapse and poorer
clinical outcomes. There are a range of potential reasons for non-engagement with services
amongst clients with psychosis and identification of these may be helpful in guiding the
development of interventions to aid engagement.

This study will involve using questionnaires to assess multi-disciplinary Community Mental
Health Team (CMHT) staff members' causal attributions for non-engagement behaviour amongst
fictional and real clients with psychosis.

The aim of the study is to improve our understanding of non-engagement amongst clients with
psychosis as there has been a lack of research in this area to date.

<u>Why have I been asked to take part?</u>

Multidisciplinary staff from all CMHTs throughout NHS Ayrshire and Arran will be approached
to participate in this study.

<u>Do I have to take part?</u>

No, it is up to you whether you decide to take part. If you decide to take part you will be asked to
sign a consent form. If you decide to take part you are still free to withdraw at any time and
without giving a reason.

<u>What will happen to me if I take part?</u>

The research will be carried out over a 2-week period. You will be asked to fill in a brief
demographic questionnaire and a questionnaire relating to four fictional clients with psychosis.
You will also be asked to complete a similar questionnaire over a 2-week period each time one of
your own clients with psychosis does not engage with some aspect of care and treatment. No
client-identifying information will be collected. Participating in the research should take no
longer than one hour in total.

All information that is collected from you will be anonymised and kept strictly confidential. Your name will not be used during any stage of data analysis, instead you will be assigned a number which will be substituted for you name on all of the questionnaires you complete.

What are the potential benefits of taking part?

The research will help to identify factors which may be important for community mental health services when engaging clients with psychosis. It is hoped that the study will be of interest to those who take part and that it will have valuable implications for the development of future interventions and training courses to tackle the problem of non-engagement.

What will happen to the results?

The results will be fed back to everyone who participates in the study and the implications for understanding non-engagement will be discussed. No participant will be identified in any report or publication.

Who is carrying out the research?

The research will be carried out by Rebecca Dafters (Trainee Clinical Psychologist) as part of a Doctorate in Clinical Psychology. The project has been peer reviewed by three other clinical psychologists and will be overseen by Dr Andrew Gumley (Senior Lecturer in Clinical Psychology, University of Glasgow) and Dr Janice Harper (Clinical Psychologist, NHS Ayrshire and Arran). The project has been approved by NHS Ayrshire and Arran ethics committee.

Contact for further information

If you are still unsure whether to participate in the study or if you have further questions you would like answered please contact:

Rebecca.Dafters@aapct.scot.nhs.uk

or

Janice.Harper@aapct.scot.nhs.uk

Complaints procedure

If you have any complaints in relation to the above research you can contact the NHS Ayrshire and Arran complaints line by telephoning: 01563 521 133.

Thank you for your time in reading this information.

Appendix 3.vii. Participant consent form

Title of Project: An investigation of multidisciplinary community mental health staff members' causal attributions for non-engagement amongst clients with psychosis

Name of Researcher:	Rebecca Dafters (Trainee Clinical Psychologist)

Academic Supervisor:	Dr Andrew Gumley (Consultant Clinical Psychologist, University of Glasgow)

Field Supervisor:	Dr Janice Harper (Consultant Clinical Psychologist, NHS Ayrshire and Arran)

Please tick

1/ I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐

2/ I understand that my participation is voluntary and I am free to withdraw at any time without giving a reason. ☐

3/ I agree to take part in the above study. ☐

_____   _____   _____
Name of staff member   Date   Signature

Appendix 4.i. Requirements for submission to *British Journal of Clinical Psychology*

The British Journal of Clinical Psychology publishes original contributions to scientific knowledge in clinical psychology. This includes descriptive comparisons, as well as studies of the assessment, aetiology and treatment of people with a wide range of psychological problems in all age groups and settings. The level of analysis of studies ranges from biological influences on individual behaviour through to studies of psychological interventions and treatments on individuals, dyads, families and groups, to investigations of the relationships between explicitly social and psychological levels of analysis.

The following types of paper are invited:

- Papers reporting original empirical investigations;
- Theoretical papers, provided that these are sufficiently related to the empirical data;
- Review articles which need not be exhaustive but which should give an interpretation of the state of the research in a given field and, where appropriate, identify its clinical implications;
- Brief reports and comments.

1. Circulation
The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.
2. Length
Papers should normally be no more than 5,000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.
3. Reviewing
The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to the title page (and the text should be free of such clues as identifiable self-citations e.g. 'In our earlier work...').
4. Online submission process
1) All manuscripts must be submitted online at http://bjcp.edmgr.com .

First-time users: click the REGISTER button from the menu and enter in your details as instructed. On successful registration, an email will be sent informing you of your user name and password. Please keep this email for future reference and proceed to LOGIN. (You do not need to re-register if your status changes e.g. author, reviewer or editor).
Registered users: click the LOGIN button from the menu and enter your user name and password for immediate access. Click 'Author Login'.
2) Follow the step-by-step instructions to submit your manuscript.

3) The submission must include the following as separate files:

o Title page consisting of manuscript title, authors' full names and affiliations, name and

   address for corresponding author - Editorial Manager Title Page for Manuscript Submission
o Abstract
o Full manuscript omitting authors' names and affiliations. Figures and tables can be attached separately if necessary.

4) If you require further help in submitting your manuscript, please consult the Tutorial for Authors - Editorial Manager - Tutorial for Authors

Authors can log on at any time to check the status of the manuscript.

5. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript with their approximate locations indicated in the text.
- Figures can be included at the end of the document or attached as separate files, carefully labelled in initial capital/lower case lettering with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate page. The resolution of digital images must be at least 300 dpi.
- For articles containing original scientific research, a structured abstract of up to 250 words should be included with the headings: Objectives, Design, Methods, results, Conclusions. Review articles should use these headings: Purpose, Methods, Results, Conclusions: British Journal of Clinical Psychology - Structured Abstracts Information
- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full.
- SI units must be used for all measurements, rounded off to practical values if appropriate, with the Imperial equivalent in parentheses.
- In normal circumstances, effect size should be incorporated.
- Authors are requested to avoid the use of sexist language.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations etc for which they do not own copyright.

For Guidelines on editorial style, please consult the *APA Publication Manual* published by the American Psychological Association, Washington DC, USA (http://www.apastyle.org).

6. Brief reports and comments

These allow publication of research studies and theoretical, critical or review comments with an essential contribution to make. They should be limited to 2000 words, including references. The abstract should not exceed 120 words and should be structured under these headings: Objective, Method, Results, Conclusions. There should be no more than one table or figure, which should only be included if it conveys information more efficiently than the text. Title, author and name and address are not included in the word limit.

7. Publication ethics

Code of Conduct - Code of Conduct, Ethical Principles and Guidelines

Principles of Publishing - Principle of Publishing

8. Supplementary data

Supplementary data too extensive for publication may be deposited with the British Library Document Supply Centre. Such material includes numerical data, computer programs, fuller details of case studies and experimental techniques. The material should be submitted to the Editor together with the article, for simultaneous refereeing.

9. Post acceptance

PDF page proofs are sent to authors via email for correction of print but not for rewriting or the introduction of new material. Authors will be provided with a PDF file of their article prior to publication.

10. Copyright

To protect authors and journals against unauthorised reproduction of articles, The British Psychological Society requires copyright to be assigned to itself as publisher, on the express condition that authors may use their own material at any time without permission. On acceptance of a paper submitted to a journal, authors will be requested to sign an appropriate assignment of copyright form.

11. Checklist of requirements

- Abstract (100-200 words)
- Title page (include title, authors' names, affiliations, full contact details)
- Full article text (double-spaced with numbered pages and anonymised)
- References (APA style). Authors are responsible for bibliographic accuracy and must check every reference in the manuscript and proofread again in the page proofs.
- Tables, figures, captions placed at the end of the article or attached as separate files.

Ayrshire & Arran Local Research Ethics Committee

NHS Ayrshire & Arran
Eglinton House
Ailsa Hospital
Dalmellington Road
Ayr
KA6 6AB

Telephone: 01292 513628
Facsimile: 01292 513655

22 August 2005

Dr Janice Harper
Consultant Clinical Psychologist
CCPS
Strathdoon House
50 Racecourse Road
AYR

Dear Dr Harper

Full title of study: **An investigation of multi-disciplinary community mental health staff members' causal attributions for non-engagement amongst clients with psychosis**

REC reference number: 05/S0201/38

The Research Ethics Committee reviewed the above application at the meeting held on 10 August 2005.

Documents reviewed

The documents reviewed at the meeting were:

Document	Version	Date
Application	1	13 July 2005
Investigator CV	1	13 July 2005
Protocol 2	1	29 April 2005
Participant Information Sheet	1	(None Specified)
Participant Information Sheet	1	15 July 2005
Participant Consent Form	1	15 July 2005
Demographic questionnaire	2	29 April 2005
Vignettes	1	15 July 2005
Summary CV for Supervisor	1	13 July 2005
Summary CV for principal investigator	1	13 July 2005

Provisional opinion

The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. The Committee would find it helpful for you to attend the next meeting to discuss the application further. The next meeting will be held on Wednesday, 14 September at 1 pm in Room 2A, Education Centre, Crosshouse Hospital. Please let me know if you are available.

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Communication with sponsor and care organisation(s)

This communication is confidential but you may wish to forward copies to your sponsor and/or relevant NHS care organisation(s) for their information.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/S0201/37	Please quote this number on all correspondence

Yours sincerely

Susan Dillon

Mrs Susan Dillon
Administrator

Email: susan.dillon@aaaht.scot.nhs.uk

Cc   Miss R Dafters, Trainee Clinical Psychologist, Strathdoon House, Ayr ✓

Enclosure:

Attendance at Committee meeting on 10 August 2005

Ayrshire & Arran Local Research Ethics Committee

Attendance at Committee meeting on 10 August 2005

Committee Members:

Name	Profession	Present?	Notes
Fr Matthew McManus	Chairman	Yes	
Dr David Price	Editor	Yes	
Mrs Jodi Binning	Podiatry Coordinator, North Ayrshire & Arran	Yes	
Mr Stuart Hislop	Consultant Maxillofacial Surgeon	No	
Dr William McAlpine	General Practitioner	Yes	
Mr John McGuffie	Principal Pharmacist - Dispensing Services	No	
Ms Christina McMichael	Health Improvement Officer	No	
Dr J David Watts	General Practitioner	No	
Mr John Mitchell	Assistant Head Teacher (Retired)	Yes	
Dr Rani Sinnak	Consultant Clinical Psychologist	No	
Mr Raymond Thomson	Retired Chief Executive	Yes	
Mrs Jenny Preston	Head Occupational Therapist	NO	
Rev J Huggett	Chaplain	No	

Ayrshire & Arran Local Research Ethics Committee

NHS Ayrshire & Arran
Eglinton House
Ailsa Hospital
Dalmellington Road
Ayr
KA6 6AB

Telephone: 01292 513628
Facsimile: 01292 513655

18 November 2005

Dr Janice Harper
Consultant Clinical Psychologist
NHS Ayrshire and Arran
CCPS, Strathdoon House,
50 Racecourse Road,
Ayr
KA7 2UZ

Dear Dr Harper

Full title of study: **An Investigation of multi-disciplinary community mental health staff members' causal attributions for non-engagement amongst clients with psychosis**

REC reference number: **05/S0201/38**

Thank you for your letter of 23 September 2005, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Committee held on 18 November 2005. A list of the members who were present at the meeting is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application	1	13 July 2005
Investigator CV	1	13 July 2005

Protocol 2		29 April 2005
Participant Information Sheet		
Participant Information Sheet	1	15 July 2005
Participant Consent Form	1	15 July 2005
Response to Request for Further Information		23 September 2005
Response to Request for Further Information	2	23 September 2005
Demographic questionnaire	2	29 April 2005
Vignettes	1	15 July 2005
Summary CV for Supervisor	1	13 July 2005
summary CV for principal investigator	1	13 July 2005

Research governance approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final research governance approval from the R&D Department for the relevant NHS care organisation.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/S0201/38	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Fr M McManus
Chair

Email: susan.dillon@aaaht.scot.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*

Standard approval conditions

Site approval form

Copy to: Karen Bell, Research & Development,
                      Eglinton House, Ailsa Hospital,
                      Dalmellington Road, Ayr
                      KA6 6AB

Ayrshire & Arran Local Research Ethics Committee

Attendance at Committee meeting on 18 November 2005

Committee Members:

Name	Profession	Present?	Notes
Fr M McManus	Chairman	Yes	
Rev J Huggett	Chaplain	Yes	

Ayrshire & Arran Local Research Ethics Committee

LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.

REC reference number:	05/S0201/38	Issue number:	2	Date of Issue:	18 November 2005

Chief Investigator: Dr Janice Harper

Full title of study: An Investigation of multi-disciplinary community mental health staff members' causal attributions for non-engagement amongst clients with psychosis

This study was given a favourable ethical opinion by Ayrshire & Arran Local Research Ethics Committee on 18 November 2005. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.

Principal Investigator	Post	Research site	Site assessor	Date of favourable opinion for this site	Notes [1]
Miss Rebecca Dafters	Trainee Clinical Psychologist	Dr Karen Bell NHS Ayrshire and Arran. Executive Department, Eglinton House, Ailsa Hospital, Dalmellington Road, Ayr KA6 6AB	Ayrshire & Arran Local Research Ethics Committee	18/11/2005	

Approved by the Chair on behalf of the REC:

.... (Signature of Chair/Administrator)

(delete as applicable)

.... (Name)

(1) The notes column may be used by the main REC to record the early closure or withdrawal of a site (where notified by the Chief Investigator or sponsor), the suspension of termination of the favourable opinion for an individual site, or any other relevant development. The date should be recorded.

NHS

Ayrshire
& Arran

Dr Janice Harper
Consultant Clinical Psychologist
NHS Ayrshire & Arran
CCPS
Strathdoon House
50 Racecourse Road
Ayr
KA7 2UZ

Tel: (01292) 614590/614480
Fax: (01292) 288952

Date: 25th November 2005
Your Ref:
Our Ref: RM/KLB/NM *(R&D 248)*

Enquiries to: Karen Bell
Extension: 3622
Direct Line: 01292 513622
Email: Karen.bell@aapct.scot.nhs.uk

www.nhs-ayrshire.org

Dear Dr Harper

An Investigation of multidisciplinary community health staff members' casual attributions for non-engagement amongst clients with psychosis

I confirm that the NHS Ayrshire and Arran R&D Management Group have granted Management Approval for the above study to go ahead.

Please note that North and South Cunningham Community Mental Health Team do not wish to be involved in the study.

The terms of approval state that the investigator authorised to undertake this study within NHS Ayrshire & Arran is: -

-   Dr Janice Harper, NHS Ayrshire & Arran, Strathdoon House

With additional investigator: -

-   Rebecca Dafters, NHS Ayrshire & Arran, Strathdoon House
-   Dr Andrew Gumley, Gartnavel Royal Hospital

The sponsors for this study are NHS Ayrshire & Arran.

This approval letter is valid until March 2007.

Regular reports of the study require to be submitted. Your first report should be submitted to myself in 6 months time and subsequently at yearly intervals until the work is completed.

In addition approval is granted subject to the following conditions: -

•   All research activity must comply with the standards detailed in the Research Governance Framework for Health and Community Care and appropriate statutory legislation.

- If any amendments are to be made to this study protocol and or the Research Team the Researcher must seek Ethical and Management Approval for the changes before they can be implemented.

- The Researcher and NHS Ayrshire and Arran must permit and assist with any monitoring, auditing or inspection of the project by the relevant authorities.

- The NHS Ayrshire and Arran Complaints procedure should be accessed if any complaints arise regarding the project and the R&D Department must be informed.

- The outcome and lessons learnt from complaints must be communicated to funders, sponsors and other partners associated with the project.

If I can be of any further assistance please do not hesitate to contact me. On behalf of the committee, I wish you every success with the project.

Yours sincerely

Dr R Masterton
Executive Medical Director

c.c. Rebecca Dafters, CCPS, Strathdoon House, 50 Racecourse Road, Ayr KA7 2UZ

Appendix 4.iv. Participant information sheet – version 2

TITLE: <u>An investigation of multidisciplinary community mental health staff members'</u>
<u>causal attributions for non-engagement amongst clients with psychosis</u>

You are being invited to take part in a research study. Before you decide it is important for you
to understand why the research is being done and what it will involve. Please take time to read
the following information carefully and ask if there is anything that is not clear or if you would
like more information. Take your time to decide whether you would like to take part or not.

Purpose of the study

A significant number of people with psychosis are challenging for community-based mental
health services to engage. Non-engagement can lead to increased risk of relapse and poorer
clinical outcomes. There are a range of potential reasons for non-engagement with services
amongst clients with psychosis and identification of these may be helpful in guiding the
development of interventions to aid engagement.

This study will involve using questionnaires to assess multi-disciplinary Community Mental
Health Team (CMHT) staff members' causal attributions for non-engagement behaviour amongst
fictional and real clients with psychosis.

The aim of the study is to improve our understanding of non-engagement amongst clients with
psychosis as there has been a lack of research in this area to date.

Why have I been asked to take part?

Multidisciplinary staff with a wide range of experience from all CMHTs throughout NHS
Ayrshire and Arran will be approached to participate in this study. Your participation in this
research will have implications for the development of future training courses and interventions
to tackle the issue of non-engagement with this client group.

Do I have to take part?

No, it is up to you whether you decide to take part. If you decide to take part you will be asked to
sign a consent form and to post it back to me in the envelope provided. Your decision about
whether to participate in the research will be treated as confidential. If you decide to take part
you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

The research will be carried out over a 2-week period. You will be asked to fill in a brief
demographic questionnaire and a questionnaire relating to four fictional clients with psychosis.

You will also be asked to fill in a similar questionnaire over a 2-week period each time one of your own clients with psychosis does not engage with some aspect of care and treatment. Participating in the research should take no longer than one hour in total.

No client-identifying information will be collected. All information that is collected from you will be anonymised and kept within the normal boundaries of clinical confidentiality. Your name will not be used during any stage of data analysis, instead you will be assigned a number which will be substituted for your name.

No individual's responses or individual CMHT responses will be revealed in any reports or publications or disclosed at any time.

What are the potential benefits of taking part?

The research will help to identify factors which may be important for community mental health services when engaging clients with psychosis. It is hoped that the study will be of interest to those who take part and that it will have valuable implications for the development of future interventions and training courses to tackle the problem of non-engagement.

What will happen to the results?

The results will be fedback to everyone who participates in the study and the implications for understanding non-engagement will be discussed. No individual or individual CMHT will be identified in any report or publication or disclosed at any time.

Who is carrying out the research?

The research will be carried out by Rebecca Dafters (Trainee Clinical Psychologist) as part of a Doctorate in Clinical Psychology. The project has been peer reviewed by three other clinical psychologists and will be overseen by Dr Andrew Gumley (Senior Lecturer in Clinical Psychology, University of Glasgow) and Dr Janice Harper (Clinical Psychologist, NHS Ayrshire and Arran). The project has been approved by NHS Ayrshire and Arran ethics committee.

Contact for further information

If you are still unsure whether to participate in the study or if you have further questions you would like answered please contact:

Rebecca.Dafters@aapct.scot.nhs.uk

or

Janice.Harper@aapct.scot.nhs.uk

Complaints procedure

If you have any complaints in relation to the above research you can contact the NHS Ayrshire and Arran complaints line by telephoning: 01563 521 133.

Thank you for your time in reading this information.