Application of the Theory of Planned Behaviour to Understand Responses to Self-Injurious Challenging Behaviour in People with Learning Disabilities

by

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Volume I

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Statement of Anonymity

All names, places and identifiable information within this portfolio have been changed. This is to preserve the confidentiality and anonymity of services, service users and research participants.
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Academic Dossier

This section contains two essays, which were submitted during the three years of training. The first is about how effective and cost-effective Cognitive-Behavioural psychological approaches are for treating borderline personality disorder. The second is about the strengths and weaknesses of multidisciplinary teams from the perspectives of staff and service users, and how psychologists can contribute to effective team functioning.

Three reflective accounts about problem based learning tasks conducted during the three years of training are also included. Finally, summaries of the two case discussion group process accounts, which were written in years one and two are presented. The full process accounts are in Volume II of the portfolio.
Is CBT for borderline personality disorder effective and cost-effective?

Year 1
December 2006
Introduction
Personality disorders (PD) refer to pervasive and long standing traits that have negative impact on the way affected individuals view themselves and their surrounding environment, their ability to regulate emotion, and their interpersonal functioning (Perry, Banon, & Ianni, 1999). The 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV, American Psychiatric Association, 1994) identifies many different types of PD (e.g. Paranoid PD, Histrionic PD), and among these disorders, Borderline Personality Disorder (BPD) is recognised as being amongst the most difficult Mental Health (MH) problem to treat. According to the DSM IV, BPD is viewed as a pervasive pattern of instability in several life domains (e.g. self-image, interpersonal relationships, and emotional regulation) along with a pattern of marked impulsivity, which begins in early adulthood.

The DSM IV suggests that 2% of the general population have this disorder, although individuals with BPD represent approximately 10% of individuals being seen in MH outpatient clinics and approximately 20% of psychiatric inpatients. These are believed to be underestimates given that many clinicians may be reluctant to apply this label, due in part to the potential stigma attached to it (Linehan, Kanter, & Comtois, 1999). BPD is also a pervasive disorder in that someone with this diagnosis is likely to continue to meet the diagnostic criteria for many years. For example, long-term follow up data indicated that 4-7 years after initial assessment, 57-67% of individuals with BPD continued to meet the diagnostic criteria for this disorder and 15 years after initial assessment 25-44% continued to meet the diagnostic criteria (Linehan et al., 1999). The majority of individuals diagnosed with BPD are female.

This population is notoriously difficult to treat, as clients often present with complex difficulties. For example:
1) 70-75% have a history of at least one "parasuicidal" act, broadly defined as any intentional non-fatal self-injurious behaviour, with or without suicidal intention (e.g. drug overdoses, cutting) (Linehan, Cochrane, & Kehrer, 2001).

2) Approximately 10% of individuals with BPD eventually commit suicide (Linehan, Rizvi, Welch, & Page, 2000).

3) Individuals with BPD have a high incidence of co-morbidity with depression, anxiety disorders, and eating disorders (Linehan et al., 1999).

4) Individuals with BPD account for a disproportionately high percentage of hospital admissions and overall healthcare expenses (Linehan et al., 1999).

5) Rates of substance abuse are high among individuals with BPD (Linehan et al., 1999).

6) Individuals with BPD quit treatment programs 70% of the time (Dingfielder, 2004).

The chronic nature of BPD, the functional impairment caused, the issue of co-morbidity with a variety of other MH problems, its prevalence, behaviours that pose risk not only to the individual with BPD but other members of society, healthcare expenses, and drop out rates all combine to highlight the importance of establishing effective, and cost-effective treatments for this disorder.

Regarding treatment options for individuals with BPD, historically, given the definition of BPD as enduring and stable, it had previously been believed that long-term effective treatment was unlikely. More recently however, this belief has changed as recent evidence from naturalistic follow-up studies have shown that patterns of instability and impulsivity in individuals with BPD appears to taper with age (Perry, et al., 1999). More importantly, reviews of the literature have shown generally positive effects of psychological intervention for individuals with BPD, and this will be discussed in more detail later.
Regarding treatment within the National Health Service (NHS), recent years have seen ever-increasing emphasis on patient choice and user involvement. Considering this I can only assume clients would want an understanding of the various treatment options available to them, in order to make informed decisions about their treatment. As a clinician in an adult MH service, I believe it my duty to be aware of such information so I can assist clients in gaining an understanding of the treatment options available. It is highly likely that I will be working with individuals diagnosed with BPD in the near future; this coupled with my own experience of having a close family member diagnosed with BPD is what attracted me to this essay.

During the following discussion I will critically analyse the effectiveness, and cost effectiveness of CBT for individuals with BPD. Firstly, I will define what is meant by the term ‘effectiveness’ in relation to this essay. Secondly, I will introduce different CBT approaches to treating BPD, including the theoretical underpinnings and techniques applied by each approach. Approaches to be discussed include ‘standard’ CBT, and approaches that have been specifically designed for treating PD, and which come under the ‘CBT umbrella’, namely, Dialectical Behaviour Therapy (DBT), and Schema-Focused Therapy (SFT). Thirdly, I will discuss the evidence for the effectiveness and cost-effectiveness of these approaches.

**What is effectiveness?**

Throughout this essay, ‘effectiveness’ refers to effectiveness in terms of:

1) Reductions in self-harm and suicide;
2) improved psychological functioning (e.g. mood);
3) improved interpersonal and social functioning;
4) improved quality of life;
5) reductions in presentation to MH services (including ‘Accident and
Emergency’ attendance, and psychiatric hospital admission); and the type
of effectiveness will be specified where appropriate. It must be noted that
‘effectiveness’ and effective treatment in relation to this essay are
measured on the above definitions and are not necessarily a complete
reduction of an individuals’ presenting problems. For example, an
individual that has engaged in self-mutilating behaviours (e.g. cutting)
daily for the last ten years, and after treatment has managed to reduce their
cutting behaviours to once a week might suggest that their treatment has
been ‘effective’ and be satisfied with this outcome. Whereas, a clinician
may interpret the fact that they are still participating in self-mutilating
behaviours on a weekly basis as them having received ‘ineffective’
treatment, or be dissatisfied with this outcome. In other words, in practice,
the clients themselves are the best judge of ‘effectiveness’ rather than the
researchers or the practitioners.

‘Cost-effectiveness’ in the context of this essay refers to financial reduction in
costs of managing the condition.

**Cognitive-Behavioural approaches to treating BPD**

**Theoretical underpinnings and techniques**

Cognitive Therapy (CT), a widely used effacious treatment for unipolar
depression (e.g. Beck, Rush, Shaw, and Emery, 1979) and anxiety disorders
(e.g. Beck, Emery, & Greenberg, 1985), has also been applied successfully to
the treatment of individuals with PD (Young, 1990). In one sense, the CT of
PD progresses in a manner similar to the CT of depression and anxiety
disorders. The therapist helps the client to identify their biased thinking
patterns and to test and modify the meanings of these thoughts and
perceptions. The main goal is to enable clients to evaluate themselves and their
problems more objectively, as well as to address their problems constructively and hopefully.

With individuals with PD, and in particular BPD however, the path towards achieving these goals is a challenging one. Layden, Newman, Freeman, & Byers-Morse (1993) suggest that because of the chronic nature of BPD client’s problems, their frequent referral through family pressure, or judicial remand, and the apparent reluctance to change, they often are the most difficult clients in a clinician's caseload: They require more work within a session, cause a drain on the therapist's energy, and evoke more powerful counter-transference reactions than any other clients. Nevertheless, Layden et al., (1993) argue that CBT offers the kind of structured support and learning experiences that are extremely helpful to this population. Similarly, CBT assists the therapists by providing a framework that makes their work with individuals with BPD manageable and promising.

In recent years, cognitive therapists and CBT therapists (Layden et al., 1993; Young, 1990; Linehan, 1993)) have offered comprehensive cognitive-behavioural treatment for treating Axis II disorders. In doing so, these authors generally acknowledge the need to modify standard short-term cognitive-behavioural approaches to better serve the client with an Axis II disorder. Suggested modifications include; emphasis on individual case conceptualization when designing intervention strategies; use of anxiety-reducing interventions; and a focus on identifying and modifying core beliefs or schemata. The following discussion will focus on an elaboration and integration of the above suggested modifications to the treatment of the client with an Axis II disorder, with a cognitive-behavioural approach.

Cognitive-behavioural therapists maintain that it is usually more productive to identify and modify ‘core problems’ in treating PD. This is in contrast to the treatment of more common Axis I problems where the problems may be dealt with without necessarily addressing and/or changing personality. However, when Axis II problems are the focus, the client may not be willing to work on
the PD, instead choosing to work on the symptoms for which they were referred (i.e. Axis I disorder).

Tarrier et al., (1999) suggest that to understand the content, style, and impact of the PD of the client, the clinician must focus on the treatment of the schemata. Furthermore, these authors argue that the degree to which particular schemata are on the continuum from active to inactive, as well as the continuum from unchangeable to changeable, are essential dimensions in conceptualising the clients problems. There are several options available for clinicians regarding work that might be done with the clients’ schemata. These include schemata restructuring, schemata modification, schemata reinterpretation, or schematic camouflaging.

Tarrier et al., (1999) further argue that the initial therapeutic focus must be on relieving the presenting symptoms, such as anxiety and/or depression. Furthermore, the essential nature of the therapeutic collaboration and the building of a strong therapeutic alliance are suggested to be no more important than with the client with an Axis II disorder. Clients significant others can also be invaluable allies in the therapeutic endeavour by helping clients do homework and by offering support to make changes.

It is generally agreed by CBT therapists that when working with individuals with PD, the more severe the disorder or greater level of dysfunction, the more behavioural work is needed. Whereas, the less severe the dysfunction, the more cognitive work is required. In summary, the individual with PD is treatable but only after the clinician accepts the client’s behaviour as the result of significant developmental deficits. The clinician must initiate active, directive, problem-focused, solution-orientated, collaborative, structured, dynamic, and psycho-educational work that is the hallmark of CBT. A specifically designed CBT treatment for PD, and in particular BPD, namely DBT, will now be introduced.
DBT approaches to treating BPD

DBT— theoretical underpinnings and techniques

Developed by Marsha Linehan (Linehan, 1993), DBT is a mode of CBT that was specifically tailored for individuals with BPD, and is one of the most widely researched treatment options for individuals with BPD. Regarding its theoretical underpinnings, DBT is based on Linehan’s (1993) conceptualisation of BPD as a problem with emotional regulation, dysfunctional environments and interactions between these over time. According to Linehan (1993), a central factor in the aetiology of BPD is an “invalidating home environment”. Such an environment fails to teach children how to label and regulate emotion, how to tolerate emotional distress, and how to trust their emotional responses as valid. In such an environment intrapersonal experiences (emotional experiences, interpretations of events) are not taken as valid responses, are punished, disregarded, or viewed as socially unacceptable.

The consequences of such an environment include deficits in learning how to label and modulate emotions, to tolerate distress, and to trust one’s emotional responses. Due to difficulty in trusting one’s emotional state, the individual scans the environment in search of cues guiding how to act. In doing this however, the individual does not develop a stable and cohesive sense of self. In dealing with their environment, one who lacks emotional regulation skills becomes more dysfunctional and in response, the environment becomes progressively more invalidating. Individuals with BPD tend to engage in impulsive behaviour such as self-mutilation, which Linehan (1993) suggests is a desperate attempt to regulate emotions. Difficulty with emotional regulation also often leads to a pattern of unstable interpersonal relationships. As emotional expression is often suppressed or invalidated in these families, the individual may oscillate between a struggle to contain one’s emotions, and a
burst of expressed emotion. Furthermore, they may learn that extreme displays are necessary to get needed reactions. In summary of Linehan’s (1993) theoretical notions about BPD, individuals with BPD often lack important self-regulation and interpersonal skills, and their environments inhibit the further development of these skills.

**DBT – Therapy targets**

According to Linehan (1993), one integral component of DBT is that targets for intervention are prioritised in each session according to the following hierarchy of importance:

1) Reducing suicidal and life threatening gestures, including parasuicidal behaviours.
2) Reducing therapy-interfering behaviours, defined as anything that prevents the client and therapist working together.
3) Reducing quality-of-life-interfering behaviours (e.g. substance abuse, eating disorders, criminal behaviour, frequent hospitalisations, failure to comply with medical regiments, homelessness, and financial difficulties).
4) Skills enhancement: Replacing maladaptive responses with skilful interpersonal behaviours, distress tolerance, enhanced emotional regulation, self-management skills, and non-judgemental self-awareness.

**Modalities of DBT and treatment strategies**

Therapy is conducted across a variety of modalities. These include weekly individual therapy sessions, weekly skills training groups, telephone consultation, management of environmental contingencies, and supervision/consultation with team members.

Individual therapy involves a balance of validation strategies, with strategies aimed at changing behaviours. The validation strategies are aimed at helping clients to feel understood, that their behaviours make sense and are justifiable
given their life experiences. The therapist focuses on attending to the client and taking their response seriously; conveying an understanding of the clients' experience; conveying respect and acceptance; conveying a belief that the client can overcome their difficulties.

Skills training groups are used to teach emotional and behavioural regulation skills. New skills are developed through modelling, instruction, rehearsal, feedback, education, and application assignments, typically done in the context of psycho-educational groups. Typically, skills training groups focus on 'mindfulness' skills, distress tolerance skills, emotional regulation skills, interpersonal skills and self-management skills. Continued work on these skills is integrated into other aspects of treatment including individual therapy and telephone consultation. Another CBT treatment for PD, and in particular BPD, namely SFT will now be introduced.

**SFT approaches to treating BPD**

SFT— theoretical underpinnings and techniques

Influenced by the constructivist movement (Mahoney, 1993), Young (1994) designed an integrative model called Schema-Focused Therapy (SFT), to expand on Beck's (Beck et al., 1979) original model, and to deliberately address the needs of clients with longstanding characterological disorders. According to Young (1994), for Beck's model to succeed, the clients have to be able to engage in collaborative relationships with the therapist; identify specific life problems; have access to thoughts and feelings; and motivation to do homework assignments. Young (1994) argues clients with PD often cannot meet these conditions, and suggests that SFT offers an alternative approach to address these issues. Briefly described, SFT assimilates and adapts strategies that are used in standard CBT, but goes beyond the short-term approach by combining interpersonal (e.g. object relations) and experiential techniques.
(e.g. Gestalt) within the cognitive-behavioural framework, utilising the concept of schema as the unifying element.

Schema-focused treatment is composed of two phases; assessment and change. Assessment focuses on the identification and activation of schemata that are most pertinent to the client. The change phase attempts to modify the relevant schemata and maladaptive patterns. The cognitive, experiential, interpersonal and behavioural techniques that are incorporated in the schema-focused will be summarised in the following section:

**Cognitive techniques**

The basic objective of cognitive strategies is to reconstruct the distorted view held by the client regarding self and others by generating evidence to refute them, and thereby creating more accurate perceptions. The goal is to improve the client’s information processing system as it relates to their schemata. Tarrier et al., (1999) describe the ‘life review’ as one cognitive exercise that examines the evidence that supports and contradicts the schema, by asking the client for relevant data. The goals are 1) to help clients appreciate how schemata distort their perceptions and feelings, thus keeping the schemata intact; and 2) to begin a process of distracting from, rather than identifying with their schemata.

**Experiential techniques**

Tarrier et al., (1999) suggest that these are used to synchronise client’s emotions in sync with cognitive changes, and seem to change underlying schemata in a fundamental way that is more powerful than with cognitive techniques alone. The two most commonly used techniques in the ‘change phase’ are imagery and schema dialogue: ‘Imagery’ is used for recalling and tolerating pain associated with the schema, and simultaneously clients are guided and encouraged to modify the image and consequently the schema by using ‘Schema Dialogue’. Clients learn to battle the feelings elicited by the
schema and to accurately interpret the meaning of their experiences. In the first phase, clients are asked to role play the ‘voice’ of the schemata (i.e. thoughts consistent with their schemata). In the next phase, clients are asked to respond to the schema from their ‘healthy side’. Here the client experiences difficulty since refuting schema requires acknowledging the validity of their schema, which is not normally within their immediate grasp. As clients progress they are able to express angry and vulnerable feelings and can reject schemas that cause their problems – newer, healthier ways of thinking and feeling start to become more natural.

Interpersonal Techniques within the Therapy relationship

The therapeutic relationship is a vital medium for schema modification. Since many of clients’ schemata emerge in relation to the therapist, addressing clients’ thoughts and feelings about the therapist is an important strategy for identifying and modifying schemata. When clients’ schema are believed to be activated in relation to the therapist, the schema-focused therapist works directly and collaboratively with the client in identifying and modifying any schema-driven thoughts and feelings. Schema-focused therapists use what Young (1994) terms ‘empathic confrontation’ as their primary working style toward the client. Empathic confrontation involves a careful balancing of validation and reality testing. The therapist fully acknowledges and validates distressing feelings and schema-driven beliefs, while tactfully pointing out another, more accurate view. This process repeatedly demonstrates to clients how their schemata operate to keep dysfunctional thoughts rigidly intact, and also serves to challenge and modify these negative conditions as they arise during therapy sessions.
Behavioural Pattern-Breaking Techniques

Tarrier et al., (1999) suggest that these are used by the schema-focused therapist to alter self-defeating patterns and behaviours that have been perpetuating the clients' problems. Behavioural exercises are used in combination with cognitive and experiential work to further challenge schema-driven thoughts and behaviours that underlie discrete conditions. Behavioural techniques aim to enlist clients in developing a better tolerance for their discomfort through identification of feelings, validation, and alternative methods for 'healthy' distraction, such as relaxation techniques, exercise, calling a friend, writing in a diary, or taking a walk. The therapist also employs well-established behavioural treatment techniques, such as assertiveness training, graduated exposure, social skill exercises, and behavioural re-conditioning to change behaviours that reinforce the schema. The effectiveness of CBT, DBT, and SFT for treating individuals with BPD will now be discussed.

Effectiveness and cost-effectiveness of CBT to treating BPD – 1) DBT

The first study to assess the effectiveness of DBT for BPD was performed by Linehan, Armstrong, Suarez, Allman, & Heard (1991). Participants comprised one group of 22 females (aged 18-45) diagnosed with BPD who underwent DBT for one year, and 22 matched females who had treatment as usual (TAU). Women in the TAU group were referred to substance abuse or MH treatment programmes in the community, or, if they were receiving treatment when they entered the study, they were allowed to continue with individual psychotherapy.

Participants were assessed at pre-treatment and at four, eight, and twelve months post-treatment. Results showed a significant reduction in the
frequency and medical risk of parasuicidal behaviour among the DBT group compared to the TAU group. Furthermore, the number of days of inpatient psychiatric hospitalisation was fewer for individuals who received DBT, resulting in greater cost-effectiveness for DBT, in spite of the DBT intensive design (i.e. individual and group therapy, and telephone consultation between sessions over one year). Although there was no significant difference between the DBT group and the TAU group in terms of improving participants' depression, hopelessness, suicide ideation or reasons for living, the reduced parasuicidal behaviour frequency, together with few psychiatric hospitalisations suggests that DBT is an effective and cost-effective treatment for the borderline population. But given the chronic and pervasive nature of BPD, would the effects of this treatment be long-term?

Linehan, Heard & Armstrong (1993) performed a naturalistic follow-up study of participants in the experimental and control group, one year following the termination of the original one-year study. Efficacy measures were taken on parasuicidal behaviour (Parasuicide History Interview), anger (State Trait Anger Scale), social adjustment (Social Adjustment Scale, Interview and self-report), global functioning (Global Assessment Scale), and psychiatric inpatient days (Treatment History Interview), and such measures were taken at six and twelve months after the year-long DBT treatment had terminated.

Comparison of the DBT and TAU groups showed that during the initial six months of the follow-up, and after twelve months, DBT participants had significantly less parasuicidal behaviour, less anger, and better interviewer-rated social adjustment. These results suggest that DBT is the significantly more effective, and cost-effective long-term treatment for BPD, compared to TAU and has long-term, benefits. More recent studies have also shown the long-term benefits of DBT for BPD (e.g. Swenson, Sanderson, Dulit & Linehan, 2001).
It is worth noting however that the developer of DBT, namely Marsha Linehan, has been involved in all of the above efficacy studies. I am not suggesting that Linehan and her colleagues have been biased in their reports on the effectiveness and cost-effectiveness of DBT for BPD, rather it has made me think about the expertise and experience of the clinicians performing in the above mentioned studies (clinicians whom I can only assume are highly skilled and qualified to have been invited to work alongside the respected Linehan), and whether the expertise and experience of clinicians who work with the borderline population within the NHS is of the same standard? If not, would NHS clinicians who treat BPD get the same treatment outcomes as Linehan and her colleagues in their studies?

I do not wish to slander clinicians within the NHS but it is fair to say that DBT is a complex theory, especially when applied to the complex (and frequently co-morbid) BPD condition. It is also fair to say that clinicians who work with individuals with BPD within the NHS have widely-varying theoretical backgrounds and experience; clinicians may have a qualification in psychiatry, MH nursing, clinical psychology, or another MH profession, for example, occupational health or MH social work. I am sure that Linehan would argue that such professionals could deliver DBT effectively within the NHS, but until studies in this country show such results, I believe the American studies discussed above showing the effectiveness and cost-effectiveness of BDT for BPD should be taken with a pinch of salt, due to differences in American and NHS MH treatment systems.

**Effectiveness and cost-effectiveness of CBT to treating BPD – 2) SFT**

There is little published research on the effectiveness of SFT for BPD. Whether this is because research has found that it is not an effective treatment for BPD, or whether it is because there is more interest in researching other
treatment approaches, is unknown. Nevertheless, a recent study conducted in the Netherlands showed that two-thirds of the BPD diagnosed participants (total \( N = 88 \)) within the study benefited significantly from SFT, as shown by ‘general psychopathologic dysfunction’, reduction in BPD symptoms and an increase in quality of life (Giesen-Bloo, Van Dyck, Spinhoven, Van Tilburg Dirkse, Van Asselt, Kremers, Nadort, & Amtz, 2006). Giesen-Bloo, et al., (2006) allocated their participants into two groups; one group received SFT for two sessions a week for three years, the other group received the same number of sessions of Transference-Focused Psychotherapy (TFP) over the same time period. The results showed that having completed three years of bi-weekly therapy, only 24% of participants in the TFP had achieved a full recovery, whereas 45% of participants in the SFT group had reportedly achieved a full recovery, as measured by the Borderline Personality Disorder Severity Index (BPDSI-IV) recovery criterion. Although individuals with BPD in both treatment groups sustained prolonged outpatient treatment, the SFT group had lower attrition rates. Giesen-Bloo, et al., (2006) suggest that SFT therefore provides individuals with BPD a greater commitment to recovery.

Regarding the cost-effectiveness of SFT, the same authors found that although there was high cost treatment sessions for each participant over the three years, there were actually long-term financial benefits for the Dutch Government. Giesen-Bloo and her colleagues reported that following SFT treatment, 4500 Euros (approximately £3000) net gain per participant was saved, and that the savings over the following years would be substantially higher (because people would no longer need treatment).

Like many authors, Giesen-Bloo et al., (2006) suggest that until recent years, psychotherapy offered help for only some of the symptoms of BPD. They further argue that the best available treatments, such as DBT, relieve many of the self-destructive behavioural symptoms of the disorder, such as self-mutilation, but do not successfully reduce any other core symptoms, especially
those related to deeper personality change. Giesen-Bloo et al., (2006) suggest that one of the benefits of SFT is its focus on deeper personality change, which can result in individuals with BPD becoming free from lives of chaos and misery.

Giesen-Bloo et al., (2006) are hoping that this validation of the effectiveness of SFT for individuals with BPD (that for so many years has been considered untreatable) will lead to more research studies. They also hope that this study will convince healthcare insurers to reimburse the costs of effective longer-term psychotherapy for this painful and costly illness. Indeed, there is currently a randomised controlled trial underway to assess the effectiveness and cost-effectiveness of SFT compared to TAU in the treatment of individuals with PD. The study is assessing six different types of PDs, and is using 250 participants. The study is not due to be completed until 01/04/2010 but it is expected that the study will add to the evidence base that SFT is an effective treatment for PD, and in particular BPD.

The Giesen-Bloo et al., (2006) study appears to suggest that SFT can provide an effective and cost-effective treatment for BPD. However, I note that the treatment was performed over a long period, namely 3 years, and was conducted in the Netherlands. Considering the current financial pressures that are on the NHS system in Britain, and in particular the expense that a three year treatment programme would incur, I cannot imagine that the NHS would utilise SFT as a treatment option for individuals with BPD until there is more scientific evidence that supports the Giesen-Bloo et al., (2006) study.

**Effectiveness and cost-effectiveness of CBT to treating BPD – 3) CBT**

Due to the many different ‘types’ of CBT that are currently available for treating BPD (e.g. CT, DBT, SFT, Compassionate Mind Training) I have
decided to use a meta-analysis to discuss the effectiveness of CBT for BPD, rather than use individual studies. Leichsenring & Leibing 2003 conducted a meta-analysis to address the effectiveness of psychodynamic therapy and CBT in the treatment of BPD. They analysed fourteen psychodynamic therapy studies and eleven CBT studies. From their analyses, Leichsenring & Leibing 2003 found that both psychodynamic therapy and CBT are effective treatments. However, since the number of studies that could be included in the meta-analysis was limited, the conclusions that were made were only preliminary. These authors concluded that further studies were necessary to examine specific forms of psychotherapy for specific types of personality disorders.

Conclusions

BPD is a chronic and debilitating MH disorder; the issue of co-morbidity, the functional impairment caused, risk behaviours, healthcare expenses, and drop out rates all combine to highlight the importance of establishing effective and cost-effective treatments for this disorder. It appears that interest in treating this population is growing. This is probably due in part to the fact that the studies discussed above suggest that there are treatments that have some efficacy, and in part due to the fact that there is now a comprehensive understanding of the aetiology of this disorder. However, in terms of the effectiveness and cost-effectiveness of treatments for BPD, interpretation of the literature is problematic: The number of participants in most studies is small, follow-up is limited, and the theoretical underpinnings and techniques employed are complex, which makes the effective components of treatment unclear. Thus, the evidence base for all of the above discussed CBT is inadequate in terms of making specific recommendations for any particular CBT approach.

At the clinical level, there is an urgent need for more research into the outcome of different forms of treatment: There is a need for more diverse research that
addresses age, class, ethnic minority and gender issues, and the latter appears to be of significant importance considering the fact that the majority of individuals diagnosed with BPD are female. Furthermore, studies of specific CBT treatments that show promise such as DBT and SFT, in addition to psychodynamic approaches (e.g. TFP) need to be replicated, and evaluated. Nevertheless, many of the new therapies for BPD (e.g. DBT and SFT) share a theoretically coherent, manual-based structure and it may be that the coherence and consistency this provides is particularly important for borderline clients. Despite many unanswered questions, recent developments give grounds for optimism and it is now difficult to sustain the view that all borderline clients are untreatable, and thus, the outlook for this challenging group of client’s may be starting to improve.

Considering the issues discussed above, it is not surprising that the NICE guidelines do not currently recommend any particular psychological approach to treating BPD. However, considering firstly, how many different MH problems NICE recommends are treated by CBT, and secondly, the above discussion that suggests CBT can be effective and cost-effective for some clients in the treatment of BPD, it is likely that the NICE guidelines will recommend CBT as the preferred treatment for BPD in the future.
References


Professional Issues Essay

What are some of the strengths and weaknesses of multidisciplinary teams from the perspectives of staff and service users? How can you as a psychologist contribute to teams functioning effectively?

Year 2
January 2008
Introduction

Interest in multidisciplinary team (MDT) working has increased over the last 15 years (e.g. Poulton & West, 1993; Leathard, 1994), probably due to a shift in emphasis from providers of services to a greater focus on ‘client-centredness’. Indeed, the importance of effective team working to deliver high quality care, focused on the needs of service users and their carers, runs throughout the National Health Service (NHS) policy agenda (Department of Health, DoH, 2000, 2001, 2003, 2004, 2005, 2006). According to the DoH, the most effective outcomes for service users are achieved when professionals work together, learn together, engage in the clinical audit of outcomes together, and generate innovation to ensure progress in practice and service (DoH, 1993).

The main aims of this essay are to draw on readily available literature, and my own clinical experience, in order to identify the advantages and disadvantages of MDT working, from a staff and service user’s perspective. How psychologists can contribute to teams functioning optimally will also be considered.

The essay is presented in five main sections:

Section 1 - defines MDT working and highlights the ambiguity which surrounds the concept

Section 2 - identifies the ‘drivers’ which are currently encouraging MDT working

Section 3 - begins with presenting the factors which appear to facilitate MDT working in the NHS, and ends with presenting the strengths of MDT working from a staff and service user’s perspective
Section 4 - presents the weaknesses of MDT working from a staff and service user’s perspective

Section 5 - discusses how psychologists can contribute to teams functioning optimally

Section 1 - What is MDT working?

What is meant by the term MDT working? From the literature it appears it is not a clear concept, as the terms ‘multidisciplinary’ and ‘interdisciplinary’ are often used interchangeably. Leathard (1994) discusses various prefixes (e.g. ‘multi’ and ‘inter’) and adjectives (‘disciplinary’ and ‘professional’) that researchers and practitioners use, and refers to this as a “terminological quagmire” (Leathard, 1994, p6). She suggests the terminology must be clarified before MDT working can be fully understood or implemented.

A question which is central to understanding MDT working is how many professions must be present before a team is truly multi-professional? Many argue that the difference between ‘inter’ and ‘multi’ is largely numerical: ‘Inter’ working appears to involve two professions, and ‘multi’ if more than two groups are involved (Carpenter, 1995). For the purpose of this essay, when referring to MDT working I will be referring to Carpenter’s (1995) description of what MDT working is, which is as follows:

* bringing more than two groups (professions) together
* focussing on complementary procedures and perspectives
* providing opportunities to learn about each other
* focussing on clients’ needs
developing participants’ understanding of their separate but inter-related roles as members of a team.

Having clarified the terminology, I will now discuss the ‘drivers’ of MDT working within the NHS.

Section 2 - What are the drivers towards MDT working?

Wilson & Pirrie (2000) suggest there are a number of ‘drivers’ which are encouraging the development of MDT working, which include:

* changes in the workplace
* the concept of competence-based assessments of professionals
* the focus on the end-user of services, and
* underpinning all, a desire to ensure that public services are delivered economically and provide the best value for money.

I will consider each of these below:

A changing workplace

Much has been written over the last few years about changes in patterns of work and how these impact on different professional groups (e.g. Leathard, 1994). In the health service in particular it is clear that the development of a primary-care led NHS has led to a significant reappraisal of working practices and a renewed emphasis on teamwork between health and social-care
professionals, in the best interest of patients (Wilson, Pirrie, & Finnigan, 1998). The focus has shifted from a concentration on the “specific combination of skills, knowledge and values” (Hugman, 1995, p41) that characterise any one health profession, to the ways in which health and social care professionals can deploy a range of skills (many of which are complementary or overlapping) in the interests of effective and efficient patient care.

Development of competence

Throughout the 1980’s and onwards there has been a movement towards describing professional knowledge and expertise in competence terms. At one level the competence-based approach provides an impetus to MDT working. Functional mapping of occupational areas and laddering of qualifications make it easier to identify skills and knowledge overlaps of various team members. However, on the other, it leaves unresolved issues of maintenance of expertise and is open to criticism, as it encourages the development of ‘generic’ team workers.

Focus on the end-user

There is some evidence that the balance of power has shifted over the past decade from professionals to the groups which they serve. In the health service, a White Paper, Working for Patients (DoH, 1989) seems to have had a profound impact on the way care is organised: It focuses on the end-user, and this is also seen in other policy areas (e.g. Wilson & Pirrie, 2000), to good effect for service users.
Economies and best value

Economy, efficiency, and effectiveness are now well-established principles underpinning the delivery of public services. Commissioners and providers are challenged to ensure that services not only meet objectives but do so according to the principles of best value. Following these precepts MDT working has been perceived as one way of ensuring that services are efficiently delivered.

Having described and provided the context of the development of MDT working, I will now consider the specific factors that appear to facilitate its development.

Section 3 - What factors facilitate MDT working in the NHS?

In the past few years there has been considerable development in MDT working throughout the NHS. Whereas before individual consultants and doctors led small teams of assistants and trainees, the development of clinical governance has promoted the development of bigger teams with bigger remits and less dominance of the individual (DoH, 1998). There are many examples of MDT’s delivering care within the NHS, for example, there are services which manage care for people with cancer, diabetes, mental health problems, drug and alcohol problems, learning disabilities, or those who have complex medical and social needs such as is the case with stroke rehabilitation (Indredavik, Bakke, Slordahl, 1999).

It is widely held that teams provide better care than individuals working in isolation (e.g. Borril, West, Shapiro, 2000; Firth-Cozens, 2000), and numerous authors have attempted to define what characteristics are required for effective team working. For example, Carter & West (1999) described an effective team
as having clear, shared objectives, differentiated roles and a need among members to work together to achieve team objectives. Team members also needed to have members with the necessary authority, autonomy and resources to achieve these objectives. Most importantly, they suggested, the team needs to frequently take time out to review what it is trying to achieve, how it is going about it and what needs to be changed. It then needs to plan and implement change and these authors report that innovation (ideas that are implemented for new and improved services or ways of working) may be the best indicator of effective team functioning.

More recently, Mickan & Rodger (2005) found that there are six characteristics that are most able to distinguish effective teams; purpose (the vision and values of the organisation), clear goals (tasks that are consistent with the purpose), leadership, communication, cohesion, and mutual respect.

Diversity is another feature of effective teams. The DoH (2007a) report that team working does not mean that all disciplines within teams should be homogenised, although some aspects of their roles will be shared among team members (e.g. record keeping and how core assessments are conducted). Instead, effective teams require diverse and differential roles in order to be effective. This paper suggests that team members need to be able to suspend assumptions and judgements, while promoting active and attentive listening, and individual and collective reflection on the thoughts and ideas that emerge, rather than focussing on areas of commonality which precludes new solutions emerging. The DoH (2007a) reports that communications within the team should instead value diversity and thus the fuller universe of solutions which might emerge. In addition, for diversity to be manifest and for team members to remain effective, Carpenter (2003) argues that role clarity is required. This means that all team members need to be clear about their specific roles within their teams.
The benefit of having a MDT filled with a diverse range of skills and expertise may seem obvious. However, research on this issue appears inconsistent, as some studies suggest that a teams’ diversity can have a negative effect. One apparent drawback is that team members tend to organise themselves into apposing cliques. This has been evident in my own clinical practice, as I have often observed team members from different professional backgrounds arguing that their approach to treatment is the best. For example, I have seen psychiatrists argue that medication is the most appropriate treatment for certain problems, while psychologists have argued that not giving someone a diagnosis and administering talking therapy is more suitable in these same instances. What I have learnt from these observations is that unless professionals work together in such cases, and unless such unhealthy group processes are resolved, then the client’s needs could go unmet.

Indeed, Doris Fay and her colleagues have proposed that the benefit of being multidisciplinary is highly dependent on whether group processes are working well (Fay, Borrill, Amir, Haward & West, 2006). In their recent study, Fay et al., (2006) looked at the quantity and quality of innovations introduced by seventy Breast Care Teams and ninety-five Primary Health Care Teams working in the United Kingdom. The number of professionals represented in each team varied from four to twelve (including nurses, surgeons and psychologists), and this was taken as a measure of how multidisciplinary a team was.

Contrary to the researcher’s expectations, teams that were more multidisciplinary tended to have introduced more innovations over the previous year, regardless of whether effective group processes were in place. Crucially, however, the quality of innovations (e.g. as measured by their benefit to patients) was dependent on group processes. Teams with more professions on board only introduced innovations of greater quality when effective group processes were in place - including all team members being
committed to the same cause; everyone in the team being listened to; the team reflecting on its own effectiveness; and there being plenty of contact between team members. The researchers concluded that from a practical perspective, the most eminent question is how to establish team processes that help capitalise on multidisciplinarity.

From the above discussion, it seems that numerous different factors contribute to effective MDT working, including: clear objectives and shared goals, collaboration and cohesion, space for reflection of the work, leadership, communication, mutual respect, diversity, and perhaps most importantly, healthy group processes.

Some of the strengths of MDT working from a staff and then a service user’s perspective will now be discussed.

**Strengths of MDT working from staff’s perspective**

Carter, Garside and Black (2003) report numerous advantages of MDT working for various staff members: Their findings suggest that a) discussing the care of individual patients leads to a cross fertilisation of ideas to other situations and other patients, which they argue would not be apparent in one-to-one clinical management. They also argue that b) sharing of knowledge makes learning easier; c) that the group can address issues of resource management in a more rounded way, avoiding waste and improving chances of arguing effectively for more resources as needed; and lastly, d) that team working increases the sense of partnership and support, particularly in difficult clinical situations like the management of complex cases.
Further research has found similar benefits of effective MDT working for staff. Borrill & West (2002) argue that it offers opportunity to integrate and share knowledge, practice and experience. Furthermore, their study found that it can enhance staff motivation and well being (Borrill & West, 2002). These authors also highlight the benefits of MDT working for service users, but I will discuss this further in the next session.

In thinking about my own clinical experience and the different MDT's that I have worked in, I have enjoyed working for, and have felt that I have made a valuable contribution to service users if a) I feel supported in my work and can talk to someone about difficult cases, b) if my opinion is valued and listened to by the team, c) if I can get easy access to information that I do not have specific knowledge about, for example, getting advice from a speech and language therapist about communication problems rather than having to look through the literature to find the answers, and d) if I have regular contact with other team members: Feelings of isolation have made effective working extremely difficult for me.

From this there appear to be several advantages for staff when working within a MDT. I will now discuss some strengths of MDT working from a service user's perspective.

**Strengths of MDT working from service user’s perspective**

There is an increasing evidence base suggesting that service users benefit from MDT working. Carter et al., (2003) suggest that service users benefit because when they are being looked after by a team they get a sense of confidence similar to that from having a second opinion, reducing the fear that their treatment is based on the knowledge of one clinician. These authors also argue
that service users benefit from access to the knowledge and expertise of different disciplines, that is, access to a wide range of services: They are involved and work collaboratively at the key transitional points of assessment, admission, referral, treatment and discharge, which empowers them, and they can direct the treatment that suits them and their families/carers best. They conclude that MDT working is good for a person-centred approach to care.

Other research shows that effective MDT working can make a substantial contribution to reduced hospitalisation time, increased patient safety, improved patient health, and innovations in patient care (Borrill & West, 2002). These authors also suggest that an ‘action-orientated’ approach from team members, that is, creating a space to reflect, think and plan, can implement improvements in client care and service delivery, and any improvement in the service provided could be seen as an advantage for service users.

In addition, a recent study researched MDT working from a patients perspective and found the following was beneficial to service users: getting help early; informed choices/best fit medication; talking therapies; recovery orientated; social support; education; and perhaps most importantly, all of the above delivered with respect, choice and involvement (Prior, 2007). Thus, it could be argued that all of these are essential if MDT working is to be beneficial to service users, and their carers.

Having considered some of the strengths of MDT working from a staff and service user perspective, the weaknesses of MDT working from a staff and service user’s perspective will now be discussed.
Section 4 - Weaknesses of MDT working in the NHS

Weaknesses of MDT working from staff’s perspective

Carter et al., (2003) suggest several weaknesses of MDT working from staff’s perspective: at an organisational level, departments and units within the NHS have traditionally secured resources through the creation of local power structures that attract money and staff. The concept of sharing responsibility may be thought to weaken this power base for resource acquisition, and staff may have to manage with little resources. On an individual level, responsibility sharing might be seen to weaken the clinician’s ability to achieve professional goals, and thus hinder their career development. These authors further argue that the NHS culture has a long way to go in encouraging staff to listen to the point of view of others while managing their own different professional views. Although differences in professional opinion can be seen as a weakness of MDT working for staff, it is acknowledged that this does not necessarily occur in all MDT’s. To help combat the weaknesses listed above, Carter et al., (2003) suggest that staff need to be more explicit, to service users, carers, as well as practitioners, the models that they base their practice on, and not keep them concealed. Otherwise failures in collaborative care occur, which is not good for staff morale, and ultimately, it is assumed that it is the service user that will be affected negatively.

From the MDT’s that I have worked in, I can reflect on several weakness of MDT working that I have noticed in my practice. Firstly, if goals are not clearly identified then work can be duplicated by different practitioners, which has left me feeling frustrated at the time that I have lost, especially when working in an NHS climate where practitioner time is precious. Secondly, staff members have ‘blamed’ other practitioners when things go wrong, and thus it seems that responsibility within teams can get easily confused. Thirdly, no clear leader has resulted in blurred boundaries and roles, and can lead to
tension and conflict. Lastly, when individuals come together to form a team they do no necessarily possess the skills, attitudes and behaviour required to work well together, and I have often observed conflict or 'personality clashes' between individuals. I am sure that anyone who has worked within a MDT will be able to think about difficulties that were caused by such human factors. Nevertheless, what is important is that professionals must try to put these factors aside when they are working within a MDT as poorly functioning teams can undermine performance and endanger patient safety (Mayor, 2002; Leonard, 2004), with clear consequences for service users.

**Weaknesses of MDT working from service user’s perspective**

Onyett’s (2003) research on mental health services found that an inability to recognise differences in values and attitudes, lack of role clarity, and poor communication are all too often present in MDT working, and are critical factors underlying poor functioning, and thus poor provision for service users and their carers. Other studies have also shown these factors to be important with regard to the service that users receive. For example, one survey of service users found that values and attitudes of staff were considered to be more important than their skills or knowledge (Williamson, 2003). This author suggests that raising awareness and developing overt dialogues regarding the values and attitudes of MDT members is essential if MDT working is to prove effective for service users. More recently, Slevin, McConkey, Truesdale-Kennedy, & Barr (2007) conducted a survey within several Community Learning Disability Teams and also found that clearly defined roles and communication are necessary for service users to perceive the service they receive as effective. Thus, it can be assumed that if poor communication, poor role clarity, and unresolved differences in values and attitudes are present within a MDT, then this will have negative effects on service users, and as such are weakness within some MDT’s.
A further weakness of MDT working, even in a team that works effectively, might be that staff have different agendas to service users. Indeed, a piece of research carried out in the 1990's, which would probably hold true to day, showed that service users prioritized practical issues such as personal finance, housing, and social support, whereas professionals saw issues such as treatment and monitoring as being highest priority (Shepherd, Murray & Muilen, 1995). This highlights the importance of listening to and supporting service users so that their voices are heard. This could be a role for psychologists and will be discussed in more detail later.

In thinking about my own clinical experience, I have noticed that service users can get confused if they are receiving a MDT approach: if they have numerous professionals managing their case, then they are unsure who best to ask for specific help. For example, they may ask a nurse about financial matters or care manager about psychological problems. This could cause confusion for some people and thus could be a weakness of MDT working from a service user's perspective.

Having discussed some of the strengths and weaknesses of MDT working, I will now discuss how psychologists might be able to contribute to teams functioning optimally.

Section 5 - How can psychologists contribute to teams functioning optimally?

The recently published DoH (2007b) paper *New Ways of Working for Applied Psychologist in Health and Social Care: Organizing, Managing and Leading Psychological Services* suggests that applied psychologist can make
significant contributions to service delivery. The following will describe their role, and how they can contribute to teams functioning optimally.

Psychologists contribute psychological knowledge from a broad theoretical base and extensive range of approaches. This broad knowledge base means that they can offer flexibility and use of integrative approaches to working with groups and individuals. Psychologists have numerous roles including using psychological theory to understand and then identify ways to alleviate psychological distress. Within this, they assess risk, promote maintenance of health, prevent and manage illness and identify psychological factors contributing to physical illness. They also apply their skills and knowledge to improve the health care system and influence the formulation of policy, optimising the performance of people at work or in training, including stress reduction and increasing self-efficacy and work satisfaction. Further ‘systems’ work may be with individual teams, staff groups, or the wider system where their psychological knowledge and skills can be applied to understand and influence organisational behaviour and the psychological impact of change on organisations and communities.

In addition to the core skills offered by psychologists, in terms of assessment, intervention, supervision, consultation, and research in relation to clinical input, managers are asking psychologists to adopt stronger leadership roles. Psychologists are also seen as important sources of knowledge concerning the ‘normal’ psychological processes associated with change and transition and how these affect the individual, groups and systems.

There are a number of ways in which the psychologist can promote effective team working, including; supporting service users and carers in finding a voice, supporting individuals in their roles, aiding communication, leadership of teams, and formulation. All of these will be discussed below:
Supporting service users and carers in finding a voice

Lack of funding and user participation being a low service-level priority have been reported to be major barriers to achieving and maintaining effective service user involvement in teams (Commission for Healthcare Audit and Inspection, 2005), and addressing attitudes of front line staff are considered essential. Psychologists therefore have a role in making the case and creating the right conditions for effective user and carer participation.

Service user and carer involvement provides clear advantages for health and social systems (Beeforth, Conlon & Graley, 1994). Beeforth et al., (1994) found that these advantages varied from notable increases in engagement and motivation of current service users when ex-service users were visibly employed in services, to changes in staff and management attitudes towards a greater understanding of service users as ‘whole people’ and a reduction in ‘us and them’ attitudes. For service users and carers becoming involved in the design, monitoring and delivery of services allowed the development of a meaningful role and identity outside their difficulties. It allowed the formation of relationships, both social and occupational, facilitated social inclusion, and when adequate payment was provided, helped address financial difficulties experienced by many service users. In aspiring towards person-centred services, providing such opportunities for service users sends a clear message regarding the real possibility of recovery and the achievement of meaningful life goals.

The involvement of service users and carers is also beneficial to health and social care more generally because of the expertise that they bring through their experience. Service user workers in teams can understand, empathise and communicate to health professionals the complexity of current service users’ difficulties from a unique perspective. They can provide a voice and much
needed advocacy. In thinking about the benefits of service user involvement described above, it is possible that psychologists can facilitate their involvement by ensuring that team members and management collaborate with them, to ensure that the service user’s voices are heard. Furthermore, psychologists can support service users to be aware of how they can take a more active role in decisions about their own care and treatment. Such informed choice is central to a collaborative psychological way of working, and psychologists can ensure its’ fundamental importance is not overlooked in busy health and social care settings.

**Supporting individuals in their roles**

As described earlier, optimal team working relies on people having clearly identified roles and goals. From my clinical experience, it seems the range of roles that team members undertake within MDT’s, alongside the increasing call for greater involvement from government bodies and watchdogs, means that team members (and service users) may become overwhelmed with involvement requests, risking overwork and high stress levels. Clear roles with clearly defined goals and objectives are important in guarding against such negative outcomes, and a psychologist’s role could be not only to help define such roles from a management perspective, but to emotionally support other team members in their role.

Furthermore, psychologists may be well placed to provide mentorship, consultancy and supervision for service users, carers and other team members by utilising their understanding of systemic processes within teams to understand, monitor and nurture staff attitudes and working practices. The provision of a simple safe space for reflection is another particularly important role (Hossack & Brookfield, 2007) and it is important that service users and carer roles have the same access to defended time for reflection as any other
team member, and psychologists may be best placed to support individuals to do this.

Communication

As described earlier, communication is key to effective MDT working, and psychologists could help aid communication within a team and between staff and service users. In particular, psychologists could aid service users to feel confident in relating to professionals and communicating within teams (Clarke, 2006). This may include public speaking, and understanding the context of services, teams and outside agencies (Sayce, 2000). Equally important for effective team working is training for team members on the advantages of working with service users and carers and how they may feel confident in relating to service users and other colleagues. It is clear that psychologists are well equipped to help facilitate this role (DoH, 2007b).

Leadership of Teams

Relating leadership specifically to team contexts, West & Mickiewicz (2004) suggest that for an effective team the leader has three key tasks: a) creating the conditions that enable the team to do its job; b) building and maintaining the team as a performing unit; and c) coaching and supporting the team to success. It could be argued that psychologists have the skills to perform these tasks within teams, as The New Ways of Working for Applied Psychologists Leadership document (2007a) states that ‘Psychologists, by virtue of their training, competencies and experience, can lead and manage teams, and take ‘clinical responsibility’ while supervising more junior staff’. However, although psychologists should be able to perform the three key tasks listed
above to enable their team to perform optimally, I cannot assume they can, as individuals may not have capabilities.

Formulation

Formulation is defined as one of the key skills of a psychologist and numerous books have been written about its importance (e.g. Dallos, Wright, Stedmon, & Johnstone, 2006). Formulations are detailed descriptions of why a person came to have a problem at this time; they draw on a range of psychological models, and one of their main purposes is to guide intervention. As with a functional analytical approach used with a variety of different care groups (Owens & Ashcroft, 1982), an effective formulation will take a systematic view that includes highlighting the circularity binding connected events where, for example, the consequences of problematic behaviours, emotions or thoughts are contributing to the conditions that created the events in the first place.

Considering the importance of formulation for psychologists, I was surprised to find that little has been written about the contribution formulation can make to team work. Nevertheless, Dallos et al., (2006) have outlined some of the dilemmas raised by formulating outside of one-to-one contexts to include wider systems such as teams and services. They suggest that taking formulation into a wider setting can be a powerful way of shifting cultures towards more psychosocial perspectives. It can be a very effective use of the psychologist’s limited time, and is appreciated by staff whose training does not equip them with these skills. It is perhaps especially useful with complex clients with long-term psychiatric histories, where transference and counter-transference issues are likely to be played out in relation to the whole team (as was evident on my mental health placement with individuals labelled as having a ‘personality disorder’). As such, it seems that the psychologist’s
ability to formulate could be used to help teams run more effectively by explaining to them the processes that individuals (like those with PD) go through and the feelings they raise in staff members.

Summary

To summarise, the research suggests that there are many advantages of MDT working for staff, service users and carers, as long as the team has clear objectives, there is collaboration and cohesion between team members and with service users, there is space for reflection of the work, there is a clear leader, there is good communication, mutual respect, diversity, and healthy group processes at work. If these are not in place however, then the effects are clearly detrimental to both staff and service users. It also seems that psychologists have a vital role to play in ensuring that teams function optimally, and their extensive training in psychological theories probably best places them to do this in comparison to other professionals. In conclusion, it seems that psychologists have a big responsibility to ensure that service user’s needs are best met.
References


Problem Based Learning Reflective
Account I

‘The Relationship to Change’

Year 1
March 2007
Problem Based Learning Task

The Problem Based Learning Task (PBL) entitled ‘the relationship to change’ required trainees to reflect on the meaning of change for them and their future clients. Trainees were placed into Case Discussion Groups (CDG) consisting of 5/6 trainees, and a facilitator, during which trainees discussed their experiences and relationship to change to produce a presentation. The following will describe this process including the PBL presentation, the group process, re-evaluation of the PBL presentation, re-evaluation of the group process and summary.

The PBL presentation

The relationship to change was presented using a theoretical model for Mental Health (MH) promotion, which was developed by McDonald and O’Hara (1998). The model is based on 10 elements of MH promotion and erosion (see Figure 1 below). Improvements in MH are made by strengthening the 5 elements in the top half of the model (e.g. social participation), and reducing the influence of the 5 factors in the bottom half of the model (e.g. stress).
Another important feature of the model, which the presentation focussed on, is the emphasis on 3 different levels of action, namely, micro, meso and macro. The micro level represents the individual, the meso level represents the wider system (e.g. the family), and the macro system represents even wider systems (e.g. the area they live in).

During the presentation we described how we as individuals had changed over time, both physically and mentally. It was acknowledged that individuals do not change/develop absolutely or chronologically, rather we grow sometimes in one dimension and remain childish in another. The main topic of the presentation however was how we as trainees respond to change at the micro level and how we are influenced by both the meso and macro levels. We suggested that as a trainee clinical psychologist there are pressures from the macro level in the form of the NHS and the BPS, for example, that they will shape the direction of our professional practice. Along with these more global influences we discussed how the University of Surrey at the meso level has its own expectations of us as trainees. It will try to respond to the NHS and BPS guidance by shaping our training and supporting our development.
We also discussed how we have the potential to influence change in the other direction, namely, shaping the future of the profession, the BPS and the NHS.

Using video footage of a reflective diary we also presented how considerably an individual can change within the space of a few weeks. We also described how people respond differently to change; some embrace it, accept it, while others resist, avoid, are unaware of, or worry about it.

The reason we focussed on McDonald and O’Hara’s (1998) model rather than the more traditional stage models of change (e.g. Prochaska and DiClemete, 1982) was to show the multitude of different factors external to the individual that can influence change. In deed, in terms of clinical practice, McDonald and O’Hara (1998) suggest there is increasing evidence to suggest that you have to shift away from working solely with individuals, to a greater emphasis on the influencing surrounding wider systems. As a group we thought it wise to consider those important external influences, not just for better understanding of the change process we are to experience during training but to be able to apply the knowledge in clinical practice.

The group process

I was anxious at the beginning of the first CDG meeting for two reasons; 1) the PBL task seemed vague, and thus I did not know what the process would involve, and 2) would we ‘bond’ as a group and work well together? I felt slightly reassured when the ‘group boundaries’ were created, which included respecting difference and diversity within the group (e.g. sexual orientation, difference of opinion), confidentiality, equal participation and sharing of ideas. Having these group rules made me feel safe and secure and thus willing to share my experiences and ideas in group.

We discussed numerous different topics about ‘change’ in the first CDG meeting and I remember feeling overwhelmed by the abundance of new information and unsure how the various psychological theories discussed could be linked to the task. The

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1 This reflective account is written in the first person to allow for personal reflections.
group talked about personal experiences of change and it became apparent that the group members respond differently to change (i.e. some welcome it, others avoid it). We also thought about how our own experiences of change could be used to identify and empathise with clients in order to help facilitate change in them, and similarly how clients may respond differently to change, as our group did.

Various theories of change (e.g. Prochaska and DiClemete, 1982) were talked about in relation to our own experiences and also how they might be applied in clinical practice. From these discussions it appeared that all group members were diverse in terms of their experiences of change. However, we were united in our anxieties about working with clients, and in about what was expected of us in the PBL presentation, and as trainees in general. These similarities seemed to connect us as a group and formed the foundation for which the group dynamic could develop positively.

The group decided that the roles of 'script' and 'chair' should be undertaken by different group members every meeting. This was firstly, so that the responsibility of such roles could be shared between the group members rather than relying on particular individuals, and secondly, so that all members could develop skills in these varying roles. During the PBL task each meeting the assigned 'chair' would encourage group members to set the agenda for the meeting, ensure all agenda items were discussed, and enable all group members to have an opportunity to voice their opinions. The assigned 'scribe' would record discussions and make summaries of the discussion if appropriate.

At the end of the first meeting the PBL task felt mammoth so to relieve anxieties we set ourselves homework to explore different psychological models of change and the literature on 'reflective practice'. Every member of the group was assigned a task to do and asked to feed back to the group next meeting, to allow a broad amount of literature to be reviewed. I remember thinking that if everyone did their homework it would show their commitment to the task, and perhaps more importantly to the group. In the next meeting it transpired that all group members had completed their assignments. To me this was the start of a positive collaborative working relationship,
and in hearing about more negative experiences in other CDG, I felt lucky and proud to be an ‘in-group’ member of my CDG group.

Re-evaluation of the PBL presentation

Reflecting on my own thoughts and feelings at the start of the PBL task, namely a feeling of being overwhelmed with new information, and confusion about how the psychological theories and concepts would be relevant to the task, it made me wonder if clients feel similarly at the start of their therapy. If so, I think this not only highlights the importance of psycho-education around the relevance of psychological models and theories employed by clinicians, but also the necessity for clinicians to have excellent communication skills to be able to guide this process.

In thinking about my current CBT work with clients, it seems those who have a good understanding of the CBT model are progressing better than those who do not, suggesting the importance of good theoretical understanding by clients when applying the CBT approach. I have also come to recognise from my recent clinical experience however, that some clients do not ‘fit’ precisely into the CBT models (e.g. Well’s, 1997 anxiety model). From this I have learnt that although CBT models provide a good foundation for therapeutic work with clients, they must be applied flexibly and idiosyncratically to stand a chance of being effective.

Our CDG group used McDonald and O’Hara’s (1998) model as the foundation of our presentation. As a result during my clinical practice I often consider factors at the meso and macro levels that may affect an individual’s ability to change (i.e. work, support systems). Although I may not be able to influence such external factors directly in my sessions with clients, I can direct clients to other members of the CMHT in which I work who may be able to help (e.g. social workers). In my clinical experience, finding work has proved extremely difficult for some of my clients, which is unsurprising considering that 75% of people with severe mental health problems who want to find employment cannot (Drake, 2003). Such meso/macro
factors have proven to be obstacles to individuals' ability to change or make progress and will continue to be considered in my future work with clients.

Although knowledge of McDonald and O'Hara's (1998) model has proven beneficial in my clinical work, other factors not considered in the model have also proven to be essential in my clinical practice if I am to help elicit positive change in a client. Most importantly seems to be the therapeutic relationship. Indeed, Roth and Fonagy (2005) argue that a good therapeutic alliance makes a small, but consistent contribution in clients, and acts as a moderating variable in the process of change.

During my clinical practice I have also discovered that the importance of therapist empathy and motivation from the client to enable positive outcomes, as was suggested by Lafferty, Davidson, Scott, Schmidt, Tata, Thornton, & Tyrer's (1989) study of trainee therapists. Furthermore, working with individuals from different backgrounds/cultures has made me appreciate the need to consider difference and diversity issues when working with clients, which again McDonald and O'Hara's (1998) model does not address.

**Re-evaluation of the group process**

After having attended a few CDG meetings our group was informed that we were to receive an additional group member. Resultantly, my anxieties rose because we had already formed a group bond and I did not know how the new individual would affect the group dynamic, which I was comfortable with. In reflecting on these anxieties, and the anxieties I had felt at the initial CDG meeting, the former felt more powerful and I also felt resistant. I expect this was because I had no choice over the second 'change', whereas I had chosen to enter the original 'change' process. The strength of the anxiety and resistance felt when 'forced' to change is worth bearing in mind in my clinical practice, as it is likely that those individuals who have not had much choice about entering therapy will experience feelings of anxiety and in particular resistance, as I did. Not being aware of resistance could have negative impact on the therapeutic process (Prochaska and DiClemente, 1982).
Summary

Sometimes we choose to change, other times we resist it. However, change is an inevitable process, as we live in ever evolving systems. It is impossible to predict how I will change in the future and similarly how my clients will change. All I can say is that change is a process that has to be experienced, and everyone experiences it differently, seemingly dependent on personality, the context, and previous life experience.

McDonald and O’Hara’s (1998) model highlights how meso and macro levels can influence change in the individual at the micro level, and it has proven essential to consider these potential influencing factors when working with clients. However, McDonald and O’Hara’s (1998) model does not account for the other factors that influence change, for example, the therapeutic relationship (Roth and Fonagy, 2005), therapist empathy and motivation from the client (Lafferty, 1989), to name a few.

Although the PBL task originally proved challenging for me, from going through the process I have learnt the importance of 1) reflective practice, 2) considering the individuality of people I work with (both colleagues and clients), and 3) critical analysis of theory-practice links. I intend to continue to develop skills in these areas throughout my training and beyond.
References


Problem Based Learning Reflective
Account II

‘Child Protection, Domestic Violence,
Parenting and Learning Disability’

Year 2
March 2008
Problem Based Learning (PBL) Task

The PBL task entitled ‘Child Protection, Domestic Violence, Parenting and Learning Disability’ required trainees, within their Case Discussion Groups (CDG’s), to discuss and present a case example (The Stride family), considering all of the material provided. The following will describe this process including a brief description of the case example, the PBL presentation, the group process, re-evaluation of the PBL presentation, re-evaluation of the group process, and summary.

Case example

The case example described how two 3-year-old twins had been placed in short-term foster care following a child protection case conference, as the children were “at risk in the care of their parents”. The children were on the child protection register due to “emotional abuse and neglect”, and we (as psychologists) had been approached to help the Court conduct a full risk assessment, and develop a rehabilitation plan for the children, if appropriate. We were informed that the Local Authority wanted to place the children for adoption in belief that their parents could not care adequately for their children. However, the parents were passionate about having the children returned to their care. We were given detailed background information about the family including information on: learning disability diagnosis, support systems, domestic violence issues, finances, functional abilities, and mental health problems. The question we were asked to present relating to the case example was, ‘Who’s problem is it?’ and ‘Why?’.

The PBL presentation

As the main task of the exercise was to help the Court to conduct a full risk assessment,
we presented the case using a courtroom environment in order to demonstrate some of the issues and complexities that may have arisen in a Court hearing. Mrs Stride, a child psychologist, and a learning disability psychologist were put on the witness stand and cross examined by a prosecution and a defence solicitor. A jury then reflected on the information presented and summarised the issues that were raised.

We drew on various psychological theories, policies and guidelines to inform our presentation. These included policies/guidelines relating to parents with learning disabilities (e.g. Goodinge, 2000), learning disability in general (e.g. The White Paper: Valuing People, 2001) domestic violence (e.g. Byrne, 2007), and child protection (e.g. Every Child Matters, 2003; the Children Act, 2004) to name a few. The intention of incorporating such policies into the presentation was not only to gain knowledge in such issues but also for the CDG group members to learn about what challenges they may encounter when working within a child or learning disability service. We also demonstrated how the views of service users can often be ignored by asking Mrs Stride questions she did not understand, or by ignoring the answers she gave when she was on the witness stand.

The group process

I[1] was not as anxious at the beginning of the task as I had been in the previous PBL task. This was because I had already experienced ‘the PBL process’ and had an idea of what was expected of me and what would be involved. However, I became anxious when I

[1] This reflective account is written in the first person to allow for personal reflections.
realised how many policies and guidelines there were relating to Child Protection, Domestic Violence, Parenting and Learning Disability issues. I remember thinking, “How are we ever going to get a good understanding of all those?!”. My anxieties subsided temporarily when we decided to split into 3 groups in order to cover as much of this literature as possible, and these included a ‘parents’, a ‘children’, and a ‘complexities’ groups. We agreed that each group would read the appropriate literature and then feedback to the larger group so that we could all have a basic understanding of all the relevant policies. I remember thinking that it would be likely that I would have to refresh my knowledge of the various policies and guidelines when I went out on placement, especially as it would be six months before I would need to use some of them. In thinking about this it was not long before the seemingly overwhelming volume of material had raised my anxieties again.

In terms of how the CDG group worked together, we came up with numerous ideas about how the case should be presented and there were several arguments about which idea was best. Furthermore, splitting into smaller groups felt productive but it did not feel like we were working as a team in this task, rather lots of individuals working against each other. This was very different from the original PBL task (‘the relationship to change’) as we were all willing to accept other peoples ideas, or modify our own during this task. On reflection, it seems that in our first year we held back our views because we wanted to be a part of the group, or wanted to be liked or to fit in. Whereas in this task, group membership had been established in the first year, and perhaps in the current task group members felt more comfortable to argue against other peoples ideas and/or were more confident to communicate different ideas.
Re-evaluation of the PBL presentation

In thinking about how people reacted to the case example, initial reactions towards the Stride family included anger towards Mr Stride for his violence towards his wife, and anger for him not being prepared to help his wife with domestic chores. Also, the group sensed that the family situation felt ‘desperate’ and in immediate need of intervention. On reflection, the case clearly raised powerful feelings for people within the group, including myself, and I think this was reflected and ‘acted out’ in how we treated Mr Stride: In thinking about the characters that we had included in the court room scenario, it became apparent that we had totally excluded Mr Stride and his point of view (probably due to emotions raised by the fact that he is violent towards his wife), we only considered the views of Mrs Stride. On reflection, it seems that the powerful feelings that Mr Stride raised in us, influenced our decisions and how we treated him. This task has taught me how easy it is to judge people by their behaviour, and how this can affect my own behaviour (i.e. not listening to people or ignoring their views). This is definitely something I need to be wary of so it does not affect my practice with service users. Due to my own life experiences it has also taught me that ‘domestic violence’ is a sensitive issue for me, and something that I need to be particularly mindful of.

Our CDG group used various policies and guidelines (e.g. The White Paper on Valuing People, 2001; Goodinge, 2000) as the foundation of our presentation, and I have found the knowledge gained from such papers invaluable during my placement. However, such policies do not necessarily highlight how institutionalised some services are, and how difficult it is to get staff to implement new guidelines! For example, guidelines around ‘capacity to consent’ (Mental Capacity Act, 2007) make supporting people to make
decisions sound relatively simple but the majority of clients that I have worked with on placement are unable to give consent, and amongst carers there still seems to be the idea that *they* can give consent for the client rather than consider in *every* instance what service users can and cannot consent to themselves. Professionals seem very keen to make a ‘best interest’ decision on behalf of the service user, maybe because it is quicker/easier to make the decision for them. I have found this extremely frustrating, as it is the service users who are losing out. I hope that when the new capacity act has been in place for a while, carers and professionals will have a better understanding of it, and apply it more appropriately.

**Re-evaluation of the group process**

In thinking about the group process, and how we as a group responded to Mr Stride, it is also evident that we at times failed to listen to our only male member of our group. We did this by occasionally excluding his suggestions, and at one stage we did not tell him that we had rescheduled one of our meetings. This is something the group had never done in the past, as previously we had considered everyone’s views and if needed, we would go with the consensus. We also excluded a suggestion made by our group facilitator, who also happened to be male. On reflection, this shows how easy it is to not consider issues of difference and diversity (e.g. gender differences). This also shows how much of ourselves we bring to clinical situations, and how much our assumptions/judgements can influence our work. Clearly I need to be mindful of this in my clinical practice, especially in a workforce that is predominantly female.

As we had not worked well as a group in this task, after the presentation we also had
numerous discussions about how we could rectify the situation. Topics included how we all have different styles of working (e.g. organised versus last minute), differences of opinion, and how some could dedicate more time to the task than others. After these discussions it was agreed that such differences within the group should not only be acknowledged but respected; just because people work and think differently to oneself does not mean that it is wrong or less worthy. This highlighted the fact that we cannot judge other people by our own standards, or availability to a task. This has been an invaluable learning experience, not just for future PBL tasks but in terms of how we view different working styles and availability of the people we will work with in our clinical practice in the future. We also discussed how as clinical psychologists we need to get accustomed to the feeling of difference of opinion, as this is something that we will face in various capacities within our practice, and we need to develop a voice to be able to express these opinions.

Summary

The PBL task was most challenging for me in terms of how we worked together as a team (or not). The whole process felt very different from the original PBL task, and consequently I have found the importance of the following; 1) reflective practice, 2) considering and respecting the individuality of people I work with (both colleagues and clients), 3) critical analysis of theory-practice links, 4) the importance of listening to clients views and empowering them to have a voice, 5) the importance of listening to colleagues views, in order to be able to work collaboratively. In my view team work is essential, and if you do not work as a team it can leave you feeling isolated, unsupported and the task does not get done as efficiently as possible, which in practice would
probably have a negative effect on service users. I would like to continue to develop my
skills in all of these areas during the rest of my training and look forward to the next task
for yet another different learning experience.

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Problem Based Learning Reflective Account III

‘Working With People in Later Life, their Families, and the Professional Network’

Year 3
February 2009
Problem Based Learning (PBL) Task

The PBL task entitled ‘Working With People in Later Life, their Families, and the Professional Network’ required trainees, within groups, to discuss and present a case example (Mr Nikolas), considering all of the material provided. Unlike previous PBL exercises, which had been conducted by groups which had already worked together on previous PBL exercises, this task was done by a newly formed group of second and third year trainees. The following will describe this process including a brief description of the case example, the PBL presentation, the group process, re-evaluation of the PBL presentation, re-evaluation of the group process, and summary.

Case example

The case example described how 69 year old Mr Nikolas had been referred to the psychology department for assessment of short-term memory problems, and his needs for care, as his social worker believed that he was not looking after himself properly. There had been some disputes within the family about Mr Nikolas’ finances and the Court of Protection had been called on to help manage his affairs. Background information about Mr Nikolas was provided, including his cultural background, his family of origin, religious beliefs, marital status, and current family situation. The questions we were asked to present included ‘What is the problem?’, ‘Who has the problem?’ and ‘What might happen?’

The PBL presentation

Our group decided to present Mr Nikolas’ case to the audience by pretending to be in a Case Discussion Group (CDG). Such groups are usually used by trainees to present cases, and this format was used because it seemed an ideal way to get all of the case material across. Within the presentation, I introduced the case and then asked the other group members to help me think about
certain issues, as might happen within a normal CDG. For the presentation we had pre-planned our discussions, what questions we were going to ask each other and the appropriate responses to these. The discussion focussed on ‘differential diagnosis’, ‘Mr Nikolas’ ability to do practical things for himself’, ‘life cycle and transitions’, ‘loss, old age and attachment’, ‘financial and emotional abuse’, and the ‘role of the psychologist’.

We drew on various psychological theories, policies and guidelines to inform our presentation. These included the Court of Protection (2007), Mental Capacity Act (2005), the relationship between depression and dementia (Ballard, Bannister & Solis, 1996; Allen & Burns, 1995), role identity theory (Marks & MacDermid, 1996), attachment in old age (Evans & Garner, 2004), and financial abuse (Reay, & Browne, 2001) to name a few. The intention of incorporating such policies into the presentation was not only to gain knowledge on these topics but also to prepare us as trainees for what challenges we may encounter when working within older adult services. Within our presentation we also discussed how easily Mr Nikolas’ views could be ignored, as the variety of professionals working with him were trying to meet both his and his families seemingly opposing needs.

The group process

My anxieties at the beginning of the PBL task were not as high as they had been in previous PBL tasks. This was because firstly, I had already experienced ‘the PBL process’ and knew what was expected and what would be involved. Secondly, I was looking forward to learning about older adults, as it had been a placement I had been eagerly anticipating since the beginning of training, due to my interest in this client group. However, I soon became anxious when, as a third year trainee, I realised that the second year trainees within our group were looking to me, and the other third years within our group for direction in the task. I felt like I had been put on a peddle stool and
was supposed to impart my superior knowledge and experience with them. On reflection, I think having second and third years within the same group worked well with regards to how we worked as a team. The perceived pressure I had put on myself to keep myself on the peddle stool and impress my new group members made me work harder than perhaps I would have had we stayed in the same groups as the previous two PBL tasks. Similarly, it seemed that the second years wanted to exert their knowledge and expertise to the third years, as they often came to meetings having seemingly done hours of research. The result of this ‘trying to impress each other’ resulted in several worthwhile discussions about the client group of interest. Being in a team where everyone was working hard to reach the team goal soon made my anxieties subside.

We came up with numerous ideas about how the case could be presented but we soon noticed that the most interesting discussions that we had came from simply talking about the case and the related theories (e.g. differential diagnosis, attachment in old age). From this we decided to the present the case as if we were in a CDG. We all picked topics that we were particularly interested in, which for me was differential diagnosis, and we separately prepared what we wanted to talk about in the presentation before bringing it back to the group for discussion. On reflection, it was interesting to observe which topics individual group members were interested in, in that some topics raised powerful feelings for some but not for others, and it seemed that the topics that raised powerful feelings for people were the ones they wanted to explore further. For me this indicated how much of our private life and beliefs we take to our work and how we can get ‘caught up’ on the topics that interest us, or parts of a case that interest us. It is obviously important for us as clinicians to be mindful of this in our practice else we may unconsciously ignore critical aspects of a client’s presenting case.
Re-evaluation of the PBL presentation

In reflecting on the task, it seems that our presentation was not as creative as other groups’ presentations. One particular presentation that stuck in my mind was the group which presented Mr Nikolas’ case as a popular television programme, ‘the lions den’. As this presentation stuck in my mind it seems that the creativity which they used not only gained my attention but I was also able to recall it from memory easily. The same may not be true for those who watched our groups’ presentation, which in comparison was quite bland. In thinking about ‘bland’ and ‘creative’ approaches that I have used in my clinical work when giving presentations, it seems that the bland, formal, ‘powerpoint’ presentations have not always stimulated as much psychological thinking or discussion as I would like. However, when I have used more creative approaches to give presentations, like role plays, it has resulted in more interest rather than the staff ‘just being lectured at’. From this, I have learnt that using a creative element in future presentations or educational work within my clinical work could prove extremely useful.

Our group used various policies and guidelines (e.g. Evans & Garner, 2004; Mental Capacity Act, 2005) as the foundation of our presentation. Subsequently, these have been of great importance in my work with clients. For example, I recently formulated a client using an attachment framework to understand the emotional difficulties that they were experiencing in the context of the aging process, and this greatly informed my work with them. However, having not researched attachment in older adults myself within the PBL task, I found myself having to re-do the research for myself on placement. For me, this indicated how quickly you have to practice the theory-practice links before the information is forgotten. Splitting into smaller groups to acquire a wealth of knowledge for the task seemed like a good idea at the time but has resulted in me having to re-do the research separately anyway.
Although knowledge of the various policies and guidelines I learned about in the PBL process has proven beneficial in my clinical work, other factors have also proven to be essential in my clinical practice. Most importantly seems to be the therapeutic relationship. In deed, Roth and Fonagy (2005) argue that a good therapeutic alliance makes a small, but consistent contribution in clients, and acts as a moderating variable in the process of change. From my own clinical experience this seems to be especially true for clients with long and enduring difficulties, who have tried a variety of psychological approaches and report that it is the therapists warmth and non-judgemental attitude that proves the most effective for them in a treatment programme.

Re-evaluation of the group process

In our presentation it seems that our group were biased towards Mr Nikolas to ensure that his needs were met and on reflection, we neglected the family’s needs and desires. I realise now that we should have focussed more on Mr Nikolas' family because as a community client, it would be more than likely that it would be the family who would help implement a recommended treatment plan within the community. If this was a real case, and if the family had not been considered, or if the treatment plan did not meet the family’s needs, it is likely that they would have had no motivation to implement a treatment plan. This reflection has taught me to always consider the wider systems of the presenting client, to ensure that everyone’s needs are considered.

In thinking about why our group were biased toward Mr Nikolas, it may be that the group had preconceived ideas about what an older client would need from a psychologist, which in this case meant focussing mainly on Mr Nikolas to ensure that his needs were met. An alternative explanation of why we were biased towards Mr Nikolas is that because our group was formed of ‘White British’, female, middle class, individuals of similar working age, we focussed
more on Mr Nikolas because we were consciously aware that his background
was very different from our own. It was if we did not want to miss anything
out and worked especially hard to eliminate the differences between him and
us. I wonder how the process would have been affected had we had a group
which was formed of different ages, cultures, genders, and classes? I am
assuming it would have been very different.

My final point before I summarise is that I am grateful to the second years
within our group for helping me to build my leadership skills and confidence
in this area. If they had not put me and the other third years in the group on a
peddle stool, then I probably would have not taken up the leadership
challenge!!

Summary

From being involved in this PBL task I have learnt the importance of 1) being
creative when giving presentations to maximise attention and the probability
of recall, 2) considering the wider context of the presenting client in all cases,
3) being aware of any preconceived ideas and making assumptions about what
the client needs, and lastly, 4) maintaining a warm and non-judgemental
attitude toward clients at all times. I intend to continue to develop skills in
these areas throughout my training and beyond.
References


‘A Reflective Process Account of the Case Discussion Group in Year I’

Year 1

September 2007
This account depicts my experience of the case discussion group (CDG) in year 1. I share my reflections of this experience into sections; group development, group structure; relationships within the group, including my relationship with the group facilitator and other group members; key learning experiences; weaknesses within the group; and finally a summary.

During the account I discuss in detail group processes like differences within the group and the role of the group, and relate these to the literature base on group processes (e.g. group cohesion). I also reflect on my personal learning experiences, most importantly, the significance of the therapeutic relationship and the use of language, in addition to acknowledging my own anxieties about change. I also discuss how talking about and listening to other group member’s case presentations can improve professional development.

The account is concluded by a discussion on how attending the CDG group was an extremely positive experience for me, as it was a fantastic learning opportunity in terms of both personal and professional development. Positive working relationships with others as a contributor to this were discussed. Anticipations about the future of the group, in particular, a new group facilitator, changes and my resistance to this are presented.
Summary of Case Discussion Group
Process Account II

‘A Reflective Process Account of the Case Discussion Group in Year II’

Year 2
July 2008
This account depicts my experience of the case discussion group (CDG) in year 2. I share my reflections of this experience into sections; the influence of the new CDG facilitator; what I learnt from the CDG; what I contributed to the learning experience of other members of the CDG; how the CDG has helped me in my work on placement; and finally a summary.

During the account I discuss how the new facilitator broadened my knowledge base with regard to different psychological approaches (e.g. CBT, systemic family therapy). I also talk about 'professional issues', like the influence of the 'medical model' in services, the strengths and weaknesses of working within multi-disciplinary teams, and leadership and management for us as clinicians in the future. I also link my experiences in the second year to my first year, for example, I discuss how my role and contributions within the group have changed, in addition to how I continue to use the CDG group to inform my clinical practice.

The account is concluded by discussion about how the CDG group continues to offer a positive learning experience for me, in terms of both personal and professional development. I also offer my reflections on why it has been so positive.
Clinical Dossier

This section contains summaries of my clinical experience during the core clinical placements (adult mental health, learning disabilities, child and adolescent mental health and older adults), in addition to a summary of the advanced competencies placement (adult neuropsychology).

The section also contains summaries of the four written clinical case reports (two for adult mental health, one for learning disabilities, and one for older adults), in addition to a summary of the documentation relating to an oral presentation of clinical activity (for child and adolescent mental health). The full clinical case reports are in Volume II of the portfolio.
Summaries of my Clinical Experience during Clinical Placements
Adult Mental Health Core Placement Summary

Placement Setting: A Community Mental Health Team (CMHT) that provide clients with primary and secondary care, although my work was in the secondary care service. The majority of work was conducted on a one-to-one therapeutic basis, based at the CMHT. However, there was also opportunity to work in an in-patient mental health rehabilitation service, and to provide group therapy.

Psychological Model(s) Employed: The main therapeutic model when working directly with service users was Cognitive-Behavioural Therapy (CBT); however, there was also opportunity to think systemically and psychodynamically when formulating service user’s difficulties.

Clinical Experience Gained: The majority of work during this placement involved the assessment and/or intervention of adults of working age who presented with a variety of different difficulties. These difficulties included depression, anxiety, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD), psychosis, health anxiety, phobia (including vomit and insect phobia) and personality disorder. Standardised assessments conducted included the WAIS III, Raven’s Progressive Matrices, HADS, BAI, BDI-ii, and health anxiety questionnaire.

Other Opportunities and Experiences Gained: Low mood group, ‘well-being’ group for people with psychosis, presentations, and service related project.

People with Learning Disabilities Core Placement Summary

Placement Setting: A healthcare and social services joint community learning disability team for adults. The work was conducted in a variety of different settings including the team base, service user’s homes, day care services and residential homes.

Psychological Model(s) Employed: The main model employed was integrative, with a particular focus on CBT when working on a one-to-one
basis with service users, and a focus on the behavioural approach when working within the service user’s system.

**Clinical Experience Gained:** The work during this placement was extremely varied; and involved the assessment and/or intervention of a diverse range of difficulties. These difficulties included depression, anxiety, challenging behaviour, anger, self-injurious behaviour, low self-esteem, dementia and autistic spectrum disorders (ASD). Assessments conducted included the WAIS III, adapted BDI-ii, HALO short form, Vineland Adaptive Behaviour Scales (Maladaptive Behaviour Scales), BPVS, Oliver and Crayton Dementia Screening Test, Early Signs of Dementia Interview/Checklist, Theory of Mind Tests, HoNOS, functional assessments (ABC charts and MAS), and observations. Eligibility for services assessments were also conducted.

**Other Opportunities and Experiences Gained:** A case study presentation to Clinical Psychologists about the concerning matter of restrictive practices.

**Child and Adolescent Mental Health Core Placement Summary**

**Placement Setting:** A tier three Child and Adolescent Mental Health Service (CAMHS). The majority of work was conducted on a one-to-one therapeutic basis, based at the CAMHS. However, there was also opportunity to work with individuals in schools.

**Psychological Model(s) Employed:** The main model employed was integrative, with a particular focus on CBT when working on a one-to-one basis with service users. However, experience of using Systemic Family Therapy was also gained, both as a therapist and as part of a reflecting team.

**Clinical Experience Gained:** The majority of work during this placement involved the assessment and/or intervention of children aged 7-18, who presented with a variety of different difficulties. These difficulties included depression, anxiety, OCD, vomit phobia, low self-esteem, anger, Attention Deficit Hyperactivity Disorder and diabetes. Assessments conducted included the WISC IV, SDQ, Draw a Family and Draw a Person Tests.
Other Opportunities and Experiences Gained: Regular attendance at team meetings and at a psychodynamic group meeting. I presented cases to various professionals within the CAMHS services in the area. I helped to run an ASD clinic.

Older Adult Core Placement Summary

Placement Setting: The majority of work was conducted on a mental health inpatient ward for adults over the age of 65. However, there was also opportunity to work on a dementia inpatient ward for adults of the same age, and in primary care settings.

Psychological Model(s) Employed: The main model employed was integrative, with a particular focus on using CBT (and Mindfulness) and psychodynamic approaches when working on a one-to-one basis with service users.

Clinical Experience Gained: The majority of work during this placement involved the assessment and/or intervention of adults aged 65-92, who presented with a variety of different difficulties. These difficulties included depression, anxiety, psychosis, personality disorder and dementia. Assessments conducted included the WAIS IV, WMS III, WTAR, Hayling Sentence Completion Test, Delis Kaplan Executive Function System (DKEFS) Trail Making Test, STROOP Test, CORE, HADS and MMSE.

Other Opportunities and Experiences Gained: Throughout the placement I ran a 'Patient discussion group' (CBT group for individuals on the mental health inpatient ward who presented with a variety of different difficulties). I also gave a presentation about dementia to staff on the dementia inpatient ward, and co-facilitated a reflective practice group for nurses on the mental health inpatient ward.
Advanced Competencies Placement Summary: Adult Neuropsychology

Placement Setting: A community neuro-rehabilitation service for adults with an acquired brain injury. The majority of the work was conducted at the team base; however, there was also opportunity to work with service users at their home.

Psychological Model(s) Employed: The main models used were bio-psycho-social models of neuro-disability; neuropsychology models of brain-behaviour relationships; and CBT.

Clinical Experience Gained: The majority of work during this placement involved the assessment and/or intervention of adults with an acquired brain injury, who presented with a variety of different difficulties. These difficulties included depression, anxiety, personality disorder, Parkinson’s Disease, Multiple Sclerosis, Stroke, HIV, brain injury following trauma, adjustment problems, and memory problems. An array of psychometric assessments were conducted and included the WAIS IV, WTAR, WMS III, Hayling and Brixton Test of Dysexecutive Syndrome, STROOP Test, Trail Making Test (tests A and B), FAS (letters and animals), BADS, Rey Complex Figure Test, Figural Fluency Test, Wiegl Colour Form Sort Test, Raven’s Progressive Matrices, CVLT-II, Doors and People, AMIPB, Figural Fluency Test, and R-BANS. Other assessment measures included the BDI, HADS and Illness Perception Questionnaire.

Other Opportunities and Experiences Gained: Regular attendance at multidisciplinary team (MDT) meetings and Psychology team meetings. I also conducted a satisfaction survey, and based on this, co-facilitated a focus group for service users to try and help improve the services they receive.
Summaries of my Clinical Case Reports
Adult Mental Health Case Report I
Summary

‘Cognitive-Behavioural Therapy with a 29 year old woman presenting with phobia and anxiety’

Year 1
April 2007
Referral and Presenting Problem
Katy was referred to the primary care service by her GP, who reported a number of problems including vomit phobia, anxiety and depression but requested “specifically to deal with her phobic state”. Katy reported that her main problem was her vomit phobia but suggested that this was also affecting her eating habits, as she was so frightened of being sick that she did not eat for 2-3 days.

Assessment
Information about Katy’s difficulties was collected during two hour-long semi-structured clinical interviews with her and from the referral letter. Her scores on the BDI (Beck, Ward & Mendelson, 1961) and BAI (Beck, Epstein, Brown & Steer, 1988) suggested that she was having significant difficulties with both anxiety and depression (both in ‘severe’ range). Although Katy had attempted suicide four years previously, a risk assessment concluded that there were no immediate risk issues.

Formulation
Katy’s difficulties were formulated within Clark’s (1986) cognitive model of panic, as Katy’s presenting problems seemed to ‘fit’ more appropriately into this panic model, rather than a phobia model. Katy’s triggers to anxiety about vomiting included thinking she is going to vomit; being near an individual who is vomiting; or believing she will catch a vomiting virus. These triggers cause Katy to experience physical symptoms, which include shaking, nausea, breathing difficulties and sweating, in addition to cognitive symptoms like racing thoughts (“I’ll lose my mind”) and difficulty concentrating. To avoid these physical and cognitive symptoms, Katy employs safety behaviours, and these include distracting herself, taking anti-sickness medication, burning food to ensure all of the germs are killed, not eating at unknown restaurants, not eating for 2 or 3 days at a time, and avoidance. These safety behaviours however were hypothesised to be maintaining Katy’s vomit phobia. It was also hypothesised that Katy’s vomit phobia was contributing towards her depression.
Intervention

Katy had seven intervention sessions that were conducted within a CBT framework and aimed at reducing her feelings of anxiety and depression. Well's (1997) CBT model of panic was employed to socialise Katy to the CBT model. Sessions focused on: eliciting negative automatic thoughts (NAT's); verbal reattribution; and behavioural reattribution.

Outcome

Katy attended seven of the 12 intervention sessions that were offered to her before not wishing to continue therapy. Katy's reason for ending therapy was that she was reportedly finding it easier to manage her anxiety. This was reflected in her BAI (Beck, Epstein, Brown & Steer, 1988) score at the end of treatment; Katy originally scored 35 (an indicator of severe anxiety) and after session seven she scored 22 (an indicator of moderate anxiety). Katy also reported a significant reduction in depression, which was reflected in her BDI (Beck, Ward & Mendelson, 1961) score; Katy originally scored 32 (an indicator of severe depression) and after session seven she scored 15 (an indicator of mild depression).
Adult Mental Health Case Report II
Summary

‘Cognitive-Behavioural Therapy with a 27 year old woman presenting with health anxiety’

Year 1
August 2007
Referral and Presenting Problem

Anna was referred to the primary care service by her GP who reported several problems including recurrent viral infections, reoccurrence of anxiety and depression, and that Anna interprets any physical symptoms as, “The worst diagnosis”. Anna reported being anxious about her health, in particular, she was concerned about having/getting cancer, and had been experiencing a reoccurring viral chest infection over the last few months. Anna reported finding it increasingly difficult to function or get enjoyment from activities due to her preoccupation with her health.

Assessment

Information about Anna’s difficulties was collected during two hour-long semi-structured clinical interviews with her and from the referral letter. The assessment was conducted in a cognitive-behavioural framework and therefore information was collected in relation to a) cognitions (e.g. selective attention, thinking errors), b) mood (e.g. anxiety), c) behaviours (e.g. reassurance seeking, body checking) and d) physical symptoms (e.g. bodily sensations) (Wells, 1997). Anna’s score on the Health Anxiety Questionnaire (HAQ, Lucock & Morley, 1996) indicated severe health anxiety difficulties. A risk assessment found that there were no immediate risk issues.

Formulation

Anna’s difficulties were formulated within Warwick & Salkovskis’ (2001) cognitive model of health anxiety. The main tenant of this cognitive model is that anxiety results from, and is maintained by, misinterpretation of normal bodily signs and symptoms as a sign of serious organic pathology. In Warwick & Salkovskis’ (2001) model, individuals are considered to develop health-anxiety when critical incidents activate dysfunctional assumptions concerning health. Anna’s critical incidents were hypothesised to be; recurrent chest infection; knowing two people that recently died of cancer; and exposure to illness related information. Once activated, her dysfunctional beliefs lead to misinterpretation of bodily signs as evidence of serious physical illness. For Anna, these interpretations occur as negative automatic thoughts (NAT’s), and
include thoughts like “the cancer is taking over my body”, or “I’ve got cancer”. Once NAT’s occur, a number of other related mechanisms are activated which are involved in the maintenance of health-anxiety. Warwick and Salkovskis (2001) distinguish four maintenance mechanisms; cognitive, affective, behavioural and physiological. Anna’s cognitive maintenance factors were ‘selective attention and self-focus’; ‘rumination’; and ‘thinking errors’. Her affective maintenance factors were anxiety and depression and her behavioural maintenance factors were ‘bodily checking’; ‘avoidance’; and ‘reassurance seeking’.

**Intervention**

Anna had six intervention sessions that were conducted within a CBT framework and aimed at reducing her feelings of health-related anxiety and depression. Sessions focused on; socialising Anna to the CBT model; eliciting and challenging NAT’s; ‘dropping’ bodily checking; and banning reassurance seeking and avoidance strategies.

**Outcome**

Anna attended six intervention sessions that were offered to her before not wishing to continue therapy. Anna’s reason for ending therapy was that she believed she could manage her health-anxiety on her own. Anna was believed to have made good progress during therapy for several reasons including; her motivation and personal responsibility to change; her commitment to homework assignments; her good understanding of the CBT model; her ability to focus on her goals; her intellect and psychological mindedness; and her ability to accept an alternative, psychological formulation of her problems.
Behavioural work with a staff team to manage the challenging behaviour of a 30-year-old man with Autistic Spectrum Disorder and a Learning Disability

Year 2
April 2008
Referral and Presenting Problem
Steven was referred to the psychology service by the manager of his residential home, following a recommendation from Steven’s care manager. The care manager was concerned about Steven being “highly anxious” and “displaying behaviours” when asked to slow down during tasks (e.g. when eating). Consequently, Steven’s care manager requested that the home manager make the referral, and he referred Steven for an assessment and intervention “to aid Steven with a management programme for the anxieties which he suffers from”. The ‘behaviours’ that Steven reportedly displayed include slapping/hitting himself and others, scratching himself and others, biting himself, and screaming.

Assessment
The assessment included an initial interview with a member of staff, followed by one naturalistic observation, two Momentary Time Sampling (MTS) observations, further interviews with other members of staff, a review of Steven’s personal residential file (including incident report forms), and a review of a recent Speech and Language Therapy report.

Formulation
Steven’s behaviours were formulated within McGill, Clare, & Murphey’s (1998) behavioural model. This model includes the personal and environmental contexts of the individual, and the personal and environmental contexts of the carers, and how they all interact to explain challenging behaviour. Steven’s personal context is that he has a Learning Disability and an ASD, and his environmental context is that he lives with other service users who also have an ASD and difficulties with communication, social interaction, imagination, and managing change. The personal context of Steven’s carers was that they can have difficulty identifying his needs, and the environmental context of his carers was that they need to help other clients and have other service demands (e.g. cleaning). The antecedents to Steven’s behaviour included being in social situations that he did not understand, and dealing with
unexpected change to his routine. Consequences of his behaviour included him being reassured by staff or having unclear social situations resolved.

Although not mentioned in the referral as a problem, during the observation it was noted that Steven was engaging in self-stimulatory behaviour. The antecedents to this behaviour were hypothesised to be Steven not having an activity to engage in, or him wanting a rest from the activity that he was doing. The consequences of his behaviour were hypothesised to be that he amuses himself and enjoys the stimulation that he receives.

**Intervention**

The aim of intervention was to reduce Steven’s aggressive behaviours where possible by compensating for the difficulties he has as a result of his ASD and LD. This was done by helping staff to change their approach toward Steven, by devising and introducing with them proactive and reactive behavioural management strategies.

**Outcome**

In a three month period prior to the assessment and intervention, incident forms showed that Steven had displayed aggressive challenging behaviour on ten different occasions, and had displayed self-injurious behaviour ten times. In the two and a half month period following the intervention, Steven had displayed aggressive challenging behaviour three times and self-injurious behaviour twice, indicating a significant reduction in challenging behaviours.
Child and Adolescent Mental Health
Oral Presentation of Clinical Activity
Summary

‘An Eclectic Intervention with a Eight-Year-Old Boy Presenting with Behavioural Difficulties’

Year 2
September 2008
Referral and Presenting Problem
Barry was an eight-year-old mixed race boy (his father is African-American and his mother is white British) who was referred to the Child and Adolescent Mental Health Service (CAMHS) by his GP. His mother was reportedly having difficulty managing his behaviour (aggressive outbursts) since Barry’s father moved back to America. There had been no contact between Barry’s father and the family since he returned to America. Barry reported that his main concerns were that he disliked having arguments with his mother, and disliked getting into fights at school. He also worried about his father’s whereabouts and well-being.

Assessment
The assessment included two clinical interviews with Barry and his mother. The ‘strengths and difficulties questionnaire’ (SDQ), was completed by Barry’s mother and his teaching assistant at school. The results indicated that Barry had significant difficulties in the domains of ‘emotional symptoms’, ‘conduct/behavioural difficulties’, ‘hyperactivity and attentional difficulties’, and ‘difficulties getting along with others’, as his classifications on these items were all ‘high’ or ‘very high’.

Formulation
Barry’s difficulties were formulated within a behavioural model (in terms of how his mother could ‘model’ appropriate behaviour, and provide positive reinforcement for appropriate behaviour). His difficulties were also formulated systemically, in terms of how his current family situation (in particular, the loss of his father) might be contributing to Barry’s aggressive outbursts.

Intervention
Barry and his mother attended four treatment sessions, which were conducted under the umbrella of a Systemic Family Therapy framework, where I was the therapist and I had the aid of a reflecting team. Due to Barry’s difficulty with emotional language, toys and drawings were used to enable Barry to engage in the therapeutic process. Behavioural ideas were also included in the
intervention, for example, Barry’s mother was given guidance about how to respond to Barry’s behaviour using the ‘The Incredible Years’ book (Webster-Stratton, 2000).

**Outcome**

Both Barry and his mother found it difficult to engage in the assessment and intervention processes, and did not want to attend more than four intervention sessions. On reflection, it seems that both Barry and his mother disengaged from therapy because they were not able to talk to each other about ‘difficult things’ (e.g. Barry’s father leaving them to return to America), as this was too emotionally painful for them. Instead, I suggested Barry’s mother had individual counselling herself, attended her local parenting support group, and read more chapters of ‘The Incredible Years’ book (Webster-Stratton, 2000), which she had reportedly found helpful during treatment.
Older Adult Case Report Summary

A neuropsychological assessment of a 68 year old woman referred with memory problems

Year 3
April 2009
**Referral and Presenting Problem**

Pat was referred for a neuropsychological assessment by her Consultant Psychiatrist. Pat had reported memory difficulties and following a score of 83 on the Addenbrooke's Cognitive Assessment (ACE), her Consultant Psychiatrist requested that Psychology answer the following question “Is there any evidence of cognitive impairment on neuropsychological testing?”

**Assessment**

The assessment included clinical interviews with Pat, her care-co-ordinator, her community psychiatric nurse, and her cognitive-behavioural therapist, in addition to a review of her psychiatry file. The following psychometric assessments were also conducted over six one-hour long sessions; WAIS III, WMS IV, WTAR, Hayling Sentence Completion Test, Delis Kaplan Executive Function System (DKEFS) Trail Making Test and the STROOP Test.

**Outcome**

Several hypotheses were made in relation to Pat's difficulties. Hypothesis one suggested that Pat would have a neuropsychological profile consistent with having had a frontal Leucotomy, that is, her intellectual functions would remain intact, but she would experience loss of initiative, apathy, concentration problems, loss of enthusiasm for life, and reduced creativity and artistic expression. This hypothesis was accepted based on the results of the assessment.

Hypothesis two suggested that Pat would have a neuropsychological profile consistent with having had numerous ECT treatments (i.e. memory difficulties). Hypothesis two could not be accepted or rejected due to the invalidity of the memory assessment results. However, Pat’s anxiety seemed to influence her memory abilities.

Hypothesis three suggested that Pat would have a neuropsychological profile consistent with having depression, anxiety and OCD, that is, she would
experience memory functioning and executive functioning difficulties. In addition, attention, processing speed, psychomotor speed and visual-spatial abilities were likely to be observed. The only part of hypothesis three that was not supported (aside from memory functioning) was Pat’s performance on the visual-spatial ability tests because she scored in the ‘Superior’ range.

The referral question was answered; yes, there was evidence of cognitive impairment, in particular in the cognitive domain of processing speed. There was also mild impairment in the cognitive domains of psychomotor speed, executive function (response inhibition) and attention. Unfortunately her memory abilities could not be formally assessed.

**Recommendations**

The following recommendations were made as a result of the assessment:

1) Due to processing speed difficulties Pat will need time to process any new information. Helping her with this difficulty will involve repeating new information/instructions to her on numerous occasions. To ensure that she has processed the information, it is recommended that you ask her to repeat the information in her own words.

2) Due to fine motor skill problems, Pat will need time to be able to do things with her hands.

3) Pat finds it difficult to stay focused on a task so will need regular encouragement and positive reinforcement to able to do so.

4) Pat could employ a number of strategies to help her with her perceived memory deficits. These include using a diary, having a structured outline for the day, visual reminders (e.g. post-it notes), and not doing more than one task at the same time. However, keeping her anxiety levels as low as possible is most likely to enhance her memory functioning.
5) If Pat experiences any further deterioration in her memory functioning, it is recommended that she has another memory assessment. The results of this will only be valid if her anxiety levels are normal during testing.

6) Repeat neuropsychological assessment using results of this assessment as a baseline measurement if Pat notices any changes in her cognitive functioning in the future.


Research Dossier

This section contains the research conducted during clinical training. This includes: research log checklist; service related research project; abstract of a group qualitative research project; and the major research project.
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Service Related Research Project

‘Investigation into Practitioners CBT Training, Clinical CBT Supervision, and ‘Level of CBT Practice’ within a Primary Care Mental Health Team’

Year 1
June 2007
Abstract

Background and purpose
Following recent guidelines, the purpose of this study was to investigate what CBT training and clinical CBT supervision practitioners have received, whether this is sufficient for their role in the team, and if not, what CBT training or supervision they would like. Furthermore, the study aimed to investigate what ‘level of CBT’ practitioners provide their clients in treatment.

Design, participants and procedure
Participants were selected on the basis that they incorporate CBT techniques or a CBT framework within their approach to patient care, and 15 practitioners from various professional backgrounds met this criterion. A structured interview was designed based on discussions with senior members of the PCMHT and previously employed audit tools. Participants were interviewed individually and data were analysed using descriptive statistics, except for one open-ended question which was analysed using thematic analysis.

Results
Results showed 87% of participants have received formal and/or informal CBT training, and 73% reported having had sufficient CBT training for their role in the team. Furthermore, 87% of participants reported that the clinical CBT supervision that they received was sufficient, and these results suggest that the PCMHT is following NICE guidelines, which suggest that CBT is delivered by suitably trained and supervised people. However, the study found that funding and opportunities to train in CBT can be problematic. Results also showed that the majority of practitioners are practicing CBT at levels one and two, and only the psychologists are practicing at the more complex levels of three and four.
Introduction

Policy guidelines

There are a number of guidelines for the treatment of Mental Health (MH) problems. For example, the National Institute for Health and Clinical Excellence (NICE) recommend the following disorders be managed and treated in primary and secondary care services: schizophrenia (NICE, 2002), anxiety (NICE, 2004a), depression (NICE, 2004b), eating disorders (NICE, 2004c), obsessive-compulsive disorder (OCD, NICE, 2005a) and post-traumatic stress disorder (PTSD, NICE, 2005b). NICE further recommends that cognitive-behavioural therapy (CBT) is the treatment choice for schizophrenia (NICE, 2002) and eating disorders (NICE, 2004). Layard (2006) describes the social and economic costs of people suffering from anxiety and depression and promotes CBT as the treatment choice for these disorders. The Sainsbury Centre for Mental Health (SCMH, 2001) suggests various MH practitioners should be capable of delivering various evidence based interventions, including CBT.

The service

The service evaluation was conducted within a PCMHT which provides primary and secondary care for adults with MH problems. The Department of Health (DOH, 2004) recommend that psychological therapies are an essential part of healthcare, and that therapists from all professional backgrounds can make a valuable contribution. In particular, as mental health nurses (MHN’s) are the largest profession working in MH, the DOH (2006) suggests they should provide more evidence-based psychological therapies. In line with these documents, psychological treatment within the service is offered by clinicians from various professional backgrounds.

Training and Supervision

Numerous NICE guidelines (e.g.2005a) suggest that CBT should only be delivered by suitably trained and supervised people who can demonstrate that they adhere to treatment protocols. If applied like this, the short-term success rate for CBT varies according to the disorder being treated. For example, the
success rate for depression is typically 50% (Wikipedia, 2007), and approximately 60% for eating disorders (Mental Help.Net, 2007). However, evidence also suggests that CBT works if provided by properly qualified people, and is less effective if given by less qualified people (Roy-Byrne, 2005).

MH professionals frequently express the wish to develop expertise in psychological therapies as part of their continuing professional development, and commonly report they lack the psychological skills they need (e.g. Thomas, 1993). Resultantly, several papers have highlighted the importance of staff training to ensure practitioners are delivering psychological services to the highest standard (e.g. DOH, 2004). Such papers further suggest that access to good supervision is a means of enhancing the quality of practitioners work (e.g. DOH, 2004).

**CBT within the Trust**
Shawe-Taylor (2006) suggests that it is unrealistic and unnecessary for all practitioners within the Trust to be accredited CBT therapists. She proposes that CBT can be provided by practitioners with different levels of CBT knowledge. According to Shawe-Taylor (2006), CBT provision within the Trust is currently conceptualised at 4 different levels (please see Appendix 1 for different ‘levels of CBT’).

**Current study and research questions**
Based on Shawe-Taylor’s (2006) ‘levels of CBT’, and the suggestions of SCMH (2001) and DOH (2006) discussed above, it is believed that the majority of practitioners are delivering CBT at levels 1 and 2, and that the practitioners that have spent more time training in CBT (i.e. psychologists), are practicing at levels 3 and 4. Furthermore, as NICE suggests CBT should only be delivered by suitably trained and supervised people, the current study also aimed to investigate the CBT training and clinical CBT supervision that practitioners receive. Thus, the specific aims of this study were to investigate whether:
1) Practitioners have received CBT training, and if so, what training they have had.

2) Practitioners think they have had sufficient CBT training for their role in the service, and what further training they would like.

3) Practitioners receive CBT clinical supervision, and whether they are satisfied with the amount of supervision they receive.

4) More practitioners are delivering CBT at levels 1 and 2, compared to levels 3 and 4, and whether the level of CBT that individuals are practicing at is related to the amount of CBT training that they have received.
**Method**

**Participants and Sampling**
Practitioners who do not incorporate CBT techniques or a CBT framework within their approach to patient care were excluded from the study. On this basis, 1 consultant psychiatrist, 4 social workers, and 1 support worker were excluded. Furthermore, 1 consultant clinical psychologist was excluded due to supervising the study and 1 MHN because they had recently returned from sick leave. In total, 15 team members including 1 staff grade psychiatrist, 1 SHO psychiatrist, 1 social worker, 5 psychologists, 4 MHN’s, 1 community psychiatric nurse, and 2 senior occupational therapists participated.

**Materials**
A structured interview was designed to collect data regarding the research questions (see Appendix 2). The interview schedule was designed on the basis of discussions with senior members of the team, and previous audit tools used within the Trust. The interview was the only means of data collection.

**Procedure**
Data was collected over a 1 week period in June 2007. At the beginning of the interview, participants were asked, “Do you incorporate CBT techniques or a CBT framework within your approach to patient care?” If they replied, “Yes”, they were included in the study, and if they replied, “No”, then they were excluded. Participants were interviewed by one researcher and the discussion lasted 10-15 minutes. Interviews took place in a room where only interviewer and interviewee were present.

The last question of the interview gave participants the opportunity to discuss things that they had not already discussed. This open-ended question gave participants the opportunity to discuss topics that the structured interview had not allowed for. At the end of the interview participants were informed that the results would be fed back to the team after the study had been completed.
Data analysis
Prior to data collection, the relationship between time individuals had spent training in CBT, and level of CBT that they were practicing at was to be analysed using non-parametric statistical testing. However, analyses proved invalid due to the number of participants in each cell (this will be discussed in more detail later). Thus, all data were analysed using descriptive statistics.

Thematic Analysis, as described by Braun & Clark (2006) was used to analyse the transcribed data (see appendix 3 for transcripts), as these authors suggest it provides a detailed account of data. Once data was transcribed, interesting features of the data were coded, and then collated into themes.

Categorisation of data
‘Levels of CBT’ were categorised into ‘levels 1 and 2’, and ‘levels 3 and 4’ rather than 4 separate levels as several participants classified their practice as, “Between levels 1 and 2”, or, “Between levels 3 and 4”.

CBT training was categorised into ‘formal CBT training’ and ‘informal CBT training’. ‘Formal CBT training’ refers to any training provided by an accredited university programme (e.g. diploma in CBT). 'Informal CBT training' refers to any training not provided by a university (e.g. CBT conference, or teaching provided by professionals within the Trust.)
Results

CBT training

Formal CBT training
Results showed 60% (N=9) of participants have completed formal CBT training, while 40% (N=6) have not received formal CBT training. Figure 1 shows the highest level of formal CBT training that participants have completed.

Figure 1 - Highest level of formal CBT training that participants have completed

Informal CBT training
Results showed 87% (N=13) have completed informal CBT training, while 13% (N=2) have not received informal CBT training. Of the 13 participants who have had informal CBT training, 10 have attended both CBT conferences and at least one CBT workshop/teaching slot/in-house training session within the Trust, and 3 have attended a conference only.
Sufficient CBT training, and further CBT training that practitioners would like to receive

Results showed 73% (N=11) have had sufficient training in CBT for their current role in the team, and 27% (N=4) reported the opposite. Although 73% (N=11) reported having sufficient CBT training, 73% (N=11) said that they would like to receive further CBT training. Of these 11, 5 reported wanting to complete formal CBT training, and Figure 2 shows the formal CBT training that these individuals would like to receive.

Figure 2 - formal CBT training that team members would like to receive

Of the 11 who reported that they would like to receive further informal CBT training, 8 said they would like to attend a CBT conference and attend a CBT workshop/teaching slot/in-house training session within the Trust, and 3 said that they would like to attend a CBT conference only. Figure 3 shows the informal CBT training topics that team members would like to receive in a CBT workshop/teaching slot/in-house training session (some participants mentioned more than one topic).
Figure 3 - Informal CBT training topics that team members would like to receive in a CBT workshop/teaching slot/in-house training session within the Trust.

Furthermore, 2 participants requested training on 'mentalisation', however, this is a psychoanalytical/psychodynamic treatment (Fonagy & Target, 1998) and thus not included in the above figure.

**CBT supervision**

Results indicated 67% (N=10) are receiving clinical CBT supervision for their clinical practice and 33% (N=5) are not. Of the 10 who receive CBT supervision, 8 receive monthly supervision, 1 receives it fortnightly and 1 weekly, and all indicated they receive sufficient CBT supervision for their clinical practice. Of the 5 who reported not receiving clinical CBT supervision, 2 would like to receive it, 1 would ask for it if they needed it, and 2 reported practicing sufficiently without it. It is important to note that the 2 who reported wanting to receive supervision were psychiatrists who said their professional group were not supportive regarding CBT supervision. Plus, the other 3 were all highly experienced, senior members of the team. In total, 87% (N=13) were satisfied with the clinical CBT supervision that they were receiving.
**Level of CBT practice**

The intention was to assess the relationship between the number of months spent training in CBT and the level of CBT that people were practicing at using non-parametric statistical tests. However, only one professional group was providing CBT at levels 3 and 4, thus, analyses proved invalid. Instead, descriptive statistics showed that 73% (N=11) delivered CBT at levels 1 and 2, while 27% (N=4) delivered CBT at levels 3 and 4. Only psychologists reported practicing at levels 3 and 4.

**Qualitative Analysis**

Thematic analysis revealed 2 main themes. Firstly, was ‘Expanding on topics already mentioned’, which emerged 6 times. From this came a sense that training is important to practitioners, and that they have benefited greatly from previous CBT workshops provided. Secondly, was ‘Opportunities to train can be problematic’, which emerged 3 times and suggests access to training is difficult. Participant 9 reported, “I would like more time to train in CBT”. Participant 7 said, “There is no time to train in CBT” and participant 14 reported “Funding and opportunities to train are an issue.”
Discussion

Following guidelines (e.g. NICE), the aims of this study was to investigate the CBT training, CBT clinical supervision, and CBT practicing level of practitioners within the service.

1) Investigate whether practitioners have received CBT training, and if so, what training they have had.

Results showed that 87% of team members have had informal CBT training. This is positive as firstly, it suggests the service is making CBT training available so that practitioners can provide CBT within primary and secondary care to treat a range of MH disorders, as NICE (e.g. NICE, 2002) suggests. Secondly, it suggests a high proportion of the team is keen to train in CBT in order to use it in their clinical practice. Thirdly, it shows that those who already have CBT skills are keen to extend their existing knowledge base to keep up with developments.

The study also found that 60% of team members have had formal CBT training within an accredited university programme of study. Considering the evidence that suggests CBT works if it is provided by properly qualified people (Roy-Byrne, 2005), and the NICE guideline which suggests CBT should only be delivered by suitably trained people, this reflects positively on the team. It shows that the service is following evidence-based practice and NICE treatment guidelines, in that more than half of the team has the knowledge to incorporate CBT formally within their clinical practice. However, these results highlight the possible need for formal CBT training for the remaining 40% of team.
2) Investigate whether practitioners think they have had sufficient CBT training for their role in the service, and what further training they would like, if any.

The study found 73% of participants have had sufficient training in CBT for their current role in the team. This result is surprising as previous research has shown that MH professionals commonly report they lack the psychological skills they need (Thomas, 1993). Such a result is encouraging as it suggests that the service has considered recent policies which have highlighted the importance of staff training (e.g. DOH, 2004), and consequently it appears that the service is making CBT training available to its team members.

Results showed 73% of team members would like more CBT training. These results are comparable to previous studies which have shown that MH professionals frequently express the wish to develop expertise in psychological therapies as part of their continuing professional development (Thomas, 1993).

Over 50% of participants showed interest in attending CBT workshop(s)/teaching slot(s)/in-house training sessions. Numerous topics for these were suggested with the two most popular being ‘case discussions/presentations involving all of the team’, and ‘basic CBT techniques/refresher courses’. From this it is recommended that CBT workshop(s)/teaching slot(s)/in-house training sessions are made available to team members in the future.

3) Investigate whether practitioners receive CBT clinical supervision, and whether they are satisfied with the amount of supervision they receive.

Results showed that 67% (N=10) were receiving clinical CBT supervision. Of the 33% (N=5) who did not receive clinical supervision, only 2 reported that they would like to receive it, and thus, 87% (N=13) were satisfied with the supervision they receive. These results are encouraging, as the service is providing the large majority with sufficient supervision, which is following
NICE guidelines that suggest CBT should be delivered by suitable trained and *supervised* people. However, in considering this NICE guideline, the study highlights the fact that 33% (N=5) of team members should be receiving CBT supervision if they are using CBT techniques or CBT framework as they suggested, regardless of whether they feel they need supervision or not.

4) *Investigate whether more practitioners are delivering CBT at levels 1 and 2, compared to levels 3 and 4, and whether the level of CBT that individuals are practicing at is related to the amount of CBT training that they have received.*

Results showed that more practitioners are practicing at levels 1 and 2 compared to levels 3 and 4 (73% and 27%, respectively). Although statistical analysis proved invalid, the results are interesting because it highlighted that only the psychologists are practicing at levels 3 and 4. It is assumed that this is due to the fact that psychologists train for at least 3 years at post-graduate level (which generally includes intensive CBT modules), whereas other professions may not train for this length of time, and indicates that psychologists are the profession most likely to be treating complex case presentations.

**Qualitative Analysis**

A theme that emerged was that some team members felt ‘Opportunities to train can be problematic’. The author acknowledges that allowing team member’s time off their clinical duties to train is not practical, given the pressure to keep waiting lists down. However, the DOH (2004) highlights the importance of staff training to ensure practitioners are able to deliver high standard psychological services, and thus provides strong evidence as to why individuals should be encouraged to pursue their training needs.
Summary of Recommendations to service

1) Due to popular demand, it is recommended that regular CBT workshop/teaching slot/in-house training sessions/case discussions occur within the service.

2) Continue providing clinical CBT supervision for those team members who are receiving it, and to contemplate how supervision could be provided for those professional groups who are currently not receiving it.

3) If training is not being accessed because of funding and opportunity problems, it is recommended that those who attend training share the knowledge that they gain through training by presenting the information to the rest of the team.

Limitations of study and further evaluation

There are a number of limitations of this study; firstly, as data was only collected from one PCMHT, the results are not generalisable to other PCMHT’s within the Trust. Secondly, the importance of results must be questioned due to data not being analysed with statistical analysis. Thirdly, it is only assumed that data collected from participants was truthful and not a product of demand characteristics. The validity of data could have been increased by an independent interviewer collecting data rather than a team member. Alternatively, data could have been collected by other means (e.g. from practitioner’s personal development log books). Fourthly, evidence suggests that CBT can help treat people with MH problems if provided by properly qualified people (Roy-Byrne, 2005), however, just because practitioners within the service have trained in CBT does not necessarily mean they are adhering to CBT treatment protocols, or are proficient practitioners. A study measuring model fidelity could be employed to assess whether practitioners are adhering closely to the empirically grounded CBT treatment protocols. Such a study is recommended as numerous studies have demonstrated improved outcomes in services that show high fidelity compared to those with lower scores (e.g. McHugo, Drake, and Teague, 1999).
Further studies could also focus on 'routine outcomes'. Lambert and colleagues have conducted a series of studies to investigate whether client feedback to therapists about progress leads to improvement in treatment outcomes (e.g. Lambert, Harman, Slade, Whipple and Hawkins, 2005). They showed that feedback resulted in improved outcomes for clients, reduced time in treatment and consequently, reduced costs of treatment. Thus, introducing 'routine outcomes' into the service would be a means of allowing more time and resources for practitioners to access CBT training, and is thus highly recommended.
References


Sainsbury Centre for Mental Health (2001). *The capable practitioner: A framework and list of the practitioner capabilities required to implement the national service framework for mental health.* SCMH: London.


Acknowledgements

I would like to thank Dr ________, my placement supervisor and Dr________, my research tutor, and all of the senior members of the service for their help in developing the service evaluation. I would also like to thank Dr ________ and Dr ________ for their continual encouragement and guidance during the process of conducting the study. Thanks are also extended to all the practitioners within the service who gave their time to participate in the interview.
Appendix contents page

Appendix 1 – Different ‘levels of CBT’ within the Trust.

Appendix 2 – CBT interview schedule

Appendix 3 – Transcripts from last question of interview

Appendix 4 – Ethical Scrutiny Form
Appendix 1 – Different ‘levels of CBT’ within the Trust

CBT within the trust is conceptualised at 4 different levels:

**LEVEL 1:** Use of single CBT techniques, for example, therapeutic work at this level may include behavioural strategies such as activation programmes or exposure programmes.

**LEVEL 2:** Use of a number of CBT techniques, for example, planning therapy goals, various behavioural techniques, and use of negative automatic thought records.

**LEVEL 3:** Specific CBT programmes for different disorders (clinicians practising at this level will have done post-qualification training in one or more specific CBT treatments) for example, time limited treatments for different anxiety disorders and depression, or specific CBT treatments such as DBT for BPD.

**LEVEL 4:** Formulating complex and co-morbid presentations and delivering individualised CBT treatment plans for such service users. Will have done post-qualification training and be eligible for accreditation by the British Association of Behavioural and Cognitive Psychotherapists (BABCP).
Appendix 2 - CBT Interview Schedule

The following questionnaire is designed to obtain information regarding CBT training you have received, CBT training you would like to receive, CBT supervision you receive, and your clinical practice.

Section 1) Personal information and CBT training:

i) Job title: ______________________________

ii) Have you done any training in CBT? (please tick the appropriate box):

YES ☐ ☐ NO

If no, please go to section 2).

If yes, please tick the appropriate boxes in the formal and informal CBT training sections below:

Formal CBT training

I have completed a CBT module within undergraduate study ☐

I have completed a CBT undergraduate programme of study ☐
(e.g. BSc Cognitive Behaviour Therapy)

I have completed a CBT module within postgraduate study ☐

I have completed a CBT postgraduate programme of study ☐
(e.g. Diploma/MSc in CBT)

Other (please specify) _______________________________

I have not had any formal CBT training ☐

Informal CBT training

I have attended a CBT conference(s) ☐

I have attended a CBT workshop(s)/teaching slot(s)/in-house training within the Trust ☐

I have attended a CBT workshop(s)/teaching slot(s)/in-house training external to the Trust ☐

Other (please specify) _______________________________

iii) Approximately how many years/months training have you had in CBT? ____________________________________________________________
Section 2) Treatment you are providing your clients:

i) Do you incorporate CBT techniques or a CBT framework within your approach to patient care?

(please tick the appropriate box): YES □ NO □

To enable you to answer the following question, please read the following information:

CBT level classification

CBT within the trust is conceptualised at 4 different levels:

LEVEL 1: Use of single CBT techniques, for example, therapeutic work at this level may include behavioural strategies such as activation programmes or exposure programmes.

LEVEL 2: Use of a number of CBT techniques, for example, planning therapy goals, various behavioural techniques, and use of negative automatic thought records.

LEVEL 3: Specific CBT programmes for different disorders (clinicians practising at this level will have done post-qualification training in one or more specific CBT treatments) for example, time limited treatments for different anxiety disorders and depression, or specific CBT treatments such as DBT for BPD.

LEVEL 4: Formulating complex and co-morbid presentations and delivering individualised CBT treatment plans for such service users. Will have done post-qualification training and be eligible for accreditation by the British Association of Behavioural and Cognitive Psychotherapists (BABCP).

ii) Based on the information provided above, over the last 5 working days, at what level would you say you have been practicing at with the majority of your clients? (Please circle the appropriate answer)

Level 1 Level 2 Level 3 Level 4

Section 3) Supervision

i) Do you receive CBT supervision? (please tick the appropriate box):

I have never had CBT supervision □
I have CBT supervision weekly □
I have CBT supervision fortnightly □
I have CBT supervision monthly □
Other (please specify) ____________________________
ii) If you do have CBT supervision, do you feel you receive sufficient CBT supervision for your clinical practice?

(please tick the appropriate box): YES □ NO □

Section 4) Your CBT Practice

i) Do you feel you have had sufficient training in CBT for your current role in the team?

(please tick the appropriate box): YES □ NO □

ii) Would you like to receive further CBT training?

(please tick the appropriate box): YES □ NO □

If yes, what further formal and informal CBT training would you like? (please tick the appropriate boxes below):

**Formal CBT training**

At college/university, I would like to complete a basic CBT module

At college/university, I would like to complete an advanced CBT module (e.g. CBT for a specific disorder)

I would like to complete a CBT undergraduate programme of study (e.g. BSc Cognitive Behaviour Therapy)

I would like to complete a CBT postgraduate programme of study (e.g. Diploma/MSc in CBT)

Other (please specify) ____________________________ □ □

**Informal CBT training**

I would like to attend a CBT conference(s)

I would like to attend a CBT workshop(s)/teaching slot(s)/in-house training within the PCMHT

Other (please specify) ____________________________
### Appendix 3 – Transcripts from last question of interview

<table>
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<tr>
<th>Participant number</th>
<th>Transcript</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>“Structured teaching and the use of materials is a good way to learn CBT”.</td>
<td>Expanding on topics already mentioned</td>
</tr>
<tr>
<td>2</td>
<td>No comments made</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>“Access to the praxis cd’s that I’ve used before for training would be good”.</td>
<td>Expanding on topics already mentioned</td>
</tr>
<tr>
<td>4</td>
<td>“In the CBT workshop you can learn techniques, go away and practice them, come back and discuss having tried it on a case and this really works”.</td>
<td>Expanding on topics already mentioned</td>
</tr>
<tr>
<td>5</td>
<td>“Case presentations would be really useful because they give you ideas of how to work on certain cases”</td>
<td>Expanding on topics already mentioned</td>
</tr>
<tr>
<td>6</td>
<td>No comments made</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>“There is no time to train in CBT”</td>
<td>Opportunities to train can be problematic</td>
</tr>
<tr>
<td>8</td>
<td>No comments made</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>“I would like more time to train in CBT”</td>
<td>Opportunities to train can be problematic</td>
</tr>
<tr>
<td>10</td>
<td>“I feel life-long learning is important and you need to train to keep up to date with developments”</td>
<td>Life-long learning important</td>
</tr>
<tr>
<td>11</td>
<td>“We used to have team case discussions once a month and I would like that again, that is, ”</td>
<td>Expanding on topics already mentioned</td>
</tr>
<tr>
<td></td>
<td>Discussing CBT together as team”</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>12</td>
<td>“I would like to sit in a watch a psychologist do it (CBT) properly but every time I ask they say I can’t”</td>
<td>Would like to see how CBT is done in practice</td>
</tr>
<tr>
<td>13</td>
<td>“I feel attending workshops should be a priority”</td>
<td>Expanding on topics already mentioned</td>
</tr>
<tr>
<td>14</td>
<td>“Funding and opportunities to train are an issue.”</td>
<td>Opportunities to train can be problematic</td>
</tr>
<tr>
<td>15</td>
<td>I’m all for CBT but I prefer the psychodynamic way of working and I feel CBT is being pushed on us (practitioners). How can you learn about CBT in 5 days? You need time to learn it and you can’t do it in 5 days it takes years. Plus, how can CBT be done in 6 sessions? I work in primary care and you can’t do an effective CBT package in 6 sessions there’s simply not enough time. 6 sessions is not long enough.</td>
<td>CBT being used in preference to other psychological ways of working. It takes time to learn how to practice CBT. 6 sessions of CBT not long enough to be effective</td>
</tr>
</tbody>
</table>
Appendix 4 – Ethical Scrutiny Form
The nature of the proposed project is such that I am satisfied that it will not require scrutiny by the trust’s ethical committee.

Name of Field/Placement Supervisor: [Signature]

Signature of Field/Placement Supervisor: [Signature]

Name of Trainee: [Signature]

Title of SRRP: Investigation into Practitioners’ CBT Training, Clinical CBT Supervision and ‘Level of CBT Practice’ within a Primary Care Mental Health Team (PCMHT)

Date: 04/07/07
Abstract of Qualitative Research Project

‘How do Clinical and Counselling Psychology Trainees Construct Racism Following the Events of Celebrity Big Brother 7?’

Year 1

May 2007
**Introduction:** The existence of racism was recently highlighted by media coverage of Celebrity Big Brother (series 7). Racism has long been of interest to researchers, and there is a wealth of research on how people construct racism. These studies highlight the importance of a sense of difference in the formation and maintenance of racism. Following the recent media coverage, the present study aimed to explore Clinical Psychology and Counselling Trainees interpretations of the issues that were raised.

**Method:** A self-selected sample of eight first year trainees based at a southern University took part in a focus group. Answers to a semi-structured interview were analysed using Interpretative Phenomenological Analysis (IPA).

**Results:** Six main themes from the IPA analysis were produced, which include expressions, causes and emotional reactions, British identity, fear of perception and confusion. All of these themes were salient in the construction of racism. Trainees were frustrated by the media’s narrow focus regarding the recent media events and by their failure to address the wider problem of racism in society.

**Discussion:** The results are considered in relation to previous similar studies. The use of IPA and a focus group is discussed, and the research evaluated.

**Conclusions:** The importance of exploring how trainees construct racism cannot be underestimated, as unintentional racism in a clinical setting could have negative effects for service users. More research is needed in order for health care trusts and practitioners to develop a competency in understanding and working with unintentional racism.
Major Research Project

Application of the Theory of Planned Behaviour to Understand Responses to Self-Injurious Challenging Behaviour in People with Learning Disabilities

Year 3

March 2010
Acknowledgments

First and foremost I would like to express my sincere appreciation to all of the participants that took part in my major research project. I am also extremely grateful to Andrew Barnes, the computer technician who made my questionnaire available online.

Thanks also go to my research supervisors, for their patience and advice throughout, and to Heather Liddiard for being so flexible and advising during my hours of need. Last but not least, I would like to thank my partner, family, friends and fellow trainees for their undivided support, for which I would not have managed without.
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1. ABSTRACT

Introduction: The main aim of the study was to apply the Theory of Planned Behaviour (TPB) to understand intended helping behaviour of healthcare students towards people with a learning disability (LD) who display self-injurious challenging behaviour (CB), as the model has never been applied in this context. It is important to understand healthcare students' attitudes and behaviour towards this vulnerable group, as they are likely to come into contact with them during their professions.

Method: 70 healthcare students at a University in the South of England read a vignette about a fictitious character with an LD engaging in self-injurious CB. Participants completed questions about the depicted character via an online questionnaire. Variables of interest included components of the TPB model (attitudes, subjective norm, and perceived behavioural control as predictors of intention to help), in addition to empathy, past behaviour, familiarity and anticipated regret. Data was analysed using correlational and multiple regression analyses.

Results: Mean score on the intention measure (5.70 on a scale of 1-7) showed healthcare students had positive intentions to help. The traditional TPB model explained 58% of the variation in intentions. Attitude and perceived behavioural control were the strongest predictors of intention. The additional variables explained little further variation in intention to help.

Discussion: The study adds to the relatively small literature base that has used the TPB to understand behaviours that benefit others. It also extends the literature on student healthcare attitudes towards people with an LD by exploring their attitudes towards helping this group. Clinical implications include healthcare educational courses promoting positive attitudes towards helping people with an LD, and providing students with opportunities to practise helping to increase their perceived behavioural control.

Conclusions: Future researchers could further explore the TPB in this area, or in relation to aggressive CB. Future research could also examine how attitudes towards the object (i.e. people with an LD) could be integrated with the TPB and attribution theory models, which presently do not explicitly incorporate them.
2. INTRODUCTION

2.1 Overview of Current Study

Several studies have researched the willingness of care staff to help people with an LD who display CB. Some researchers have focussed on aggressive CB (e.g. Dagnan et al., 1998; Wanless & Jahoda, 2002) others on self-injurious CB (e.g. Hastings et al., 2003; Jones & Hastings, 2003). Such studies have found that care staffs’ cognitions about CB, and their emotional responses to CB, influence their willingness to help the person displaying CB (e.g. Bailey et al., 2006; Dagnan & Cairns, 2005; Hastings et al., 2003; Wanless & Jahoda, 2002).

The most widely used psychological model to try and understand the relationship between care staffs’ cognitive, emotional and behavioural responses to aggressive and self-injurious CB, is attribution theory (Weiner 1980, 1986). However, a recent literature review found only partial support for predictions based on this model in relation to helping behaviour towards people who display CB (Willner & Smith, 2008). Due to finding inconsistent relationships between attributions and affective responses when applying this theory to understand helping behaviour towards people with an LD who display self-injurious CB, Jones & Hastings (2003) made a suggestion. This study explores their suggestion that the TPB (Ajzen 1985, 1988, 1991) might be a more useful cognitive model to try and understand the relationship between individuals’ cognitive, emotional and behavioural responses to self-injurious CB.

People with an LD who display CB might require help to protect themselves and others from the negative consequences of CB. The challenge that is presented to people without a disability when they encounter CB is not only how to help but whether to help. As many people with an LD now live in the community, it is important to explore helping behaviour towards this group within the community.
It appears that the majority of research on care staffs’ willingness to help people with an LD who display CB has been conducted in relation to aggressive rather than self-injurious CB (Willner & Smith, 2008). Generally speaking, within the literature there seems to be more research on aggressive rather than self-injurious CB in contexts other than care. One reason for researching self-injurious CB within this study is therefore to increase the comparatively small evidence base relative to aggressive CB.

Research on healthcare professionals’ attitudes towards people with physical and/or intellectual difficulties has shown that professionals can have negative attitudes towards this population (e.g. Gething, 1992; Paris, 1993), which can reportedly affect the treatment they receive in healthcare services (Carter & Markham, 2001). There is also increasing interest in healthcare student attitudes towards people with an LD. Such studies have shown that they too can hold negative attitudes (e.g. Tervo et al., 2004; Tracy & Iacono, 2008). As far as is known, there is no published research that has explored healthcare students’ attitudes and feelings towards helping people with an LD who display self-injurious CB.

The main aim of the current study is therefore to use the TPB (Ajzen, 1991) to try and understand healthcare students’ intended helping behaviour towards people with an LD who display self-injurious CB. The TPB has been used to predict various different behaviours. The model is described in detail later but succinctly described, predictors of helping behaviour proposed by the model include, attitude towards helping, perceived ability to help, and perceived pressure from significant others to help. Additional predictor variables will also be explored.
2.2 Learning Disability

2.2.1 Definition and Prevalence

The British Psychological Society (BPS, 2000), in defining the term ‘Learning Disability (LD)’\(^1\), report, “there are three core criteria for learning disability: Significant impairment of intellectual functioning; significant impairment of adaptive/social functioning; age of onset before adulthood. All three criteria must be met for a person to be considered to have a learning disability” (BPS, 2000, p. 4). The White Paper ‘Valuing People: A New Strategy for Learning Disability for the 21st Century’, reports that there are 1.2 million people in England who have an LD (Department of Health, DoH, 2001).

2.2.2 Challenging Behaviour

Individuals with an LD can engage in behaviours labelled by theorists and clinicians as ‘Challenging Behaviour’ (CB)\(^2\). Emerson (1995) defined CB as “Culturally abnormal behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit the use of, or result in the person being denied access to ordinary community facilities” (Emerson, 1995, pp. 4-5). This behaviour includes self-injurious and aggressive CB, and is only termed CB in the context of LD. Emerson (1995) estimated that 10% of people with an LD engage in ‘severe’ CB (high frequency and intensity) while McClean (1995) estimates this figure to be 15%.

2.2.3 Negative Consequences of CB

Several studies document the negative consequences of CB for people with an LD (e.g. DoH, 2007; Devereux et al., 2009; Durrand & Merges, 2009; Emerson et al., 1994). For example, Emerson et al. (1994) reported that people with an LD who display CB are at increased risk from abuse (physical, sexual,

\(^1\) Throughout this study, the term ‘people with an LD’ should be interpreted as people ‘diagnosed with an LD’.

\(^2\) Throughout this study, the term ‘self-injurious’ CB should be interpreted as people who have a diagnosis of an LD, who engage in self-injurious CB (which is explained in more detail later). It does not relate to non-disabled people who engage in self-injurious CB (i.e. those with mental health difficulties), which is often termed ‘self-harm’, and it does not relate to people with dual diagnosis, that is, people diagnosed with an LD and mental health difficulties, who may display both self-injurious and self-harm behaviours.
financial), deprivation and neglect. Regarding self-injurious CB, the most obvious consequences for the person are the self-inflicted injuries.

2.3 Helping Behaviour Models
There are several social psychological models of helping behaviour but discussing them in detail is beyond the scope of this study. The following therefore provides a summary of these models, especially those most relevant in this context. When the word ‘helper’ is used, this applies to an individual helping someone else, and the word ‘helpee’ applies to an individual being helped.

Within the literature, ‘helping behaviour’ models can be defined as either ‘egoistical’ or ‘altruistic’. Examples of ‘egoistical’ helping behaviour models include Trivers’ (1971) ‘reciprocal-altruism model’; and Foa & Foa’s (1975) ‘social exchange theory’. These models posit that the helper displays helping behaviour as they perceive they will gain reward for helping later (e.g. praise, financial reward). Examples of ‘altruistic’ models include Batson’s (1991) ‘empathy-altruism model’, which posits that if a helper feels empathy towards the helpee, this increases helping behaviour towards the helpee, even if helping is demanding or self-sacrificing. Another ‘altruistic’ model is Weiner’s (1980) ‘attribution-emotion-behaviour model’, which posits that if the need of another person is perceived as uncontrollable, then help is offered, however, if the need of another person is perceived as controllable, then help is withheld. Weiner (1980) reports however that the relationship between perceived controllability and helping behaviour is mediated by the affective responses sympathy and anger; the less controllable the need is perceived to be, the more empathy and less anger will be experienced, and the more likely the person will help, and vice versa.

Brammer & MacDonald (2003) argue that ‘helping behaviour’ cannot be understood at an individual, theoretical level, rather, factors like intergroup relations must also be considered. Indeed, recent research about empathy-altruism models have shown that empathy moves people to behave
altruistically, but not as much if the person is an out-group member (Sturmer et al., 2006; Sturmer & Snyder, 2010). Saucier et al. (2005) argue that as the costs of helping an out-group member increase, helping behaviour towards the helpee reduces.

The most frequently used model applied to understand helping intentions/behaviour of care staff towards people with an LD who display CB is Weiner’s (1986) ‘attribution theory’.

2.4 Attribution Theory
Weiner (1979) proposed that when individuals view an event, their causal attributions are categorised along three different dimensions: ‘locus’ (whether the cause is internal or external to the individual), ‘stability’ (the behaviour occurs consistently or not), and ‘controllability’ (the behaviour is perceived to be under the individuals’ control or not). Weiner (1980) reported that causal attributions with their associated emotional reactions can help to predict behavioural responses. To give an example in this context, an individual who attributes the responsibility for CB as internal, stable within and controllable will experience a negative emotional response (e.g. anger) and will therefore be less likely to help.

Weiner’s (1986) attribution theory has not been used to investigate attitudes towards people with an LD explicitly; rather, it has been applied to try and understand helping behaviour of care staff in response to CB. Willner & Smith’s (2008) recent literature review reported three reasons why the application of attribution theory to CB differs from the application of the theory in other contexts, like education, where predictions of the theory are solidly supported (Weiner, 1986; Schmidt & Weiner, 1988). First, is ecological validity, as the majority used case vignettes. Second, ‘helping behaviour’ is reportedly not well defined. Third, “attribution theory was intended to apply to low-frequency behaviours, and may be less applicable to regular, frequent behaviours because care staff habituate to them” (Willner & Smith, 2008, p. 153).
2.5 TPB

Ajzen's (1991) TPB model developed from the Theory of Reasoned Action (TRA, Fishbein & Ajzen, 1975; 1980), which was created following previous research trying to understand attitude-behaviour relationships. Before the TRA and TPB models are described, the attitude-behaviour relationship will be discussed more generally, as it is fundamental to both models.

2.5.1 Attitude-Behaviour Relationship

Since Thurstone (1928) wrote "attitudes can be measured", there has been debate about the 'attitude' construct, especially how 'attitude' is conceptualised, measured, and whether attitudes predict behaviour(s). Early researchers defined an 'attitude' as a learned response to an 'object' (objects, people or events) in a consistently favourable or unfavourable manner (Campbell, 1963; Krech et al., 1958). This definition implies a strong predictive relationship between attitude and behaviour. Wicker (1969) however reviewed the literature examining the attitude-behaviour relationship and concluded "it is considerably more likely that attitudes will be unrelated or only slightly related to overt behaviours than that attitudes will be closely related to actions" (Wicker, 1969, p. 69). Despite this evidence, researchers continued to research attitude-behaviour relationships. Of particular interest from the late 1960s was how individuals' cognitions and feelings towards an object influence their behaviour towards the object (e.g. Ostrom, 1969). Fishbein & Ajzen (1975) proposed a different 'conceptual framework' to try and gain a better understanding of the attitude-behaviour relationship. According to these authors, attitude towards an object is determined by beliefs about the object, and attitude toward an object influences both intentions and behaviour with respect to the object.

The assumption that attitudes can be measured quantitatively, at least not by short isolated answers to questionnaires has been questioned. A criticism of the 'attitude' concept is that the function of language and the contexts in which language is used is ignored (Potter & Wetherall, 1987). Others argue that the 'attitude' concept ignores the relationship between the individual and their
social world (Fraser, 1994). To truly understand an individuals’ attitudes, it has been argued that new conceptual tools that consider these issues are required, like discourse analysis (e.g. Potter & Wetherall, 1987), and social representations theory (e.g. Howarth, 2006).

2.5.2 Discourse Analytic Perspective
Discourse analysts look at the ways that texts and language are organised. According to Potter & Wetherall (1987), people use language to construct versions of their social world; they say things to make others view them positively, and describe people according to whether they like them or not. Potter & Wetherall (1987) argue that in relation to participants’ isolated responses to attitude measures/questionnaires, responses are varied according to context, therefore, there cannot be an underlying attitude that is measurable. Potter & Wetherall (1987) argue that the same words presented to participants will not result in participants having the same object of thought, and the same participants might formulate the object of thought differently on different occasions. They also argue that even multi-dimensional attitudes, which more complex scales assess, cannot account for variability depending on context. Instead, Potter & Wetherall (1987) argue that more powerful explanations of individuals’ attitudes can be given if the organisation of discourse is examined in relation to function and context, as people modify their behaviour and language, depending on the situation they are in.

2.5.3 Social Representations Perspective
Social representations theory is about shared beliefs and values amongst group members. For social representation theorists, understanding behaviour is about focusing on what is happening around the individual (e.g. their culture, social history); and how individuals orientate themselves in their social world, in order to be able to communicate with other group members (Moscovici, 1973). For social representations theorists, ‘attitude’ is created through social discourse and negotiation rather than it being a fixed, defined and measurable thing.
In critiquing the attitude concept, Howarth (2006) argues that most 'attitude' research has focussed on individual attitudes rather than on shared social attitudes, or how these developed. Howarth's (2006) main criticism is that society influences the individual and vice versa, and without considering societal factors, societal attitudes cannot be fully understood. Howarth (2006) highlights the importance of researching how attitudes are shared and developed within society, and what the relationship is between attitudes and identities. She argues that this can be best approached using social representations theory.

Discourse analytic and social representations approaches provide a holistic approach to understanding individuals' attitudes, due to considering societal factors. However, Howarth (2006) herself reported that the 'attitude' concept has something to offer within the world of social psychology. Therefore, it is better to view the various approaches described above that research 'attitudes' as complementary of each other, rather than being in competition with one another. A main strength of the quantitative approach is that quantitative measures can be helpful in elucidating generalisable patterns.

2.5.4 Attitudes Towards People with an LD
While this study focuses on attitudes to helping those with an LD exhibiting CB, it seems likely that such attitudes would be formed in the context of the individuals' attitudes towards those with an LD.

2.5.4.1 General Population Attitudes Towards People with an LD
Bates & Davis (2004) report that despite a volume of government papers that promote social inclusion for people with an LD (e.g. Valuing People, 2001), "current service arrangements often segregate learning disabled people, particularly those with the least natural ability to articulate their interests" (Bates & Davis, 2004, p. 198). Several studies have shown that physical integration does not guarantee social inclusion (e.g. Cummins & Lau, 2003; Fichten et al., 2005), and over the years, the general populations' attitudes towards people with an LD has generally been found to be negative (e.g. DoH,
2005; Dubrow, 1965; Fries, 1997; Gething, 1992). Negative attitudes can reportedly result in people with an LD experiencing prejudice (Morris, 1991) and feeling like they are excluded from society (e.g. Stiker, 1997). Recent research has shown that negative attitudes can result in people with an LD having few opportunities to be independent, having poor health, and having little money (DoH, 2005).

‘Social distance’ studies have become a popular way of measuring individuals’ attitudes towards people with an LD. ‘Social distance’ has been defined as a “willingness to recognise, live near, or be associated with” (Harth, 1971, p. 143) particular groups or individuals. Social distance studies are used to measure the extent to which members of the public wish to distance themselves from people with an LD. Those who express less social distance towards people with an LD are assumed to hold less negative attitudes towards them compared to those who express more social distance, and thus more negative attitudes. Such studies have found that females are likely to display attitudes that reflect less social distance compared to males (e.g. Krajewski & Flaherty, 2000); and that younger people show less social distance compared to older people (e.g. Ouellette-Kuntz et al., 2010; Yazbeck et al., 2004). Studies have also shown that people who have knowledge about people with an LD, and those with a close family member who has an LD also express less social distance (Yazbeck et al., 2004; Ouellette-Kuntz et al., 2010, respectively). Consequently, researchers have suggested that contact with people with an LD can improve attitudes towards them (e.g. Yazbeck et al., 2004).

2.5.4.2 Healthcare Professional Attitudes Toward People with an LD
Studies have shown that healthcare professionals can have negative attitudes towards people with physical and intellectual disabilities (e.g. Gething, 1992; Paris, 1993). Studies have also shown that professional attitudes and behaviours towards people with an LD can be a barrier to people with an LD using health services (Carter & Markham, 2001). People with an LD have reported that they were not satisfied with the service they received from
healthcare services, and reported negative experiences (Mencap, 2004, 2007). A recent literature review of people with an LD’s experience of secondary care by Backer et al. (2009) highlighted important factors for people with an LD: Healthcare professional attitudes; communication style of the healthcare worker; and the healthcare environment. Backer et al. (2009) recommended that the attitudes, knowledge and confidence of healthcare workers needed to be improved. While & Clark (2010) found that male professionals were more likely to have negative attitudes towards people with an LD compared to females, and that healthcare professionals’ attitudes towards this client group needed to be improved.

2.5.4.3 Healthcare Student Attitudes Towards People with an LD

There is increasing interest in healthcare student attitudes towards people with an LD (Tervo et al., 2004; Tracy & Iacono, 2008). Tervo et al. (2004) studied 338 graduate and post-graduate healthcare students on the ‘Leadership in neuro-developmental disabilities’ course, and found that a significant number held negative attitudes. They also found significant differences among nursing, medical and other healthcare professional students, with nursing students holding the least positive attitudes. They reported that students who had frequent contact with people with an LD held more positive attitudes, and students who had worked previously with people with an LD reported more confidence in handling challenging situations. Tervo et al. (2004) suggested that to prevent healthcare professionals from developing negative attitudes, their attitudes towards people with an LD needed to be recognised and addressed, and positive attitudes promoted within educational programmes. Tracy & Iacono (2008) suggested that healthcare students’ teaching should focus on encouraging ‘positive personal experiences’, for example, by employing people with an LD to help teach lectures.

This section has discussed individuals’ attitudes towards people with an LD. It is worth noting that the TRA, TPB and attribution theory models do not explicitly include attitude towards the object (in this case people with an LD). The TRA and TPB focus more specifically on attitudes to the behaviour (in
this case helping behaviour). Although it is likely that attitudes towards people with an LD will influence helping behaviour, this cannot be explicitly incorporated using either the TRA, TPB or attribution theory models. In attribution theory, the focus is on hypothesising about behaviour rather than the actor even though such hypothesising implicitly entails judgments about the actor.

Fishbein & Ajzen (1975) acknowledge that attitudes alone cannot predict behaviour. Fishbein & Ajzen (1980) therefore proposed the TRA model to better understand attitude-behaviour relationships, which was revised by Ajzen (1991). Both these models are described below.

2.5.5 Description of TRA and TPB

Fishbein & Ajzen (1975, 1980), suggest the TRA has four general constructs; ‘behavioural intention’, ‘attitude’, ‘subjective norm’ and ‘actual behaviour’. Succinctly described, an individual’s intended behaviour is predicted by the individual’s attitude toward the behaviour, and how the individual perceives others would think about them if they performed the behaviour. Intended behaviour is the antecedent of actual behaviour. The TRA can be seen in Figure 1 below.

```
Attitude
         ↠ Behavioural Intention
            ↗ Subjective Norm
                           ↟ Actual Behaviour
```

*Figure 1 - Fishbein & Ajzen’s (1975, 1980) TRA Model*
According to Ajzen’s (1991) extended model, intention to behave is influenced by three factors rather than the two identified in the TRA (attitude and subjective norm), the additional factor being ‘perceived behavioural control’. Ajzen (1991) suggests these three factors are influenced by an individuals’ beliefs; 1) ‘behavioural beliefs’ are about a particular behaviour and its consequences. These beliefs produce a positive or negative attitude toward the behaviour, depending on the individuals’ subjective evaluation of the behaviour. 2) ‘Normative beliefs’ are influenced by the judgements of significant others (e.g. family, friends). The perceived pressure to behave in certain ways is based on significant other’s beliefs, which results in subjective norm. 3) ‘Control beliefs’ are factors that may help or hinder the behaviour from occurring, and how much control the individual perceives he/she has over these factors. These beliefs produce perceived behavioural control, which is the individual’s perception about how difficult or easy the behaviour would be to perform.

In combination, these three factors lead to ‘behavioural intention’. Ajzen (1991) suggests that in general, if attitude and subjective norm are positive, and if the individual perceives that they have control over performing the behaviour, the intention to perform the behaviour increases. Behavioural intention is reportedly the antecedent of actual behaviour. Ajzen’s (1991) TPB model including behavioural, normative and control beliefs can be seen in Figure 2 below.
Researchers are interested in various components of the model. For example; some researchers focus on the ‘traditional’ TPB model, which is how the three factors predict ‘behavioural intention’ and/or ‘actual behaviour’ (e.g. Eves et al., 2003); some researchers are interested in how additional components (like past behaviour) improve the predictive power of the traditional model (e.g. Smith & McSweeney, 2007) and others research the direct relative contributions of behavioural, normative and control beliefs on actual behaviour (e.g. Rhodes et al., 2007).

Studies have found discrepancies between ‘behavioural intention’ and ‘actual behaviour’, in that intentions to behave do not reportedly lead to actual behaviour. This is referred to as the ‘intention – behaviour gap’, and a recent meta-analysis reported that the TPB model accounts for 39% and 27% of the variance in intention and behaviour, respectively (Armitage & Conner, 2001).

The TPB is a cognitive model and overlooks emotional variables like anger and empathy. This has been a major criticism of this model. Most individuals’ health behaviours are influenced by their personal emotion and as the model does not include an emotional component, it has been argued to be a crucial disadvantage for predicting health-related behaviours (Dutta-Bergman, 2005).
Fishbein & Ajzen (2005) recently stressed the importance of measuring both ‘cognitive attitudes’ and ‘affective attitudes’ when conducting TPB research. The significance of this was highlighted in a recent study on what motivates people to donate blood by Lemmens et al. (2009). These authors used six semantic items to measure ‘cognitive attitude’ (‘egoistic-socially minded’, ‘rewarding-not rewarding’, ‘good-bad’, ‘risky-safe’, ‘worthwhile-not worthwhile’, ‘wise-foolish’), and four bipolar statements to measure ‘affective attitude’ (‘pleasant-unpleasant’, ‘annoying-enjoyable’, ‘frightening-not frightening’, ‘reassuring-not reassuring’). Lemmens et al. (2009) found that ‘affective attitude’ was more strongly associated with intention than ‘cognitive attitude’ (.53 and .36, respectively), which they argue provides evidence for using affective and cognitive attitude measures.

2.5.6 Predictive Power of TPB
A search of psychology databases (including Psych-Info, Psych-Books, Psych-Articles, Psychology and Behavioural Sciences Collection, Medline, British Nursing Index, and International Bibliography of Social Sciences) conducted in March 2010 showed that the TPB was documented in 2762 research papers.

It is worth noting that health-related studies of behaviour using the TPB model can be divided into two; there are studies that research ‘benefits for the self’, (e.g. exercise, bicycle crash helmet use), and there are studies that research ‘benefits for others’ (e.g. donating blood/corneas). The vast majority of published research is on behaviours that benefit the self. An interesting aspect of this study is that it investigates behaviour that does not directly benefit the individual.
2.5.7 LD and TPB
The TPB model has been used to conduct research in relation to people with an LD, for example, the intentions of people with an LD to be physically active (Kodish et al., 2006). However, there is no known published research that has used the TPB to help understand helping behaviour exhibited towards people with an LD who display CB.

2.6 Variables that Improve the Predictive Power of the TPB
In order to improve the predictability of the TPB model, researchers have explored other variables in addition to the traditional model. As some of these were considered potentially relevant to the present study, they are described below.

2.6.1 Affect
As emotions have been shown to improve the predictive power of the TPB model, the current study explored this notion. Recently, considerable attention has been paid to ‘anticipated regret’ as a means of assessing affect in TPB research. Regret is used as a predictor of behaviour because regret affects us behaviourally because it is an emotion that we wish to avoid, if we anticipate that certain behaviour will make us feel regretful, we are unlikely to engage in the behaviour.

As a variable indicating affect, anticipated regret has been used in addition to the TPB components to better predict a variety of behaviours. Studies have measured regret about actions taken, regret about actions not taken, or both, and such studies have found that in some cases anticipated regret improves the predictive power of the TPB model. For example, Conner et al. (1999) measured anticipated regret about *actions not taken* and found that anticipated regret towards not wearing a condom increased the predictive power of the traditional TPB model. Conner & Abraham (2001) measured anticipated regret about *actions not taken* and found that anticipated regret towards ‘not looking after your health’ predicted intentions. However, Conner et al. (2007)
measured anticipated regret about *action taken* but this did not predict speeding behaviour.

Morison *et al.*'s (2009) study on parents’ intention to accept the human papillomavirus vaccination (HPV) for their daughters, measured anticipated regret about *actions taken* and *actions not taken*. Morison *et al.* (2009), like the studies cited before found that anticipated regret about actions not taken significantly predicted intention, whereas anticipated regret about actions taken did not. Sandberg & Conner (2009) recently used the TPB to predict cervical screening attendance and found that anticipated regret about actions taken and about actions not taken (and past regret) increased cervical screening attendance by 21%. Sandberg & Conner (2009) suggest that by merely including an anticipated regret variable, participants consciously think about possible outcomes, which influence intentions/behaviour. In their opinion, it does not matter whether the anticipated regret is about past regret, actions taken or not taken; rather, the importance is getting participants to consciously think about regret (Sandberg & Conner, 2009).

### 2.6.2 Past Behaviour

Conner *et al.* (2007) reported that past behaviour was an antecedent to both the ‘attitude’ and ‘perceived behavioural control’ components of the TPB model. A study investigating factors that influence helmet use among adolescent cyclists in Australia found that past behaviour significantly predicted helmet use alongside the traditional TPB model (O’Callaghan & Nausbaum, 2006). As previous studies have used ‘past behaviour’ to improve the predictive power of the TPB, the current study will explore this notion.

### 2.6.3 Familiarity

Research has suggested that contact with people with an LD can improve attitudes towards them (e.g. Hastings & Graham, 1995; Tervo *et al.*, 2004; Yazbeck *et al.*, 2004). If however people with an LD are not included in society, as discussed above, then people are unlikely to come into contact with them, and thus they may hold negative attitudes towards them. Therefore,
familiarity may be associated with attitudes towards people with an LD and intentions to help them.

According to Tajfel (1978), 'social identity theory' is about separate, yet interrelated social psychological theories (e.g. self-categorisation theory, social comparison theory, in-group/out-groups, stereotypes/prejudice) about why individuals behave as part of a social group, and share attitudes of that group. Tajfel & Turner (1986) report that individuals who categorise themselves as belonging to a group, will subsequently show favouritism towards that group, rather than 'out-groups'. Individuals will also positively compare their in-group to out-groups to achieve positive self-esteem. Oakes et al. (1991) however report that such comparisons maybe based on stereotypes (i.e. negative attitudes), and that stereotypes are more likely to be used when the individual is from a minority group (i.e. those with an LD). Individuals/groups are also more likely to judge and use stereotypes when the group is unfamiliar to them (Brodt & Ross, 1998). From this, there maybe a link between familiarity with people with an LD and likelihood to help, so familiarity was explored in this study.

2.6.4 Empathy

Empathy is defined as “an emotional response that stems from another's emotional state or situation” (Eisenberg & Strayer, 1987, p. 5). There is relatively little research about empathy improving the predictive power of the traditional TPB model. Nevertheless, Bae (2008) investigated the role of empathy and sympathy when predicting registering as a cornea donor and found that both these variables were antecedents to ‘issue involvement’; “the extent to which an individual believes an issue is of intrinsic importance or has significant consequences for his/her own life” (Bae, 2008, p. 21). Issue involvement predicted ‘attitude’, ‘subjective norm’, and ‘perceived behaviour control’, which in turn predicted intention. Bae (2008) therefore argues that empathy and sympathy improve the predictive power of the TPB model. Another study found that patients’ perceived empathy from their physician significantly predicted patients’ intentions to adhere to medical advice.
(Thomas et al., 2005). Therefore, although there is little published literature suggesting that empathy can better predict intention/behaviour; there is some evidence so it was explored in the study.

2.6.5 Demographic Differences
Feminist writers like Morris (1991) have emphasised the role of gender when considering individuals’ perception of and reaction to disability within society. Such studies have found that females are likely to display attitudes that reflect less social distance (e.g. Krajewski & Flaherty, 2000).

Fisbein & Ajzen (1980) suggest that there are age and gender differences in the contribution of the TPB variables on intended and actual behaviour. Recent studies also show age and gender differences in the relative contribution of the TPB constructs on explaining ‘behavioural intention’ when trying to understand various behaviours (e.g. Conner et al., 2008; Dennison & Shepherd, 1995; Holland & Hill, 2007). This suggests that demographic differences may moderate TPB relationships. For this study, the sample is likely to contain mainly female participants of a similar age, so it is unlikely that the influence of age and gender can be properly examined.

2.7 Research Rationale
The majority of research on trying to understand helping behaviour by professional carers toward people with an LD who display CB has focused on using attribution theory, but this model has relatively little predictive power (Willner & Smith, 2008). Furthermore, the majority of this research has focused on aggressive CB (e.g. Wanless & Jahoda, 2002) rather than self-injurious CB (e.g. Jones & Hastings, 2003). The current study therefore aims to increase the relatively small evidence base for self-injurious CB.

According to the DoH’s (1999) “Once a Day” publication, and Mencap’s (2004) “Treat Me Right” publication, compared to the general population, people with an LD experience more complex health difficulties and poorer health: Mencap (2004) reported that people with an LD are at higher risk of
respiratory disease and coronary heart disease, and that there is high risk of
dying from these problems. Despite their health needs, several studies
document barriers for people with an LD when accessing healthcare services.
For example, Alborz et al.’s (2005) literature review found that
communication problems; inadequate facilities; and healthcare professionals’
lack of skills when working with this client group, were all barriers for people
with an LD when trying to access services. Furthermore, the DoH (1999) and
Backer et al. (2009) found that negative attitudes towards people with an LD
can affect the treatment that people with an LD receive from healthcare
professionals. Although there is research on healthcare students’ attitudes
towards people with an LD, there is no known research on healthcare students’
attitudes towards helping people with an LD who display CB. It is important
to research this group because when healthcare students qualify, during their
career they may come into contact with people with an LD who display CB,
and thus, are likely to be offering them some type of help.

There is no known published research investigating whether the TPB model
can be used to understand helping behaviour (by family members, carers,
members of the public, healthcare professionals or healthcare students)
towards people with an LD who display CB. It is unlikely that attitudes
towards the object (i.e. people with an LD) alone would sufficiently explain
intended helping behaviour. Therefore, the current study assesses determinants
of helping via attitude towards helping, in addition to the other traditional
components of the TPB model. Considering the discussions above on
anticipated regret, familiarity, past behaviour and empathy, the current study
will also investigate whether these variables improve the traditional model’s
predictive power.

The main aim of the current study is therefore to investigate the application of
Ajzen’s (1991) TPB in relation to understanding the intended helping
behaviour of healthcare students towards people with an LD who display self-
injurious CB. This will be achieved by using a vignette depicting a person
with an LD engaging in self-injurious CB, and an online questionnaire asking
questions about the vignette. Due to the unethical nature of observing actual responses to self-injurious CB, ‘behavioural intention’ will be measured rather than ‘actual behaviour’.

2.8 Hypotheses

2.8.1 Main Hypotheses

1) To investigate the application of Ajzen’s (1991) TPB model in relation to understanding the intended helping behaviour of healthcare students towards people with LD who display self-injurious CB, the following hypothesis is suggested;

\[ H1: \text{Attitude, subjective norm, and perceived behavioural control will account for a significant amount of the variance in healthcare students' intention to help a person with an LD displaying self-injurious CB.} \]

2) The current study investigates the role of anticipated regret (action taken and action not taken) in addition to the traditional TPB model to see if it provides a more powerful model. The research discussed above suggests that regret about actions not taken significantly predicts intention better than regret about actions taken. However, based on Sandberg & Conner’s (2009) paper that suggests the mere presence of anticipated regret will influence intention, two exploratory hypotheses are proposed;

\[ H2a: \text{Anticipated regret about action taken will significantly increase the proportion of variance explained in healthcare students' intention to help a person with an LD displaying self-injurious CB.} \]
\[ H2b: \text{Anticipated regret about action not taken will significantly increase the proportion of variance explained in healthcare students' intention to help a person with an LD displaying self-injurious CB.} \]

3) The current study investigates the role of similar past behaviour in addition to the traditional TPB model to see if it provides a more powerful model. The following hypothesis is thus suggested;
H3: Similar past experience of helping behaviour will significantly increase the proportion of variance explained in healthcare students' intention to help a person with an LD displaying self-injurious CB.

4) The current study investigates the role of empathy in addition to the traditional TPB model to see if it provides a more powerful model. Few studies report that empathy improves the predictive power of the model, nevertheless, the following exploratory hypothesis is suggested;

H4: Empathy will significantly increase the proportion of variance explained in healthcare students' intention to help a person with an LD displaying self-injurious CB.

5) The current study investigates the role of familiarity in addition to the traditional TPB model. The following hypothesis is thus suggested;

H5: Familiarity with people with an LD will significantly increase the proportion of variance explained in healthcare students' intention to help a person with an LD displaying self-injurious CB.

2.8.2 Further Exploration
Depending on the results of the main hypotheses testing, further exploration will be conducted to see which predictor variables produce the most powerful model to understand healthcare students' intended helping behaviour towards people with an LD who display self-injurious CB.
3. METHOD

3.1 Study Design
The current study employed a quantitative design. This approach assumes that researchers are objective in identifying, numerically measuring and controlling relevant variables. Benefits of employing a quantitative design include data being collected from a large number of participants, and data being collected anonymously, which can help reduce the powerful social pressures that can influence responses.

3.2 Questionnaire Design
The online questionnaire was designed in accordance with Ajzen’s (2002) paper ‘Constructing a TPB questionnaire: Conceptual and methodological considerations’. Section 3.2.1 discusses how the vignette was designed. Section 3.2.2 describes how data was collected for each variable.

3.2.1 Vignette Design
Participants were asked to read a fictitious vignette about a 25-year-old lady named Jenny, who has an LD and who was engaging in self-injurious CB. Participants were then asked to answer several questions. The character “Jenny” and the vignette describing her self-injurious CB were created by researching the literature on people that display self-injurious CB, from consultation with professionals, and from a vignette pilot study, which are discussed below.

3.2.1.1 Literature on Self-injurious CB
Individuals with an LD can engage in different types of self-injurious CB. Murphy & Wilson (1985) suggest this is any behaviour initiated by the individual that results in physical harm. These authors report the following most commonly observed self-injurious CBs; hand-biting; eating in-edible substances; skin-picking; gouging (of ears, mouth, eyes); and kicking or hitting body parts against hard surfaces.
3.2.1.2 Consultation with Professionals

When selecting a self-injurious CB to use in this study, it was believed that the behaviour should be severe enough for an individual to want to help the person displaying self-injurious CB. If participants did not want to help, then researchers would have been unable to analyse what predicted the intended helping behaviour. It was decided that 'kicking or hitting body parts against hard surfaces' may elicit the most willingness to help, and was thus used as the self-injurious CB.

The character "Jenny" and the scenario that she was in were subsequently created. An experienced Clinical Psychologist who works within an adult LD team was consulted with regard to the accuracy of the character and the scenario depicted in the vignette. The information gained was used accordingly.

3.2.1.3 Vignette Pilot Study

A pilot study was conducted to ask people that were familiar with people with an LD and self-injurious CB (Trainee Clinical Psychologists at a University in the South of England) whether the vignette was as near to 'real life' as possible, and to discover if non-familiar individuals understood what was being presented (an opportunist sample of friends and family was used). Feedback from the pilot study was used accordingly (please see Appendix 1 for details).

3.2.2 Measures and Variables

The online questionnaire is in Appendix 2. The questions in the first section of the questionnaire related to the traditional TPB constructs, and both 'anticipated regret' variables. The questions in the second section of the questionnaire included items about 'past behaviour', 'familiarity', 'empathy', 'social desirability' and demographic information. All of these variables are discussed below. Before discussing them however, it must be noted that Ajzen (2002) suggests that good internal consistency between sub-concepts is required. Therefore, internal consistency was measured for the variables
‘intention’, ‘attitude’, ‘perceived behavioural control’, ‘subjective norm’, and both ‘anticipated regret’ variables, as these all had different sub-concepts measuring them. The reliability of these measures as found in this study are presented in the Results chapter.

3.2.2.1 TPB
The main components of Ajzen’s (1991) TPB model that are of interest to this study can be seen in figure 2 on page 158. It is predicted that in combination, ‘attitude’, ‘subjective norm’, and ‘perceived behavioural control’ will predict ‘intention to help’.

3.2.2.2 Intention
People with an LD often need ‘help’ to live independently. The ‘help’ needed depends entirely on the individual and their level of disability. For example, some may need help with all their basic needs (e.g. eating, washing), and others may only need help with more complex activities (e.g. paying bills, finding employment).

People with an LD who display CB may also require help from professionals (i.e. clinical psychologists, community LD nurses) to reduce the frequency with which CB is displayed. Consequently, CB has received significant clinical and research attention (Emerson, 1995). Within this field there is research on carers’ willingness to help people with an LD who display CB (e.g. Bailey et al., 2006; Jones & Hastings, 2003; Rose & Rose, 2005). However, studies that have researched ‘helping behaviour’ within this context have had difficulty defining ‘helping behaviour’. For example, Jones & Hastings (2003) defined ‘helping behaviour’ as “behaviour more or less likely to reinforce challenging behaviour” (Jones & Hastings, 2003, p. 189) other studies have defined it as spending time and effort responding to CB (e.g. Rose & Rose, 2005).

3 Support’ is the most appropriate word to use but as the current study focuses on helping behaviour, the word ‘help’ rather than ‘support’ is used.
What seems to have been overlooked in these studies is exactly how staff would ‘help’. Bailey et al. (2006) appear to have been the most explicit, as they categorised ‘helping behaviour’ into ‘physical intervention’ (e.g. physically preventing the person from engaging in the behaviour) and ‘verbal intervention’ (e.g. asking the person to stop the behaviour). They also categorised non-helping behaviours (e.g. ‘negative restraint’, ‘staff not present’). They did not however report whether carer’s had the skills to ‘help’ the person displaying CB. From this, the current study was going to define ‘helping behaviour’ into ‘physical’ and ‘verbal’ helping behaviours. However, it was decided that rather than asking participants if they would ‘physically’ and ‘verbally’ intervene to help, a pilot study should be conducted to ensure that alternative responses to ‘physical’ and ‘verbal’ intended helping behaviour were not overlooked.

Defining Helping Behaviour - Pilot Study

Following the vignette pilot study, people that were familiar with people with an LD and self-injurious CB (Trainee Clinical Psychologists at a University in the South of England) and non-familiar individuals (an opportunist sample of friends and family) were presented with the amended vignette and asked, “If you saw Jenny behaving like this, please describe briefly what you would do?” (Please see Appendix 3, for full details). In summary, responses could be categorised into ‘verbal’ and ‘physical’ intervening with the latter being the most frequently cited responses. The two most commonly cited examples of physically intervening provided by respondents was therefore presented to participants at the end of the vignette, to help ensure that they knew what “physically intervening” meant.

Ajzen (2002) suggests that to obtain a reliable measure of ‘intention’, more than one question is required to measure it, and that these questions should be randomly dispersed within the questionnaire. The variable ‘intention to help’ was assessed using three sub-concepts; 1) “If I came across a situation like the one with Jenny, I intend to physically intervene to stop her from harming herself”. This was measured on a 7-point Likert scale from 1 = Strongly
Disagree to 7 = Strongly Agree; 2) “If I was in the situation like the one with Jenny, I will physically intervene to stop her harming herself’. This was measured on a 7-point Likert scale from 1 = Strongly Intend to Intervene to 7 = Strongly Intend not to Intervene; and 3) “If you came across a situation like the one with Jenny, how likely is it that you will physically intervene to stop her from harming herself?”. This was measured on a 7-point Likert scale from 1 = Extremely Likely to 7 = Extremely Unlikely.

These three sub-concepts were interspersed within the first section of the questionnaire. Questions 12 and 20 were reversed so that higher scores indicated more positive intention to help. Using the Statistical Package for Social Sciences for Windows (SPSS, version 17, 2009), a mean average score was calculated for each participant from the scores they obtained on questions 1, 12 and 20 (please see Appendix 2, questions 1, 12 and 20 for more details). Scores ranged from 1-7 for each question, which corresponded to the 1-7 Likert scale (i.e. if the Likert scale 2 was selected the participant would get a score of 2 for that question, if they marked 6 they would get a score of 6). This provided a mean ‘intention’ score for each participant, with higher scores indicating more positive intention to help.

3.2.2.3 Attitude

Ajzen (2002) suggests that to obtain a reliable measure of ‘attitude’, which captures an individual’s “overall evaluation of performing the behaviour in question” (Ajzen, 2002, p. 5), the sub-concepts that measure it must have what he termed ‘instrumental’ and ‘experiential’ components. ‘Instrumental’ components are represented by scales like ‘valuable - worthless’, and ‘harmful - beneficial’. ‘Experiential’ components have a more experiential quality and are represented by scales like ‘enjoyable – un-enjoyable’, and ‘pleasant – unpleasant’. Ajzen (2002) acknowledges that when designing a TPB questionnaire, “different items may have to be used for different behaviours” (Ajzen, 2002, p. 4). Subsequently, ‘experiential’ components (e.g. ‘enjoyable – un-enjoyable’, ‘pleasant – unpleasant’) included in a draft questionnaire were removed from the final version. This is because ‘experiential’
components were not deemed appropriate for the behaviour of interest (i.e. helping someone displaying self-injurious CB is unlikely to be enjoyable or pleasant for the person helping). Furthermore, Ajzen (2002) suggests that a 'good - bad' scale is required, as it captures the individuals’ overall evaluation well.

Participants’ attitude was measured by six semantic differential scales. Participants responded to the following question, “For me to physically intervene to stop Jenny from harming herself if I came across the situation described above is...”: 1) Important to me-Unimportant to me, 2) Bad for me-Good for me, 3) Wise-Unwise, 4) Undesirable-Desirable, 5) Worthless to me-Valuable to me, and 6) Beneficial to me-Harmful to me. These were measured on 7-point Likert scales. Questions 2, 4 and 7 were reversed so that higher scores indicated more positive attitude towards intention to help (please see Appendix 2, questions 2-7 for more details). Similar to what was described previously, using SPSS (2009), a mean average score was calculated for each participant from the scores they obtained in questions 2-7. This provided a mean ‘attitude’ score for each participant, with higher scores indicating more positive attitudes towards intended helping behaviour.

3.2.2.4 Perceived Behavioural Control
Ajzen (2002) suggests that to obtain a reliable measure of ‘perceived behavioural control’, the sub-concepts that measure it must capture ‘self-efficacy’ (participants’ self-perceived difficulty of performing the behaviour) and ‘controllability’ (participants’ self-perceived control over performing the behaviour). Participants’ perception of ‘self-efficacy’ and ‘controllability’ were both measured by 2 sub-concepts each. Participants were asked; 1) “For me to physically intervene to stop Jenny from harming herself would be.....” (self-efficacy). This was measured on a 7-point Likert scale from 1 = Impossible to 7 = Possible. 2) “How much control do you believe you would have over physically intervening to stop Jenny harming herself?” (controllability). This was measured on a 7-point Likert scale from 1 = Complete Control to 7 = No Control; 3) “If I wanted to I could physically
intervene to stop Jenny harming herself?” (self-efficacy). This was measured on a 7-point Likert scale from 1 = *Strongly Agree* to 7 = *Strongly Disagree*; and 4) “It is mostly up to me whether I physically intervene to stop Jenny harming herself” (controllability). This was measured on a 7-point Likert scale from 1 = *Strongly Disagree* to 7 = *Strongly Agree*. Questions 9 and 10 were reversed so that higher scores indicated more perceived self-efficacy and controllability towards intention to help (please see Appendix 2, questions 8-11 for more details).

Using SPSS (2009), a mean average score was calculated for each participant from the scores they obtained in questions 8-11. This provided a mean ‘perceived behavioural control’ score for each participant, with higher scores indicating more perceived control towards intended helping behaviour.

### 3.2.2.5 Subjective Norm

Ajzen (2002) suggests that to obtain a reliable measure of ‘subjective norm’, the sub-concepts that measure it must capture ‘injunctive’ and ‘descriptive’ qualities. Ajzen (2002) suggests the ‘injunctive’ part of subjective norm is the perceived social pressure to perform the behaviour, whilst the ‘descriptive’ part is whether important others themselves would perform the behaviour. Participants’ perception of ‘injunctive’ and ‘descriptive’ parts of subjective norm was both measured by 2 sub-concepts each. Participants were asked; 1) “If I physically intervened to stop Jenny from harming herself, the people in my life whose opinions I value would…..” (injunctive). This was measured on a 7-point Likert scale from 1 = *Strongly Disapprove* to 7 = *Strongly Approve*; 2) “If people who are important to me were in the situation described above, they would physically intervene to stop Jenny harming herself” (descriptive). This was measured on a 7-point Likert scale from 1 = *Strongly Agree* to 7 = *Strongly Disagree*; 3) “Most people that are important to me think that I should physically intervene to stop Jenny harming herself” (injunctive). This was measured on a 7-point Likert scale from 1 = *Strongly Disagree* to 7 = *Strongly Agree*; and 4) “I expect that the people in my life whose opinions I value would physically intervene to stop Jenny harming herself” (descriptive).
This was measured on a 7-point Likert scale from 1 = *Strongly Disagree* to 7 = *Strongly Agree*.

Question 14 was reversed so that higher scores indicated more perceived social pressure towards intention to help (please see Appendix 2, questions 13-16 for more details). Using SPSS (2009), a mean average ‘subjective norm’ score was calculated for each participant. Higher scores indicated more social pressure towards intended helping behaviour.

### 3.2.2.6 TPB - Additional Variables

The following will describe how additional variables used in this study were designed and measured.

#### 3.2.2.7 Anticipated Regret

Two measures of anticipated regret were included. One measured anticipated regret related to physically intervening to prevent Jenny harming herself (anticipated regret about action taken). The other measured anticipated regret associated with *not* physically intervening to prevent Jenny harming herself (anticipated regret about action not taken).

Anticipated regret about action taken was measured by three semantic differential scales. Participants responded to this question; “If I did physically intervene to stop Jenny harming herself, and she pushed me over and I knocked and cut my head I would feel....” 1) Regretful-Not Regretful, 2) Sorry-Not Sorry and 3) Worried-Not Worried. These were measured on 7-point Likert scales. Question 22 was reversed so that higher scores indicated more regret (please see Appendix 2, questions 21-23 for more details). Using SPSS (2009), a mean average ‘anticipated regret about action taken’ score was calculated for each participant, with higher scores indicating more regret about action taken.

Anticipated regret about action not taken was also measured by three semantic differential scales. Participants responded to this question; “If I did not
physically intervene to stop Jenny harming herself, and she knocked herself unconscious I would feel...”1) Regretful-Not Regretful, 2) Sorry-Not Sorry and 3) Worried-Not Worried. These were measured on 7-point Likert scales. Question 17 was reversed so that higher scores indicated more regret (please see Appendix 2, question 17-19 for more details). Using SPSS (2009), a mean average ‘anticipated regret about action not taken’ score was calculated for each participant, with higher scores indicating more regret about action not taken.

For the variables intention, attitude, perceived behavioural control, subjective norm and both anticipated regret variables, positive and negative endpoints of each scale were randomly allocated to avoid response bias.

3.2.2.8 Familiarity

Familiarity of people with an LD was measured by four sub-concepts. Three sub-concepts were assessed on a ‘yes’ or ‘no’ basis: 1) “Do any members of your family have a learning disability, or have you known family members who have had a learning disability?”, 2) Do any of your current friends or colleagues have a learning disability, or have you known friends or colleagues who have had a learning disability?”, and 3) “Have you ever had employment (paid or voluntary) that has involved caring for people with learning disabilities?”. For the last sub-concept participants were asked, “In a week, approximately how much contact do you have with people with learning disabilities?” This was measured on a 5-point Likert scale from $1 = 0\text{ hours}$, $2 = 1-2\text{ hours}$, $3 = 3-4\text{ hours}$, $4 = 5-6\text{ hours}$, $5 = \text{over 6 hours}$ (please see Appendix 2, questions 58-61 for more details).

The current study was exploring whether healthcare students who are familiar with people with an LD would be more willing to help compared to those who are not. Therefore, once data had been collected, raw data was analysed and participants were put into two separate groups: Participants that replied “yes” to questions 1), 2) or 3), (i.e. they know or have known someone with an LD, or have had employment that has involved caring for someone with an LD)
were deemed to be familiar with someone with an LD, and were placed in the 'yes, they are familiar' group. If they replied “no” to questions 1), 2) or 3), they were deemed to be not familiar with someone with an LD, and were placed in the ‘no, they are not familiar’ group. For the fourth concept that measured this variable, participants who indicated that they had 0 hours contact with people with an LD in a week (i.e. they ticked Likert scale 1), were placed in the ‘no, they are not familiar’ group. Those who ticked the remaining numbers in the Likert scale (i.e. numbers 2-5, indicating 1 to over 6 hours contact weekly), were deemed to be familiar with people with an LD and were placed in the ‘yes, they are familiar’ group. By categorising the groups in this way, comparisons between the two groups (familiar versus not familiar) and intention to help could be made.

**3.2.2.9 Past Behaviour**

Past behaviour was assessed by two sub-concepts: 1) Participants indicated if they had engaged in the target behaviour during their work/employment before on a 2-point scale (yes, or no) by answering the question; “Has your work ever involved you physically intervening to stop someone with a learning disability from hurting themselves, that is, someone like Jenny?” 2) Participants indicated if they had ever physically intervened outside of their work situation; “Outside your work situation have you ever intervened to help someone with a learning disability, that is, someone like Jenny?” Participants were given three options; “I have encountered a situation similar to Jenny’s and I intervened”; “I have encountered a situation similar to Jenny’s but I did not intervene”; or “I have never encountered a situation similar to Jenny’s” (please see Appendix 2, questions 62-63 for more details).

The current study was exploring whether healthcare students who have behaved similarly before (i.e. helped a person with an LD who displays self-injurious CB), would be more willing to help compared to those who had not. Therefore, once data had been collected, raw data was analysed and participants were put into two separate groups: Participants that replied “yes” to questions 1) or 2) (i.e. they had previously physically intervened to stop
someone like Jenny from hurting themselves) were deemed to have behaved similarly before and placed in the ‘yes, they have behaved similarly before’ group. If they replied “no” to questions 1) or 2) (i.e. they had not previously physically intervened to stop someone like Jenny from hurting themselves) they were deemed to not have behaved similarly before and placed in the ‘no, they have not behaved similarly before’ group. By categorising the groups in this way, comparisons between the two groups (have behaved similarly before versus have not behaved similarly before) and intention to help could be made.

3.2.2.10 Empathy

‘Empathy’ was measured by the 28 items in Davis’ multi-dimensional ‘Interpersonal Reactivity Index’ (IRI, Davis, 1980), which all require a ‘yes’ or ‘no’ response. The IRI reportedly measures four separate constructs of empathy; ‘fantasy scale’, ‘perspective taking’, ‘empathic concern’ and ‘personal distress’ (please see Appendix 2, questions 30-57 for more details). Questions 32, 33, 36, 41, 42, 43, 44, 47 and 48 were reversed so that higher scores indicated more empathy. Using SPSS (2009), a mean average score was calculated for each participant from the scores they obtained on questions 30-57. Scores ranged from 1-5 for each question, which corresponded to the 1-5 Likert scale (i.e. if the Likert scale 2 was selected the participant would get a score of 2 for that question). This provided an ‘empathy’ score for each participant, with higher scores indicating more empathy.

In designing the IRI, Davis (1980) originally used 50 items. These were reduced to 45 items following factor analysis, and then to 28 items following further factor analysis. Davis (1980) described his 28 item measure as having good internal reliability and test-retest reliability. Davis (1980) reported that “the new instrument appears quite well suited for use as a research tool in studying empathy” (Davis, 1980, p. 17). In a subsequent article, Davis (1983) tested the external validity of the IRI using correlation analysis, and found that the different constructs correlated in the way predicted, reportedly indicating good validity. This suggests that the IRI is a valid and reliable way of
measuring empathy, and is reportedly "the most widely used self-report measure in the literature over the last 20 years" (Gerdes et al., 2010, p. 9).

3.2.3 Further Variables of Interest
Further variables of interest in the current study included 'social desirability' and 'demographic information'. The following describes how they were designed and measured.

3.2.3.1 Social Desirability
Social desirability is generally regarded as the tendency of individuals to present themselves favourably to others, and to respond to others in a biased, yet socially desirable way. According to Paulhaus (1991), several measures have been developed that measure 'social desirability'. These include the 'Eysenck Personality Inventory' (EPI, Eysenck & Eysenck, 1968), as the 9-item 'Lie Scale' can be used to indicate the impaired self-appraising of individuals in relation to others. The current study used this 9-item lie scale of the EPI to determine if participants were responding in socially desirable ways. All 9-items require participants to provide a 'yes' or 'no' response. For example, "Once in a while, do you lose your temper and get angry?" Questions 65, 66, 67, 70 and 72 were reversed so that the answer 'yes' indicated socially desirable responding. (Please see Appendix 2, questions 64-72 for more details).

Using SPSS (2009), a mean average score was calculated for each participant from the scores they obtained on questions 64-72. Scores ranged from 1-2 for each question (i.e. a score of 1 was gained for a 'no' response, and 2 for a 'yes' response). This provided a 'social desirability' score for each participant, with higher scores indicating more social desirable responding.

3.2.3.2 Demographic Information
Demographic information was collected regarding participants' age; gender; name of course being studied; year of study; graduate status; and ethnicity to see if there were any differences within these groups towards intention to help,
that is, that they were moderator variables. (Please see Appendix 2, questions 24-29 for more details).

3.2.4 Ease of Completion and Presentation of Questionnaire Pilot Study
To ensure all participants could complete the questionnaire relatively easily, and were content with the presentation of it, a pilot study was conducted. Feedback from this pilot study suggested the online questionnaire took approximately 20 minutes to complete. Following other feedback, the questionnaire was amended accordingly (please see Appendix 4 for more details).

3.3 Recruitment and Inclusion Criteria
Participants were recruited from one source; an e-mail advertisement sent to current healthcare students at a University in the South of England (see Appendix 5 for e-mail advertisement). Following a review of the University's website, in particular, the various faculties within the University, and the courses available to students within each faculty, it was found that all healthcare courses (except Psychology courses) and thus healthcare students were within the Faculty of Health and Medical Sciences (FHMS). The most pragmatic way of accessing healthcare students at the University was therefore to send an e-mail to all students within the FHMS. A difficulty with this approach was that some participants may not work with people with an LD when completing their degree. For example, there are courses like 'Biomedical Studies' and 'Chemistry' within this faculty, and these students are unlikely to have contact with people with an LD when qualified. In contrast, 'Nursing Studies' students are within this faculty and are much more likely to have contact with people with an LD on qualification. Nevertheless, it was decided that an e-mail to all students within the FHMS was the most pragmatic approach to gain access to all healthcare students within the University. Psychology students were excluded from the study in case they had knowledge of the TPB, which may invalidate their responses to the questionnaire. All Psychology courses/students are in the Faculty of Arts and Human Sciences (FAHS) so they were not sent the invitation e-mail.
The University has an e-mail system in which specific faculties can be targeted. The research supervisors of this study had access to this e-mail system as they were lecturers at the University at the time the study was conducted. The research supervisors sent the e-mail invitation to every student within the FHMS faculty via an automated faculty e-mailing system. This automated system was used to ensure that only students within the FHMS received the invitation e-mail. If participants wanted to participate in the study they were invited to follow an online link at the bottom of the invitation e-mail. Only those participants that met the following criteria were sent the invitation e-mail:

- A current healthcare student (undergraduate or postgraduate) at the University in the South of England, within the FHMS. (A full list of courses within the FHMS, and a brief description of each course are in Appendix 6).

When the e-mail advertisement was originally sent to potential participants, only 40 responded. Due to the low response rate, a prize draw was used as an incentive to try and attract more participants in order to match the power calculations. The prizes on offer were ten cash amounts of £20 (total = £200) and participants could enter the prize draw by providing their e-mail address at the end of the online questionnaire. All e-mail addresses provided were drawn randomly out of a hat and the winners informed (see Appendix 7 for e-mail advertisement including information about prize draw). It is impossible to calculate a response rate, as it is not known how many FHMS students received the invitation e-mails, or how many opened the e-mails.

3.4 Ethical Issues

The research was conducted under the British Psychological Society’s (2007) guidelines on ‘Conducting Research on the Internet: Guidelines for Ethical
Practice in Psychological Research Online’ and with consultation from experienced research supervisors.

Ethical approval was obtained from the FAHS Ethics Committee at the University in the South of England (reference no: 352-PSY-09, please see Appendix 8 for ethical approval letter).

As the process for conducting the study had changed during the course of the study (i.e. prize draw added), the ethical committee were informed, and the changes agreed, without need for further ethical consideration (please see Appendix 9 for the e-mail from the Chairperson of the FAHS Ethics Committee).

The main ethical issues were as follows:

3.4.1 Information About the Study and Anonymity
Having followed the online link at the bottom of the invitation e-mail, the first page presented to participants was an ‘Information About the Study’ page (see Appendix 2, p. 232). Participants were presented with detailed information about what participating in the study would involve and approximately how long this would take. Participants were also informed that they would not be asked identifiable information (e.g. their name) and that all information collected would be kept anonymous. Anonymity was maintained throughout the research process, and data was kept on a secure encrypted database (Sawtooth Software; similar to software used by banks) and a password protected computer.

3.4.2 Potential Distress
The questionnaire was carefully worded to avoid causing participants’ distress. However, the content of the vignette was potentially distressing for participants. The ‘information about the study’ page warned participants of the potentially distressing nature of participating in the study. Participants were encouraged to contact the principal investigator before and after participating
if they were concerned about the effects on their well-being. Information about how to do this was presented on the 'information about the study' and 'debrief information' pages, respectively (see Appendix 2, p. 232 and p. 250 for details).

3.4.3 Acquiring Consent
At the bottom of the information page, participants were asked to consent to participation in the study by ticking the appropriate box. If they consented, they were automatically taken to the ‘instructions’ page (see Appendix 2, p. 234). If they did not consent, they were automatically taken to a page which said “Thank you for your interest”, and the only way out of this page was to shut the browser down. The online questionnaire could not be re-accessed unless the individual followed the online link at the bottom of the invitation e-mail, and consented to participation in the study. Participants were informed that they could withdraw from the study at any time, and to do this they had to simply close the browser.

3.5 Procedure and Participants
If participants consented to participation in the study, they then completed one online questionnaire. Piloting participants approximated a completion time of 20 minutes, so this approximate time for completion was presented in the invitation e-mail. Although the e-mail advertisement was only sent to healthcare students within the FHMS, it is only assumed that the participants recruited matched the inclusion criteria. Data was collected between January 2010 and February 2010.

3.6 Statistical Analyses
Data was analysed using correlation and multiple regression. The former was used because it is a statistical tool that can evaluate the strength of linear relationships between different variables. The latter was employed because it is a statistical technique that allows the dependent variable to be predicted by several independent variables. Both these statistical analyses were selected because it was believed that they could best answer the research hypotheses.
There are different ways of entering predictor variables into multiple regression models using SPSS (e.g. stepwise, forward, backward, and enter, SPSS, 2009). With the ‘enter’ method, all of the predictor variables are entered into the regression at the same time. The researcher then eliminates predictor variables based on theoretical and statistical considerations.

The main challenge of fitting models with large numbers of potential predictor variables, as is the case in this study, is deciding which predictors to include. If previous studies have suggested that a particular predictor variable is associated with the dependent variable, then it should be included in the model. However, there are no previous studies to be drawn on in this case. It is common for a $P$-value greater than 0.05 to be used as the cut-off for deciding whether predictors should be included in the model. Due to the potentially low power and possibilities that the predictive power of one variable might be confounded by another variable however, it was decided prior to data collection that Kirkwood and Sterne’s (2003) suggested $P$-value of 0.2 should be used as the cut-off point as to whether predictor variables should be included in the model or not. Another factor influencing the inclusion of categorical variables in the model is the numbers in each category. If these are too low then inclusion of the variable in a multivariable model can result in instability; the more parameters there are, the more caution required if there are low numbers in grouping variables. It was therefore decided prior to data collection that categorical variables would be excluded if numbers in any one category were less than 15. Although not perfect, these seemed like reasonable strategies to employ to help decide which predictor variables should be included in the model.

3.6.1 Sample Size and Power Calculations
According to Field (2005), sample size calculations utilise three related parameters; effect size, alpha and beta (power of the test). In psychological research it is common practice to aim for a medium-size effect, as this balances the clinical need to explain a relatively large amount of the variance, with the constraints of recruiting an acceptable sample size. Field (2005)
argues that the standard level for alpha is 0.05 and that beta, which represents the power of the test, should be stringent enough to detect an effect.

Specifically regarding multiple regression, Tabachnick & Fidel (2007) agree that the required sample size depends on alpha level (0.05), desired power and effect sizes, but also on the number of predictor variables. According to Tabachnick & Fidel's (2007) 'rules of thumb', with eight predictor variables ('attitude', 'subjective norm', 'perceived behavioural control', 'empathy', 'familiarity', 'past behaviour', and two 'anticipated regret' variables) a minimum of 112 participants was required (104 + 8 = 112). Specifically regarding correlation, according to Bausell & Yu-Fang (2002), to detect a moderate correlation (r = .50), a sample of 70 participants will provide 83% power at the 0.05 level.

3.6.2 Parametric Testing and the Assumptions of Parametric Tests

According to Field (2005), parametric tests are more robust, more powerful and better able to efficiently draw out real differences and effects in data sets (if they exist) compared to non-parametric tests. All assumptions of multiple regression (e.g. homogeneity of variance, Normal-distribution, linearity) were assessed to ensure that they had been met, and these are presented in the Results chapter.
4. RESULTS

4.1 Sample Obtained
A total of 106 participants started the online questionnaire. Initial data screening removed 23 participants from the first data set, and 13 from the second data set, as they had either provided insufficient data, had withdrawn from the study, and in the case of three respondents from the second data set, they were removed because their data was included in the first data set (i.e. they repeated the online questionnaire when it was re-advertised including the prize draw). One participant had not provided their age but they were not removed. There was no other missing data. Therefore, although 106 participants started the online questionnaire, only 70 participants completed it.

4.2 Description of Sample
Table 1 below summarises the demographic information of participants in the sample, including their age, gender, name of course being studied, graduate status and ethnicity.
Table 1 - Demographic Information

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<td>1.4</td>
</tr>
<tr>
<td>Other Asian Background</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Caribbean</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Other Ethnic Group</td>
<td>1</td>
<td>1.4</td>
</tr>
</tbody>
</table>
Of the 70 participants, over one third was studying Nursing Studies (38.6%), and over one quarter was studying Nutrition and Dietetics (28.6%). The next largest group of students was studying Midwifery Studies (10%) and the remaining students were studying a variety of different courses. The majority of participants were female (92.9%), undergraduates (90%), of White British ethnic origin (81.4%). The age of participants ranged from 18-48 and over half was aged 18-27 (55.8%).

4.3 Data Screening
All data were analysed using SSPS (version 17, 2009).

4.3.1 Outliers and Distribution
The predictor variables and criterion variable were checked for outliers and Normal distribution by using stem and leaf plots, Q-Q plots, histograms and statistical tests. The stringent Shapiro-Wilk statistical test was chosen in favour of the Kolmogorov-Smirnov test, as Field (2005) suggests that the former is more likely to detect a non-Normal distribution. Due to the small sample size, any z scores above 2.58 were considered significant. All of the data screening regarding outliers and Normal distribution are in Appendix 10. In summary, all the predictor variables and the criterion variable were Normally distributed except for anticipated regret about action not taken, and attempts to transform the data proved unsuccessful. The one very extreme outlier for regret about action not taken was removed and thus this outlier was excluded from all of the regression models. Lack of Normality meant that the nonparametric (Spearman) correlation coefficient was employed for this variable. As the data for predictor variables in multiple regression can be non-Normally distributed, regret about action not taken was included in the regression models as a predictor.

4.4 Reliability of Measures
The internal consistency of measures was assessed by calculating Cronbach’s alpha scores for all of the predictor and criterion variables. Many argue that a value of .7-.8 is an acceptable value for Cronbach’s alpha. Kline (1999) notes
that although these values are generally accepted, when measuring psychological constructs, values below .7 can be expected because of the diversity of the constructs being measured. There is variability in the Cronbach’s alpha scores reported in previous TPB studies, with figures of 0.6-0.9 being reported. Table 2 below shows the Cronbach’s alpha scores for the predictor and criterion variables in the current study.

Table 2 - Cronbach’s Alpha Scores for Predictor and Criterion Variables

<table>
<thead>
<tr>
<th>Criterion Variable</th>
<th>Cronbach’s Alpha Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intention to Help</td>
<td>0.63</td>
</tr>
<tr>
<td><strong>Predictor Variables</strong></td>
<td></td>
</tr>
<tr>
<td>Attitude</td>
<td>0.71</td>
</tr>
<tr>
<td>Perceived Behavioural Control</td>
<td>0.57*</td>
</tr>
<tr>
<td>Subjective Norm</td>
<td>0.73</td>
</tr>
<tr>
<td>Empathy</td>
<td>0.75</td>
</tr>
<tr>
<td>Anticipated Regret About Action Taken</td>
<td>0.75</td>
</tr>
<tr>
<td>Anticipated Regret About Action not Taken</td>
<td>0.89</td>
</tr>
</tbody>
</table>

* Field (2005) suggests this in an acceptable score considering it was measured by only four items (the more items there are, the higher the score will be).

4.5 Preliminary Analysis

Prior to conducting the multiple regression, categorical variables were examined to see if there were significant differences in intention to help between the groups. T-tests were used to see if there were significant differences between variables containing two groups (e.g. male-female, undergraduate-postgraduate). Pearson correlation was used to see if there were significant differences between ages. One-way ANOVA was used to see if there were significant relationships between variables containing three or more groups (e.g. name of course being studied). If the F-test showed the means to vary significantly, post hoc tests were used to compare between individual
means rather than planned comparisons, as there were no prior hypotheses to be tested between groups (e.g. it was not hypothesised that nursing students would intend to help more than midwifery students). Bonferroni’s test was selected as it controls for the Type I error (unlike the least significant difference pair wise comparison), and has more power than Tukey’s test when the number of comparisons is small (Field, 2005). Hochberg’s GT2 test was also used, as Field (2005) recommends this is the most powerful post hoc test to use when sample sizes are very different. If there were no significant differences between groups within the variable, the variable was not considered for further analysis.

In total, one F-test (for ‘name of course being studied’), one correlation (for ‘age’) and five t-tests were conducted (for ‘familiarity’, ‘past behaviour’, ‘gender’, ‘graduate status’, and ‘ethnicity’). Six multiple regression analyses were conducted but these are discussed later.

4.5.1 Familiarity

81.40% of students were familiar with people with an LD \((N=51)\) and 18.60% were not \((N=13)\). An independent t-test showed that students who were familiar with people with an LD (Mean \((M) = 5.78\)) did not differ in their intended helping behaviour compared to students who were not \((M = 5.31)\), \(t = -1.48, df = 68, p = 0.15, 2\text{-tailed}\).

The current study was exploring whether healthcare students who are familiar with people with an LD would be more willing to help compared to those who are not. Although the \(P\)-value was below the 0.2 suggested by Kirkwood and Sterne (2003), as there were less than 15 in one category (non-familiar, \(N=13\)), to prevent instability in the multivariable model, no further analysis was conducted with this variable.

4.5.2 Past Behaviour

64.30% of students had not physically intervened similarly before to help a person with an LD who was displaying self-injurious CB \((N=45)\) and 35.70%
of students had \((N=25)\). An independent t-test showed that students who had helped a person with an LD similarly before \((M = 5.77)\) did not differ in their intended helping behaviour compared to participants who had not \((M = 5.65)\), \(t = 0.46, df = 68, p = 0.65, 2\)-tailed.

The current study was exploring whether healthcare students who have behaved similarly before (i.e. helped a person with an LD who is display self-injurious CB), would be more willing to help compared to those who had not. As there was not a significant difference between the two groups within this variable, and the \(P\)-value was not below the 0.2 suggested by Kirkwood and Sterne (2003), no further analysis was conducted with this variable.

4.5.3 Age
Approximately half of the respondents were aged 18-27 years-old \((N=39, 55.8\%)\), and the remaining were aged 28-48 year-old \((N=30, 42.6\%)\). A Pearson correlation showed that age was not significantly positively correlated with intention to help \((M = 27.49, r = .02, p = 0.90, 2\)-tailed\) so no further analysis was conducted with this variable.

4.5.4 Gender
The majority of participants were female \((N=65, 92.9\%)\). Males \((M = 4.87)\) did not differ in their intended helping behaviour compared to females \((M = 5.76)\), \(t = -1.85, df = 68, p = 0.07, 2\)-tailed. Although the \(P\)-value was below the 0.2 suggested by Kirkwood and Sterne (2003), as there were less than 15 in one category (males, \(N=5\)), to prevent instability in the multivariable model, no further analysis was conducted with this variable.

4.5.5 Name of Course Being Studied
The majority of students were studying ‘Nursing Studies’ (38.6%), followed by ‘Nutrition and Dietetics’ students (28.6%), and ‘Midwifery’ students (10%). The remainder of participants were studying a variety of different courses and were thus grouped into one group, namely ‘other courses’. Although a graph of the mean plots suggested that there was a significant
difference between the course being studied and intention to help, especially between nursing students and midwifery students, the differences in means between the groups only ranged from 5.29 (midwifery students) to 5.83 (nursing students, full range = 1-7). The F-test from the one-way ANOVA analysis revealed that there was no significant difference between courses and intention to help ($F(3,66) = .638, p = 0.59$). As the $P$-value was not below the 0.2 suggested by Kirkwood and Sterne (2003), no further analysis was conducted with this variable.

**4.5.6 Graduate Status**

The majority of participants were undergraduates ($N=63, 90\%$).

Undergraduates ($M = 5.72$) did not differ in their intended helping behaviour compared to postgraduates ($M = 5.48$), $t = 0.57$, df = 68, $p = 0.57$, 2-tailed. As the $P$-value was not below the 0.2 suggested by Kirkwood and Sterne (2003), no further analysis was conducted with this variable.

**4.5.7 Ethnicity**

81.4\% ($N=57$) of students in the sample were of White British ethnic origin, a further 10\% ($N=7$) were of another ‘White’ ethnic origin, and the remaining were from ethnic minority groups ($N=6$). Comparisons were therefore made between ‘White’ and ‘Non-White’ ethnic minority groups. ‘White’ students ($M = 5.75$) did not differ in their intended helping behaviour compared to ‘Non-White’ students ($M = 5.11$), $t = 1.42$, df = 68, $p = 0.16$, 2-tailed.

Although the $P$-value was below the 0.2 suggested by Kirkwood and Sterne (2003), as there were less than 15 in one category (non-white, $N=6$), to prevent instability in the multivariable model, no further analysis was conducted with this variable.

**4.5.8 Social Desirability**

A Pearson correlation showed that social desirability was not significantly positively correlated with intention to help ($r = .41, p=0.41$, 2-tailed).

Therefore, this variable was excluded from any further analysis.
4.6 Pearson (and Spearman) Correlations

With a sample size of 70, the number of participants is equal to the minimum requirement suggested by Bausell & Yu-Fang (2002), and provides 83% power at the 0.05 level.

Table 3 - Means, Standard Deviations and Pearson (and Spearman) Correlations for the TPB, Empathy, and Anticipated Regret Variables (N=70)

<table>
<thead>
<tr>
<th></th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Intention to Help</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Attitude</td>
<td>.59***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Subjective Norm</td>
<td>.20</td>
<td>.14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Perceived Behavioural Control</td>
<td>.63***</td>
<td>.30**</td>
<td>.38***</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Empathy</td>
<td>-.03</td>
<td>-.06</td>
<td>.10</td>
<td>-.03</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Anticipated Regret About Action Taken</td>
<td>-.13</td>
<td>-.03</td>
<td>.01</td>
<td>-.03</td>
<td>.41***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Anticipated Regret About Action Not Taken</td>
<td>.41**</td>
<td>.40**</td>
<td>.20</td>
<td>.27*</td>
<td>.18</td>
<td>.03</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>5.70</td>
<td>5.25</td>
<td>5.02</td>
<td>4.97</td>
<td>3.49</td>
<td>3.48</td>
<td>6.67</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>.84</td>
<td>.85</td>
<td>1.07</td>
<td>.95</td>
<td>.38</td>
<td>1.41</td>
<td>.84</td>
</tr>
</tbody>
</table>

*p<0.05; **p<0.01; ***p<0.001

Table 3 shows that the mean scores for intention, attitude, subjective norm and perceived behavioural control were all above the scale mid-point (3.5), indicating positive intentions, attitudes, social pressure and perceived control towards helping behaviour. Intention to help was positively correlated with attitude (r = .59, p<0.001) and perceived behavioural control (r = .63, p<0.001), and both correlations were above 0.50, indicating a large effect size.

The non-parametric Spearman’s correlation was employed due to non-Normally distributed data.
Intention to help was also positively correlated with anticipated regret about action not taken \( (r = .41, p<0.01, \text{2-tailed}) \), and this was a medium effect size.

Perceived behavioural control was positively correlated with attitude \( (r = .30, p<0.01) \) and subjective norm \( (r = .38, p<0.001) \), and both correlations were above 0.30, indicating a medium effect size (Field, 2005). Perceived behavioural control was positively correlated with anticipated regret about action not taken \( (r = .27, p<0.05, \text{2-tailed}) \), and this was a small effect size.

Anticipated regret about action not taken was positively correlated with attitude \( (r = .40, p<0.01, \text{2-tailed}) \), and this was a medium effect size.

Anticipated regret about action taken was correlated positively with empathy \( (r = .41, p<0.001, \text{2-tailed}) \), and this was a medium effect size. This result suggests that the more empathy a healthcare student has, the more likely they are to regret their intended helping behaviour. This result is illogical and it is therefore likely that the sub-concepts used to measure either or both of these variables did not measure what they were supposed to measure. It is also possible however that the error lies in the intention variable and subsequently, further analysis in relation to all of these variables must be taken with caution. The reliability of these variables and alternative ways of measuring them will be discussed later. As it is not clear where the error lies, all of these variables will remain in the analyses.

### 4.7 Fitting the TPB Model

#### 4.7.1 Model 1 –Traditional TPB Model

With a sample size of 70, and three predictor variables, the number of cases is below the minimum requirement suggested by Tabachnick & Fidel (2007), which is 107 \((104 + 3)\). Field (2005) however suggests that you should have at least 10 participants for every predictor variable, which in this case (with three predictor variables), means 30 participants are required, and that the current sample size therefore meets the requirements. Nevertheless, the more stringent
Tabachnick & Fidel (2007) requirements are preferred, so the following results must be treated with caution.

Using the 'enter' method of multiple regression, with intended helping behaviour as the criterion variable and the traditional TPB constructs as the predictor variables, a significant model emerged ($F_{3,66} = 29.805$, $p<0.001$). With $R^2 = 0.575$, the model accounts for 57.5% of the variance in intention to help. Table 4 below shows that only attitude ($\beta = .44$, $p=0.001$) and perceived behavioural control ($\beta=.53$, $p=0.001$) were statistically significant predictors. According to Field (2005), the higher the $t$ value is, and the lower the $p$ value is, the greater the contribution of that variable, suggesting that perceived behavioural control ($t = 5.85$, $p=0.001$) is the strongest predictor in this model.

Table 4 – Multiple Regression Analysis for the TPB Model Including Intended Helping Behaviour as the Criterion Variable and Attitude, Perceived Behavioural Control and Subjective Norm as the Predictors.

<table>
<thead>
<tr>
<th>Predictor Variables</th>
<th>Standardised Beta ($\beta$)</th>
<th>Standard Error</th>
<th>$t$</th>
<th>$p$ value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude</td>
<td>.44</td>
<td>.11</td>
<td>5.17</td>
<td>0.001</td>
</tr>
<tr>
<td>Perceived Behavioural Control</td>
<td>.53</td>
<td>.10</td>
<td>5.85</td>
<td>0.001</td>
</tr>
<tr>
<td>Subjective Norm</td>
<td>-.06</td>
<td>.09</td>
<td>-.73</td>
<td>0.47</td>
</tr>
</tbody>
</table>

The Durbin-Watson test indicated a value of 2.15, which is between the ‘rule of thumb’ values suggested by Field (2005) of between 1 and 3. This suggests the independent errors assumption has been met. Furthermore, the scatterplot showed that the heteroscedasticity assumption was met for model 1. Lastly, Field (2005) suggests that variance inflation factor (VIF) scores above one and Tolerance scores below 10 meet the multicollinearity assumption. The VIF
scores in this model ranged from 1.10-1.26, and the Tolerance scores from .80-.91, indicating that the multicollinearity assumption was met.

4.7.2 Model 2 - Traditional TPB Model, with Empathy and Anticipated Regret Variables

With a sample size of 70, and six predictor variables, the number of cases is below the minimum requirement suggested by Tabachnick & Fidel (2007), which is 110 (104 + 6), so the following results must be treated with caution.

Using the 'enter' method of multiple regression, three additional predictor variables were added to model 1 (empathy and both anticipated regret variables), and this produced a significant model ($F_{6,63} = 15.88, p=0.001$). With $R^2 = 0.602$, the model accounts for 60.2% of the variance in intention to help. This suggests that the addition of these variables explains 2.7% more variance in intention to help compared to the traditional model.
Table 5 Multiple Regression Analysis for the TPB Model Including Intended Helping Behaviour as the Criterion Variable and Attitude, Perceived Behavioural Control, Subjective Norm, Empathy, and both Anticipated Regret Variables as Predictors.

<table>
<thead>
<tr>
<th>Predictor Variables</th>
<th>Standardised Beta (β)</th>
<th>Standard Error</th>
<th>t</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude</td>
<td>.40</td>
<td>.11</td>
<td>4.59</td>
<td>0.001</td>
</tr>
<tr>
<td>Perceived Behavioural Control</td>
<td>.42</td>
<td>.12</td>
<td>3.87</td>
<td>0.001</td>
</tr>
<tr>
<td>Subjective Norm</td>
<td>-.02</td>
<td>.09</td>
<td>-.18</td>
<td>0.86</td>
</tr>
<tr>
<td>Empathy</td>
<td>-.01</td>
<td>.28</td>
<td>-.10</td>
<td>0.92</td>
</tr>
<tr>
<td>Anticipated Regret About Action Taken</td>
<td>-.11</td>
<td>.07</td>
<td>-1.26</td>
<td>0.21</td>
</tr>
<tr>
<td>Anticipated Regret About Action Not Taken</td>
<td>0.18</td>
<td>0.12</td>
<td>1.60</td>
<td>0.12</td>
</tr>
</tbody>
</table>

Table 5 shows that although all six predictor variables accounted for 60.2% of the variance in intention to help, only attitude ($\beta = 0.40, p=0.001$) and perceived behavioural control ($\beta = 0.42, p=0.001$) were statistically significant predictors, as indicated by their standardised $\beta$ weights. Although not significant, the third largest standardised $\beta$ weight was anticipated regret about action not taken ($\beta = 0.18, p=0.12$). Attitude ($t = 4.59, p=0.001$) was the most statistically significant predictor in this model, followed by perceived behavioural control ($t = 3.87, p=0.001$) and anticipated regret about action not taken ($t = 1.60, p=0.12$). The correlational relationships between all of the predictor variables and intention can be seen in Figure 4 below.
4.7.3 Model 3 –Traditional TPB Model, with Subjective Norm Removed
Using the ‘enter’ method of multiple regression, the predictor variable subjective norm was removed from model 1 (so that only attitude and perceived behavioural control remained), and this produced a significant model ($F_{2,67} = 44.746$, $p=0.001$). With $R^2 = 0.572$, the model accounts for 57.2% of the variance in intention to help, which suggests that removing the
subjective norm variable accounts for 0.3% less of the variance in intention to help compared to leaving it in.

4.7.4 Model 4 – Traditional TPB Model, with Anticipated Regret About Action Taken
To explore whether anticipated regret about action taken would significantly increase the proportion of variance explained in intention to help, in addition to the traditional TPB model, using the ‘enter’ method of multiple regression, these predictor variables were placed into model 4. This produced a significant model \( (F_{4,65} = 22.656), p=0.001 \) but the contribution of anticipated regret about action taken was non-significant \( (\beta = -0.08, t = -1.04, p=0.30) \). With \( R^2 = 0.582 \), the model accounts for 58.2% of the variance in intention to help, suggesting that this model accounts for 0.7% more of the variance in intention to help compared to the traditional model.

4.7.5 Model 5 – Traditional TPB Model, with Empathy
To explore whether empathy would significantly increase the proportion of variance explained in intention to help, in addition to the traditional TPB model, using the ‘enter’ method of multiple regression, these predictor variables were placed into model 5. This produced a significant model \( (F_{4,65} = 22.051), p=0.001 \) but the contribution of empathy was non-significant \( (\beta = 0.02, t = 0.25, p=0.81) \). With \( R^2 = 0.576 \), the model accounts for 57.6% of the variance in intention to help, suggesting that this model accounts for 0.1% more of the variance in intention to help compared to the traditional model.

4.7.6 Model 6 – Traditional TPB Model, with Anticipated Regret About Action Not Taken
To explore whether anticipated regret about action not taken would significantly increase the proportion of variance explained in intention to help, in addition to the traditional TPB model, using the ‘enter’ method of multiple regression, these predictor variables were placed into model 6. This produced a significant model \( (F_{4,65} = 23.357), p=0.001 \) but the contribution of anticipated regret about action not taken was non-significant \( (\beta = 0.15, t = 1.51, \)
With \( R^2 = 0.59 \), the model accounts for 59.0% of the variance in intention to help, suggesting that this model accounts for 1.5% more of the variance in intention to help compared to the traditional model.

In relation to the independent errors, heteroscedasticity, and multicollinearity assumptions discussed on page 194-195, all of these assumption were met for all of the models: The Durbin-Watson test for models 2-6 indicated values of 2.14; 2.22; 2.16; 2.16; and 2.13, respectively; the scatterplots showed that the heteroscedasticity assumption was met for all models; the VIF scores for models 2-6 indicated values of 1.2-2.0; 1.1-1.1; 1.0-1.26; 1.02-1.26; and 1.15-1.68, respectively; and the Tolerance scores for models 2-6 indicated values of .50-.84; .91-.91; .79-.99; .79-.98; and .60-.87, respectively.

Even though subjective norm contributes little to the model, it remains in all of the models (except model 3) due to a priori considerations. In summary, model 2, which is the traditional TPB model with the addition of empathy and both anticipated regret variables is the best predictor of intention to help compared to the other models, as it accounts for 60.2% of the variance in intention to help. However, the additional variables only explain an additional 2.7% of variation in intention to help compared to the traditional model.

**4.8 Implications of the Results for Research Hypotheses**

The results of the hypotheses testing can be seen in table 6 in Appendix 11. In summary, only hypotheses 1 (\( H1: \) Attitude, Subjective Norm, and Perceived Behavioral Control will account for a significant amount of the variance in healthcare students' intention to help a person with an LD displaying self-injurious behaviour), was strongly supported by the data.
5. DISCUSSION

5.1 Summary of Findings

Previous TPB research has used a variety of statistical analyses. Consequently, the results of the current study cannot always be directly compared to previous research. Nevertheless, where possible, direct comparisons will be made to previous research by citing previous research $t$ values, standardised $\beta$ weights and how much the variable of interest accounts for variance in intention/behaviour.

5.1.1 Hypotheses

Hypothesis 1: Attitude, subjective norm, and perceived behavioural control will account for a significant amount of the variance in healthcare students’ intention to help a person with an LD displaying self-injurious CB.

Hypothesis 1 was strongly supported (model 1). Therefore, positive attitudes towards intending to help a person with an LD who is displaying self-injurious CB, perceptions of pressure from others to help, and the degree to which healthcare students believe they can control helping, were associated with greater propensity to help.

No known previous research has applied the TPB model to understand the intended helping behaviour of healthcare students towards people with an LD who display self-injurious CB. In fact, the TPB model has not been used to understand intended or actual helping behaviour of any group of individuals towards any type of CB. Nevertheless, the current results are consistent with previous research that has used the TPB to predict intended health-related behaviours that do not directly benefit the individual. For example, Giles et al.’s (2004) study on individuals’ intentions to donate blood found that the traditional model and self-efficacy (which was measured within perceived behaviour control in this study) accounted for 64% of the variance in intention. The current study found similar results, as the traditional model accounted for 57.5% of the variance in intention.
H2a: Anticipated regret about action taken will significantly increase the proportion of variance explained in healthcare students’ intention to help a person with an LD displaying self-injurious CB.

Hypotheses 2a was mildly supported (model 4), as although anticipated regret about action taken was non-significantly associated with intentions ($\beta = -.08$, $t = -1.04$, $p=0.30$, model 4), the traditional model with the additional of this variable accounted for 58.2% of the variance in intention to help, suggesting that this model accounts for 0.7% more of the variance in intention to help compared to the traditional model (model 1). However, the reliability of this variable is questionable and will be discussed in more detail later.

H2b: Anticipated regret about action not taken will significantly increase the proportion of variance explained in healthcare students’ intention to help a person with an LD displaying self-injurious CB.

Hypothesis 2b was mildly supported (model 6), as although anticipated regret about action not taken was strongly associated with intention ($r = .41$, $p<0.01$, 2-tailed), after adjusting for the TPB variables this variable explained little of the variation in intentions ($\beta = .15$, $t = 1.51$, $p=0.14$). With $R^2 = 0.59$, the model accounts for 59.0% of the variance in intention to help, suggesting that this model accounts for 1.5% more of the variance in intention to help compared to the traditional model. As above however, the reliability of this variable is questionable and will be discussed in more detail later.

Regarding hypothesis 2a, anticipated regret about action taken proved to be a non-significant predictor of intention in this study. Previous studies have shown inconsistent findings. For example, the current results are consistent with Conner et al.’s. (2007) study, which found that anticipated regret about action taken (speeding) did not predict behaviour. Conner et al. (2007) reported negative $\beta$ weights (statistics not reported) for their anticipated regret action taken variable, as did the current study ($\beta = -.08$, $p=0.30$). However, the results of the current study are not consistent with Sandberg & Conner's
(2009) study, where anticipated regret about actions taken (in addition to past regret and anticipated regret about actions not taken) improved the predictive power of the TPB model by 21%.

Regarding hypothesis 2b, based on previous research it would have been expected that an individuals' anticipated regret about not acting in a certain situation would have improved the predictive power of the traditional TPB model. Conner et al. (1999) found that anticipated regret towards not wearing a condom increased the predictive power of the traditional TPB model by 6% (along with 'moral obligation'). Morison et al. (2009) found that parent's anticipated regret about not accepting the HPV for their daughters significantly predicted intention.

It is worth noting that the sub-concepts that measured anticipated regret about actions taken came after all three intention questions, and this variable did not significantly influence intention. In contrast, one of the sub-concepts that measured anticipated regret about actions not taken was measured directly before one of the intention questions, and this variable was positively correlated with intention. According to Sandberg & Conner (2009), it is consciously thinking about anticipated regret that influences intention. It is therefore possible that asking participants to consciously think about anticipated regret about actions not taken immediately before asking them an intention question is what influenced their response to that intention question. Overall, this may have influenced why anticipated regret about actions not taken was correlated with intention while anticipated regret about actions taken was not. With hindsight, the sub-concepts that measured both of the anticipated regret variables should have been before the sub-concepts that measured intention.

H3: Similar past behaviour will significantly increase the proportion of variance explained in healthcare students’ intention to help a person with an LD displaying self-injurious CB.
Hypothesis 3 was not supported, as no association was found between past behaviour and intention. Based on previous research it would have been expected that an individuals’ past behaviour would have improved the predictive power of the traditional TPB model. For example, Conner et al. (2007) reported that past behaviour was a significant predictor of intention due to positive β weights (statistics not reported). Furthermore, O’Callaghan & Nausbaum (2006) reported that past behaviour accounted for an additional 18.5% of the variance in actual bicycle helmet wearing behaviour (β = .52, p<.01).

H4: Empathy will significantly increase the proportion of variance explained in healthcare students’ intention to help a person with an LD displaying self-injurious CB.

Hypothesis 4 was mildly supported (model 5), as although empathy was non-significantly associated with intentions (β = .02, t = 0.25, p=0.81), the traditional model with the addition of empathy accounted for 57.6% of the variance in intention to help, which accounts for 0.1% more of the variance in intention to help compared to the traditional model. Based on relatively limited previous research it would have been expected that empathy could have improved the predictive power of the traditional TPB model, as Bae (2008) found that empathy (β = .42, t = 15.00, p<0.01) significantly increased intention to register as a cornea donor. The reliability of this variable is questionable however and will be discussed in more detail later.

H5: Familiarity with people with an LD will significantly increase the proportion of variance explained in healthcare students’ intention to help a person with an LD displaying self-injurious CB.

Hypothesis 5 was not supported, as no association was found between familiarity and intention.
5.1.2 Further Exploratory Analysis

Further exploratory analysis revealed that model 2, which contained the traditional TPB components, empathy and both anticipated regret variables was the strongest predictor of intention, and accounted for 60.2% of the variance in intention to help. Possible reasons as to why empathy and anticipated regret only accounted for an additional 2.7% in the variance in intention compared to the traditional model will be discussed below.

5.2 Interpretation of Results

The results indicate that the TPB model can be used to understand the helping behaviour of healthcare students towards people with an LD who display self-injurious CB. Healthcare students' cognitive responses (attitudes) and how much self-perceived control they have over helping (perceived behavioural control) explained a large proportion of the variation in intended helping behaviour. Perceived pressure from significant others to help (subjective norm) was a non-significant predictor in this study. The addition of emotional components (anticipated regret and empathy) only mildly improved the predictive power of the traditional TPB model.

Generally speaking, as the current study is the first known time that the TPB has been used in this context, it provides foundation for future research. Furthermore, the results of the current study add to the growing literature base that shows that the traditional TPB model can better predict behaviour when emotional components are included. There is however variation in the literature about how much emotions influence different behaviours. For example, the emotional variables (empathy and anticipated regret) only accounted for an additional 2.7% in the variance in intention in this study. However, Conner et al. (1999) found that their emotional variable (anticipated regret towards not wearing a condom) increased the predictive power of the traditional TPB model by 6%. From this it seems that more research is needed in relation to how emotions influence different behaviours, and this will be discussed in more detail below.
In thinking about why empathy was a non-significant predictor of intended helping behaviour, it is possible that empathic healthcare students intended to physically intervene to help but lacked the skills and knowledge about how they would intend to help. If true, it is possible that empathic healthcare professionals would also be less likely to intend to help if they too lacked the skills and knowledge to be able to help. Previous research has focused on healthcare student and professional attitudes towards people with an LD, and how this can affect their behaviour towards them. It seems however that previous studies have not focused on whether healthcare students and professionals have the skills and knowledge to be able to help this client group when faced with challenging situations. Future research could therefore focus on this area, and subsequently provide information, skills and knowledge to healthcare students and professionals to be able to help people with an LD who display CB accordingly.

Despite there being 2762 research papers published on the TPB (as described earlier), the model has infrequently been used to understand behaviour that benefits others (e.g. blood donation). This is because the majority of research has focussed on predicting behaviours that benefit the self (e.g. eating healthily). The results of the current study therefore add to the comparatively small evidence base regarding behaviours that benefit others.

It is possible that the TPB is rarely used to research behaviours that benefit others because the target behaviours are less well defined. For example, an individual wearing a condom or a bicycle crash helmet are relatively easy to define compared to ‘physically intervening’ to help someone, or other altruistic behaviours. Furthermore, it is possible that the outcomes/benefits of behaviours that benefit the self are more obvious than those that benefit others. For example, the health benefits of wearing a condom or a bicycle crash helmet are clear (i.e. protecting self from sexually transmitted diseases and head injury, respectively). However, by donating a cornea, although it is possible that someone will benefit, exactly who or how is not always clear (i.e. who will receive the cornea? Will the cornea transplant work?). Similarly, in
this study, the outcome of the intended helping behaviour is not clear; students may have been uncertain about whether their intention to physically intervene would help Jenny or not (i.e. her behaviour may have got worse). Due to the difficulties in defining target behaviours that benefit others, and the fact that the benefits of behaving altruistically towards others are not always clear or visible, it is likely that there will continue to be more TPB studies to research behaviours that benefit the self, compared to others.

The strongest predictive model in this study accounted for more of the variance in intention (60.2%) than Armitage & Conner’s (2001) recent meta-analysis, which suggests that TPB studies account for approximately 39% of the variance in intention. Giles et al. (2004) also used the TPB to understand a behaviour that benefits others (intention to donate blood), and found that the traditional model accounted for 64% of the variance in intention. Unfortunately, Armitage & Conner (2001) did not report whether the behaviours included in their meta-analyses were behaviours that benefit the self or others. Nevertheless, the possibility that behaviours that benefit others can account for more variance in intention compared to behaviours that benefit the self is of interest, and will be discussed in the future research section below.

5.3 Critical Evaluation
5.3.1 Strengths
The current study is the first known time that the TPB has been used in this context. It was an exploratory study that investigated various different variables to try and understand healthcare students’ intended helping behaviour towards people with an LD who display self-injurious CB, and can therefore be used as a foundation for future TPB research in this area.

The study adds to the comparatively small evidence base that has used the TPB to try and understand behaviours that benefit others. It also highlights possible reasons why there is limited research in this area. These include the relative difficulty of defining behaviours that benefit others and whether or not
these behaviours will actually be of benefit to the individual, problems that are less evident when the TPB is applied to behaviours that benefit the self. The study also highlights the importance of individuals having the skills and knowledge to be able to perform the intended behaviour, which is relevant for future studies researching behaviours that benefit both the self and others. The study has also shown that behaviours that benefit others may account for more variance in intention than behaviours that benefit the self.

5.3.2 Limitations

5.3.2.1 Sample Size

One limitation of the current study is the sample size, as with 70 participants it does not meet Tabachnick & Fidel's (2007) recommended sample size calculations. Some of the variables were also excluded from further analysis because there was no significant difference between groups. However, as the study is underpowered, certainty about what this lack of significance means cannot be ascertained. Future studies may therefore want to further explore these variables, in particular, familiarity, past behaviour, healthcare course being studied, age and gender.

To increase the sample size healthcare students at other Universities could have been sent the invitation e-mail. Other healthcare courses could also have been included (e.g. medical students and clinical psychology students). The researcher could also have recruited participants by attending lectures of various healthcare courses, and asking students to complete the online questionnaire on a laptop.

5.3.2.2 Response Bias

It can only be assumed that participants in the sample are representative of all healthcare students at the University, as it is impossible to ascertain the characteristics of those who chose not to respond. As you cannot make people participate, this inherently biases the sample (Litwin, 1995).
5.3.2.3 Measures

Validity

Ecological validity of the current study is questionable due to employing a vignette. However, for pragmatic reasons, and due to the unethical nature of observing actual responses to self-injurious CB, the vignette was employed. An alternative methodological approach is discussed below.

Data was collected via an online questionnaire. This method allows data to be collected from many participants in a time resourced, standardised way. However, there are disadvantages of collecting data in this way. Firstly, discourse analytic and social representations theorists would argue that underlying theoretical constructs cannot be measured using questionnaires (e.g. Potter & Wetherall, 1987; and Howarth, 2006, respectively). Such theorists would also argue that participants vary their responses to questionnaires depending on the context (e.g. Potter & Wetherall, 1987). Davies et al. (2002) share this view and report that situational variables are highly significant in relation to consistently predicting attitudes, intentions and behaviour.

Secondly, data collection is reliant on people being honest. It is possible that participants in this study were responding in socially desirable ways, especially as students are often asked to sit exams in which they are expected to provide the “right answers”. The current study provided promise of anonymity to participants, which is a commonly used method of facilitating honesty to questionnaires of a sensitive nature (Cozby, 1993). Furthermore, there was non-significant correlation between social desirability and intention \( (r = .41, p=0.41, \text{ 2-tailed}) \). There is however no real proof that participants were not responding in socially desirable ways.

Reliability

There may be reliability issues regarding the intention variable: Two examples of ‘physical intervening’ (“taking her arm and helping Jenny to her feet”, and “putting your hand or jacket between Jenny’s head and the pavement”) were
presented to participants to help ensure that they knew what was meant by ‘physically intervening’. However, it is possible that participants interpreted ‘physically intervening’ differently (e.g. by using force to stop Jenny from hurting herself). As Potter & Wetherall (1987) suggest, the same words presented to participants may not result in them having the same object of thought. Furthermore, the language that was used to measure the intention variable was inconsistent. For example, questions 1 and 20 used “a situation”, whereas question 12 used “the situation”. Furthermore, question 12 was rated on a Likert scale ‘strongly intend to intervene’ – ‘strongly intend not to intervene’ when the question asked participants if they would “physically intervene”. It would have been more consistent to remove the word ‘strongly’. Using ‘intend to intervene’ – ‘intend not to intervene’ rather than ‘strongly disagree - strongly agree’ for question 1 would also have improved consistency. Having consistency of language would have improved the reliability of the intention variable.

Anticipated regret about action taken and empathy were positively correlated, suggesting that one or both of these variables were unreliable. It is less likely that the empathy measure was unreliable as this is reportedly a reliable measure (Gerdes et al., 2010). It therefore seems likely that the sub-concepts used to measure anticipated regret about action taken were unreliable. This is likely to be because the language employed for this variable is potentially confusing (please see Appendix 2, questions 21-23). With hindsight, the language should have been simplified to, “If I physically intervened I might feel….regretful-not regretful; sorry/not sorry; worried/not worried. Similarly, the language used for the anticipated regret about action not taken should also be simplified to, “If I did not physically intervene I might feel…regretful/not regretful; sorry/not sorry; worried/not worried. Alternatively, anticipated regret could have been measured simply by measuring not intervening. Furthermore, if all of the questions throughout the questionnaire had been randomised, this would have improved reliability. Except for the anticipated regret variables, which should be presented before the sub-concepts that measure intention, as described previously.
Participants

The most pragmatic way of accessing participants was to send an invitation e-mail to all healthcare students within the FHMS at the University in the South of England. The difficulty with this approach is that not all participants within this study will have contact with people with an LD when they qualify (e.g. 'Chemistry' students). If a larger sample had been obtained, then the study could have focused on healthcare students who would work with this client group on qualification. Comparisons between various healthcare student groups could then have been made (i.e. nursing versus other healthcare students). Ideally, the current study would have explored the TPB in relation to understanding healthcare professionals’ helping behaviour, but there were difficulties accessing this group.

The invitation e-mail and online questionnaire were both written in English. It is possible that participants did not have good English language skills, and consequently, this could affect the validity of the data obtained.

Standardised Measures

Social desirability was measured by the 9-item lie scale of Eysenck & Eysenck’s (1968) EPI. In reviewing different social desirability scales, Paulhaus (1991) described this scale as “a rationally developed lie scale” (Paulhaus, 1991, p. 21) but also said it has “little application outside the inventory” (Paulhaus, 1991, p. 21). The social desirability scale employed in this study is therefore unreliable. The study could have used Edwards’ (1957) Desirability Scale or the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960), as Paulhaus (1991) reports they both have good reliability and validity.

Analysis

Based on participants’ responses, participants were categorised into two groups for both the familiarity and past behaviour variables (please see sections 3.2.2.8, p. 175 and 3.2.2.9, p. 176 for more details). Both of these variables could however have been analysed differently. For example,
regarding past behaviour, comparisons could have been made between individuals who had previously physically intervened to help someone with an LD from hurting themselves whilst at work, compared to individuals who had physically intervened outside of their work. Furthermore, intention to help may have been predicted differently based on whether the individual had encountered a similar situation before and had intervened, compared to them encountering a similar situation and not intervening, or them never encountering a similar situation before. Regarding familiarity, analysis could have been conducted on the amount of time in hours per week the participant had contact with someone with an LD, as those who had over six hours contact may have intended to help more than those who only had one hour contact. Furthermore, intention to help may have been predicted differently based on whether the participant knew a family member, they worked with people with an LD, or had a friend or colleague with an LD.

Alternative Approaches

To improve the reliability of the intention variable a different defining helping behaviour pilot study could have been conducted: Participants could have been shown the vignette and asked what they think Jenny needed in this situation and whether they believed they have the skills to do it. This is likely to have resulted in a different conceptualisation of the intention variable, which may have proved more reliable.

To help resolve the difficulties associated with using a vignette; the fact that 'physical intervening' is open to interpretation; and actual behaviour not being observed, the current study could have employed a different methodological approach. For example, participants could have been informed that by following an online link, and signing a petition, they would improve access to healthcare services for people with an LD who display self-injurious CB. The predictors of this actual helping behaviour using the TPB could have been assessed using a questionnaire, in a similar way to the current study.
5.4 Applied Implications for Clinical Practice

Considering the design/limitations of the current study, and the fact that it is the only known study that has used the TPB in this context, the following must be taken with caution.

The results of the current study suggest that at a University in the South of England, healthcare students' intended helping behaviour toward people with an LD who display self-injurious CB is most significantly predicted by their attitude towards the intended behaviour, and their self-perceived control over performing the intended behaviour. Intended helping behaviour was not significantly predicted by perceived social pressure to help in this study. The results therefore suggest that in order to increase intended helping behaviour by healthcare students at this University towards this client group, their attitudes towards helping, and their perceived control over helping need to be targeted, rather than perceived social pressure to help.

Improving Perceived Behavioural Control Over Helping

As intentions to help were high in this study \((M=5.70\) on a scale of 1-7), providing healthcare students with the knowledge and skills about how to help (and thus increase their self-perceived control over helping), is likely to result in increased intended helping behaviour. There are several ways that students' knowledge and skills about how to help people with an LD who are displaying self-injurious CB could be improved as part of their educational programme. For example, they could be shown video clips of carers/family members helping someone who is displaying self-injurious CB (i.e. verbally and/or physically intervening until the behaviour stops). Carers/family members could also share their positive experiences of helping someone who is displaying self-injurious CB in lectures. Students could then practise what they have learnt from these experiences through role plays, which may give them the confidence, knowledge and skills (and thus increase their self-perceived control over helping), to be able to help someone with an LD displaying self-injurious CB when faced with similar challenging situations.
**Improving Attitudes Towards Helping**

Although there were generally positive attitudes towards intended helping behaviour (M = 5.25 on a scale of 1-7), students may have had a variety of different attitudes/beliefs about their intended helping behaviour or the consequences of this behaviour that may have hindered their intended helping behaviour. For example, they may have believed that they would not be able to help appropriately; that helping would not in fact help; or that there would be other negative consequences related to helping (e.g. getting hurt). The results of the current study suggest that if these and similar negative beliefs were explored, identified and challenged as part of healthcare students’ educational programme, then this may result in an increase in intended helping behaviour.

The current study only used healthcare students at one University in England. However, it is possible that the results of the current study may be applicable to other Universities within England. The applied implication for all of these Universities is that if healthcare courses focus on identifying and challenging attitudes towards helping people with an LD who display self-injurious CB, and also provide healthcare students with opportunities to practise helping so that they have the skills, knowledge and confidence to be able to help, this may lead to an increase in intended helping behaviour towards this client group.

**5.5 Future Research**

The current study was the first known study to find that the TPB can be used to understand healthcare students’ intended helping behaviour towards people with an LD who display self-injurious CB. Recommendations for future research include exploring the TPB in relation to understanding helping behaviour by other groups (e.g. carers, family members, healthcare professionals) towards other forms of CB (e.g. aggressive CB).

This study and the Giles *et al.* (2004) study both used the TPB to predict intended behaviour that would benefit others. Both studies found that the traditional TPB model accounted for higher amounts of variance in intention...
than the ‘norm’ of 39% (Armitage & Conner, 2001). One reason why the TPB may account for higher amounts of variance in intention for behaviours that benefit others compared to the self is the possibility that behaviours that benefit others are less frequent, and consequently require less thought/judgement about performing the behaviour or not. For example, donating blood, a cornea, or physically intervening to help someone displaying self-injurious CB in the community are all likely to occur less often and probably require less thought/judgment compared to regularly wearing a bicycle crash helmet. Nevertheless, it would be interesting to find out if ‘altruistic’ behaviours account for more variance in intention/behaviour compared to behaviours that benefit the self. Such research could start by simply conducting a literature review about behaviours that benefit others and the self. If differences are found then subsequent research could focus on whether frequency of, and judgments about the target behaviour are moderator variables.

The current study and the Conner et al. (1999) study (on intention to use condoms) found that the inclusion of emotional variables only accounted for an additional 2.7% and 6% (including a ‘moral obligation’ variable) of the variance in intention, respectively. Although it is acknowledged that emotion will have a different influence on behaviour, depending on the type of behaviour being predicted, it seems that a more appropriate measure of emotion is required, that measures emotions consistently. Future research could therefore focus on researching different ways of measuring emotion to see which one measures it the most effectively and consistently.

The current study has not focused explicitly on how attitude towards the object improves helping behaviour towards the object, rather; it has focused explicitly on attitudes towards helping the object. It seems likely however that attitude towards the object may influence helping behaviour exhibited towards the object. Future studies in this context may therefore wish to consider the influence of attitudes towards the object.
5.6 Conclusions

The current study found that the traditional TPB model, with additional predictor variables, can be applied to understand the helping behaviour of healthcare students towards people with an LD who display self-injurious CB. Healthcare students’ intended helping behaviour was positive, with attitude and perceived behavioural control being the most significant predictors of intended helping behaviour. Subjective norm, empathy and anticipated regret proved to be non-significant predictors. A small sample size however will have affected the power of some of the tests. Future researchers may therefore wish to further explore the TPB in this area, or in relation to aggressive CB, and/or use both this model and attribution theory to consider how both models might be informed by attitudes towards the object.
6. REFERENCES


7. APPENDICES

Appendix 1
Vignette Pilot Study
The purpose of the vignette pilot study was to ask people that were familiar with people with an LD and self-injurious behaviour (Trainee Clinical Psychologists at a University in the South of England) whether the vignette was as near to ‘real life’ as possible. An additional purpose of the pilot was to discover if non-familiar individuals understood what was being presented. The feedback from both familiar (N=10) and non-familiar (N=8) individuals is presented below.

People familiar with people with an LD
An e-mail was sent to 24 Trainee Clinical Psychologists who were in their third year of training at a University in the South of England. All of these trainees were deemed to be familiar with people with an LD because they had all completed a six month placement within an LD service, in their second year of their clinical training. The e-mail asked the trainees to read the vignette and then to provide feedback as to whether the character depicted in the vignette (Jenny) was as near to ‘real life’ as possible, based on their clinical experience. 10 trainees responded to the e-mail providing feedback, and their actual responses are listed below:

Respondent 1: Line 5 it says, “A mild learning disabilities”, should this not be “a mild learning disability”?

Respondent 2: In the paragraph where you say, “Although you have lived near Jenny’s family for some time, you do not know Jenny or her parents”, it might be helpful to put a break in the paragraph or perhaps put the first two sentences at the end i.e. talk about her abilities and then that she lives with her parents and you do not know her?

Respondent 3: All fine. Good luck with it!!

Respondent 4: Generally I think it was fine and easy to read, although it might be a bit long and maybe you should try to shorten it? Mild LD rather than mild LD’s, line 5?

Respondent 5: 1st paragraph grammatically should be “with a mild learning disability” not “with a mild learning disabilities”. Is it true that people with a mild LD “often” demonstrate challenging behaviour? You may have put this in to influence responses but I have never heard this is the case?

Respondent 6: Thought it was very good.

Respondent 7: You say she can wash, dress and toilet herself, may read better to say “she can wash dress and use the toilet independently” (toilet herself is a weird phrase if you don’t have experience in this area). Overall, very readable and user friendly.

Respondent 8: Move the first sentence “Imagine that you live in a house 3 doors down…” to the beginning of the second paragraph? The sentence “Although you have lived near Jenny’s family for some time, you do not know
Jenny or her parents" - you do know about Jenny because you state things about her!??!

Respondent 9: You suggest that all people with LD engage in CB but not all people with LD do in my experience. Otherwise, it's looking good!!

Respondent 10: Line 5, should it not read "with a mild learning disability"??

*People not familiar with people with an LD*

An opportunist sample was used to see if people who were not familiar with people with an LD understood what was being presented in the vignette. Friends and family members (N=10), were asked two questions by the researcher; 1) "Have you ever known anyone with an LD?" and 2) "Have you ever worked with anyone with an LD?" Those that responded "No" to both of these questions were asked to read the vignette and then to provide feedback as to whether the information presented was clear and understandable (their responses were written down by the researcher). Only one person had previously worked with someone with an LD, and one person reported that they had lived near someone with an LD when they were younger. Both of these respondents were excluded from the pilot study. The remaining eight respondents replied "No" to the two questions above, suggesting that they were not familiar with people with an LD. The actual responses of these eight respondents are listed below:

Respondent 11: That must really hurt. What's wrong with Jenny? I don't think she's right in the head. I think she forgot to take her medication. Apart from that, it's fine, good, easy to understand, except I don't understand why she is doing that.

Respondent 12: It looks ok to me. The information is clear about Jenny and her family, and what she can and can't do. Maybe she's lonely or scared. I'm just wondering, does she have any friends, you know, that she can hang out with?

Respondent 13: It makes perfect sense. But does Jenny often behave like that? Her behaviour seems a bit weird. I'd like to know if anyone helps Jenny?

Respondent 14: I think it's really good, really interesting. Does anyone help Jenny? What happens to her? Can she ask for help?

Respondent 15: She's not balanced (long pause). Is it clear? Yes, you're saying what she can and can't do, her abilities, her behaviour, it's clear, it's explained as you go along, very good.

Respondent 16: I can understand it. You say that I've lived near Jenny's family for some time, does Jenny live just her parents, or does she have any brothers and sisters that could help her?
Respondent 17: It’s clear to me, but can Jenny speak? Why doesn’t she tell someone what is wrong? I’m not sure I’d know what to do in that situation.

Respondent 18: It’s very easy to read. The information suggests that that she can wash by herself, but needs help with shopping, what else does she need help with?

What changed as a consequence of the pilot study?
The original and the amended vignette are provided below, to allow the reader to make reference to them. Following feedback from respondents 1, 4, 5 and 10, the original vignette, first paragraph, line 5, “with a mild learning disabilities” was changed in the amended vignette to “with a mild learning disability” (please see amended vignette, first paragraph, line 5).

Following feedback from respondent 5 and respondent 9, the original vignette, first paragraph, line 5, “People with a mild learning disability often exhibit what is known as ‘challenging behaviour’” was changed in the amended vignette to “People with a mild learning disability can exhibit what is known as ‘challenging behaviour’” (please see amended vignette, second paragraph, line 6-8).

Following feedback from respondents 14 (“Can she ask for help?”) and 17 (“Can Jenny speak?”) further information about Jenny’s communication abilities was added into the amended vignette. Furthermore, following feedback from respondents 18 (“You say that she can wash by herself, but needs help with shopping, what else does she need help with?”), further information about her general abilities was also added. (Please see amended vignette, first paragraph, lines 4-6; “Generally, people with a mild learning disability can communicate with spoken language but they do have difficulties with daily living tasks”).

Following feedback from respondent 7, the original vignette, second paragraph, line 3, “Jenny can hold conversations and is able to wash, dress and toilet herself”, was changed in the amended vignette to “Jenny can hold conversations and is able to wash, dress and use the toilet independently” (please see amended vignette, second paragraph, lines 3-4).

Following feedback from respondent 12 (“I’m just wondering, does she have any friends, you know, that she can hang out with?”), information about her friends was added (please see amended vignette, second paragraph, lines 5-6; “Jenny has two close friends but it takes her a long time to develop relationships as she has poor social skills”).

Respondent 8 suggested moving the first sentence of the original vignette (first paragraph, line 1) “Imagine that you live in a house 3 doors down...” to the beginning of the second paragraph. Respondent 2 suggested moving the contents of the second paragraph. As none of the other respondents had made these suggestions, it was decided that the text should remain the same, despite the suggestions.
Original vignette

“Imagine that you live in a house three doors away from a 25 year old lady called Jenny who has a mild learning disability. People with a mild learning disability have intellectual abilities that are significantly poorer than the average intellectual ability of the general population. People with a mild learning disability often exhibit what is known as 'challenging behaviour'. This can involve acts of aggression towards others or self-inflicted physical harm (e.g. head-hitting, gouging, skin-picking, eating inedible substances).

Jenny lives with her mother and father. Although you have lived near Jenny’s family for some time, you do not know Jenny or her parents. Jenny can hold conversations and is able to wash, dress and use the toilet independently but does need help with shopping and budgeting and can only cook simple meals.

Imagine that one day you see Jenny outside her family’s house. She is sitting on the ground and hitting her head on the pavement. She is doing this with so much force that you notice blood running down her face. She is crying and shouting whilst she hits her head on the pavement. She looks very agitated. You look up and down the street but you cannot see any member of her family. You are the only person around”.

Amended vignette
The following is the vignette that was used in the study:

“Imagine that you live in a house three doors away from a 25 year old lady called Jenny who has a mild learning disability. People with a mild learning disability have intellectual abilities that are significantly poorer than the average intellectual ability of the general population. Generally, people with a mild learning disability can communicate with spoken language but they do have difficulties with daily living tasks. People with a mild learning disability can exhibit what is known as ‘challenging behaviour’. This can involve acts of aggression towards others or self-inflicted physical harm (e.g. head-hitting, gouging, skin-picking, eating inedible substances).

Jenny lives with her mother and father. Although you have lived near Jenny’s family for some time, you do not know Jenny or her parents. Jenny can hold conversations and is able to wash, dress and use the toilet independently but does need help with shopping and budgeting and can only cook simple meals. Jenny has two close friends but it takes her a long time to develop relationships as she has poor social skills.
Imagine that one day you see Jenny outside her family’s house. She is sitting on the ground and hitting her head on the pavement. She is doing this with so much force that you notice blood running down her face. She is crying and shouting whilst she hits her head on the pavement. She looks very agitated. You look up and down the street but you cannot see any member of her family. You are the only person around."
Appendix 2
Online Questionnaire
The views of healthcare students towards people with a learning disability that display self-injurious behaviour

Information About the Study

Introduction

My name is Mandy Cawley and I am a third year clinical psychology trainee conducting some research on the views and understandings of students toward people with mild learning disability.

People with mild learning disabilities can engage in behaviours which have been labelled as "challenging behaviours". Such behaviour can include acts of self-inflicted physical harm (e.g. head-hitting, gouging, skin-picking, eating inedible substances). I am interested in investigating students' views and understanding of people with mild learning disabilities who engage in such challenging behaviours.

What will I have to do if I participate?

Participation in this study will involve completion of an on-line survey, which should take no longer than 20 minutes. Within this survey you will be asked to read a description of a person with a mild learning disability who is engaging in challenging behaviour. You will then be asked various questions about what you have read. There are no right or wrong answers and you do not need any knowledge of learning disabilities or challenging behaviour, as I am just interested in your views.

Will my taking part in this study be kept anonymous?

Yes, all the information you give during the study will be kept anonymous. You have the right to withdraw from the study at any time without having to give a reason, and to do this you simply have to close the browser. The anonymity of all information already collected will be ensured. If you choose to be entered into the prize draw, once the prize draw has taken place and winners have been notified, information about the e-mail addresses will be destroyed.

Will taking part in this study cause me any distress?

The study will involve you reading a description of a person with a mild learning disability who is engaging in challenging behaviour. Although you may have already encountered such situations in your studies or practice, reading the description may be potentially distressing for some participants.

If you would like any further information before participating in the study, if you are concerned about any effects on your well-being by participating in the study,
and/or if you have any complaint or concerns about any aspect of the way you have been dealt with during the course of the study, then please contact Mandy Cawley, Principal Investigator on or at mc00008@ac.uk.

Thank you for your time

Mandy Cawley
Trainee Clinical Psychologist

If you wish to proceed, and consent to participation in this study, then please click "Yes" below

- Yes
- No

Next
INSTRUCTIONS

Please read the vignette about Jenny below, and then answer the questions that follow it. You will be asked questions about Jenny, and questions about yourself. Please read each question carefully and please make sure you answer all the questions. There are no right or wrong answers. We are purely interested in your opinion.

Vignette about Jenny
Imagine that you live in a house three doors away from a 25 year old lady called Jenny who has a mild learning disability. People with a mild learning disability have intellectual abilities that are significantly poorer than the average intellectual ability of the general population. Generally, people with a mild learning disability can communicate with spoken language but they do have difficulties with daily living tasks. People with a mild learning disability can exhibit what is known as 'challenging behaviour'. This can involve acts of aggression towards others or self-inflicted physical harm (e.g. head-hitting, gouging, skin-picking, eating inedible substances).

Jenny lives with her mother and father. Although you have lived near Jenny's family for some time, you do not know Jenny or her parents. Jenny can hold conversations and is able to wash, dress and use the toilet independently but does need help with shopping and budgeting and can only cook simple meals. Jenny has two close friends but it takes her a long time to develop relationships as she has poor social skills.

Imagine that one day you see Jenny outside her family's house. She is sitting on the ground and hitting her head on the pavement. She is doing this with so much force that you notice blood running down her face. She is crying and shouting whilst she hits her head on the pavement. She looks very agitated. You look up and down the street but you cannot see any member of her family. You are the only person around.

Questions
There are a number of feelings and responses that people might have should they be in the situation described above. Several of the following questions ask about how you would feel about physically intervening to prevent Jenny from harming herself. For all of such questions, by physically intervening we mean a physical way of preventing Jenny from harming herself, for example, by taking her arm and helping Jenny to her feet, or by putting your hand or your jacket between Jenny's head and the pavement. There are no right or wrong answers to the following questions. Please complete all questions by clicking the most appropriate boxes.

Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If I come across a situation like the one with Jenny, I intend to physically intervene to stop her from...</td>
<td>1</td>
<td></td>
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<tr>
<td>2. If I come across a situation like the one with Jenny, I intend to physically intervene to stop her from...</td>
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<td>7</td>
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</tr>
</tbody>
</table>

234
"For me to physically intervene to stop Jenny harming herself if I came across the situation described above is....."

<table>
<thead>
<tr>
<th>Important to me</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<table>
<thead>
<tr>
<th>Good for me</th>
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<th>2</th>
<th>3</th>
<th>4</th>
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<th>6</th>
<th>7</th>
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<td>3</td>
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<tr>
<th>Wise</th>
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<th>4</th>
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<th>6</th>
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<tr>
<th>Desirable</th>
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<th>7</th>
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</table>

<table>
<thead>
<tr>
<th>Valuable to me</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<td>6</td>
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<td>6</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Harmful to me</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
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<td>7</td>
</tr>
</tbody>
</table>
### Question 3
3) For me to physically intervene to stop Jenny harming herself would be...

<table>
<thead>
<tr>
<th>Impossible</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Possible</th>
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</tbody>
</table>

### Question 9
9) How much control do you believe you would have over physically intervening to stop Jenny harming herself?

<table>
<thead>
<tr>
<th>Complete Control</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>No Control</th>
</tr>
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</tbody>
</table>

### Question 10
10) If I wanted to I could physically intervene to stop Jenny harming herself.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tr>
</tbody>
</table>

### Question 11
11) It is mostly up to me whether I physically intervene to stop Jenny harming herself.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Strongly Agree</th>
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</thead>
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</tbody>
</table>

### Question 12
12) If I was in the

<table>
<thead>
<tr>
<th>Strongly Intend to Intervene</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Strongly Intended not to Intervene</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
situation like the one with Jenny, I will physically intervene to stop her harming herself.

<table>
<thead>
<tr>
<th>Strongly disapprove</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Strongly approve</th>
</tr>
</thead>
<tbody>
<tr>
<td>13) If I physically intervened to stop Jenny harming herself, the people in my life whose opinions I value would</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>14) If people who are important to me were in the situation described above, they would physically intervene to stop Jenny from harming herself</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>15) Most people that are important to me would think that I should physically intervene to stop Jenny from harming herself</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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I expect that the people in my life whose opinions I value would physically intervene to stop Jenny from harming herself.
"If I did not physically intervene to stop Jenny harming herself, and she knocked herself unconscious I would feel....."
"If I did physically intervene to stop Jenny harming herself, and she pushed me over, and I knocked and cut my head I would feel ..."
Information about You

Now we would like to ask you some questions about yourself. Please ensure you answer all the questions.

24) How old are you? ________________

25) What gender are you?
   - Male
   - Female

26) What is the name of the course that you are currently studying? (e.g. Nursing Studies, Paramedic Studies, MSc/PGDip/PGCert in Advanced Practice, MSc/PGDip/PGCert in Professional Practice, MSc/PGDip/PGCert in Health and Social Care) Please type in your answer.

27) What year are you in? (e.g. 1st, 2nd, 3rd)

28) Undergraduate or postgraduate? (please tick box)
   - Undergraduate
   - Postgraduate

29) How would you describe your ethnicity (please tick box)
   - White British
   - White Irish
   - Other White Group
   - White and Black
   - White and Black African
   - White and Asian
   - Other Mixed Background
   - Indian
   - Pakistani
   - Bangladeshi
   - Other Asian Background
   - Caribbean
   - African
   - Other Black Background
   - Chinese
   - Other Ethnic Group
Now please answer the following questions on a scale from 1 to 5 with 1 being 'does not describe me well' and 5 being 'describes me very well'. Try not to think too much about each question but just give the answer that occurs to you immediately.

<table>
<thead>
<tr>
<th></th>
<th>Does not describe me well</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Describes me very well</th>
</tr>
</thead>
<tbody>
<tr>
<td>30) I daydream and fantasize, with some regularity, about things that might happen to me.</td>
<td>grid30_r1</td>
<td>grid30_r2</td>
<td>grid30_r3</td>
<td>grid30_r4</td>
<td>grid30_r5</td>
</tr>
<tr>
<td>31) I often have tender, concerned feelings for people less fortunate than me.</td>
<td>grid31_r1</td>
<td>grid31_r2</td>
<td>grid31_r3</td>
<td>grid31_r4</td>
<td>grid31_r5</td>
</tr>
<tr>
<td>32) I sometimes find it difficult to see things from the other person's point of view.</td>
<td>grid32_r1</td>
<td>grid32_r2</td>
<td>grid32_r3</td>
<td>grid32_r4</td>
<td>grid32_r5</td>
</tr>
<tr>
<td>33) Sometimes I don't feel sorry for other people when they are having problems.</td>
<td>grid33_r1</td>
<td>grid33_r2</td>
<td>grid33_r3</td>
<td>grid33_r4</td>
<td>grid33_r5</td>
</tr>
<tr>
<td>34) I really get involved with the feelings of the characters in a novel.</td>
<td>grid34_r1</td>
<td>grid34_r2</td>
<td>grid34_r3</td>
<td>grid34_r4</td>
<td>grid34_r5</td>
</tr>
<tr>
<td>35) In emergency situations, I feel apprehensive and ill-at-ease.</td>
<td>grid35_r1</td>
<td>grid35_r2</td>
<td>grid35_r3</td>
<td>grid35_r4</td>
<td>grid35_r5</td>
</tr>
<tr>
<td>36) I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.</td>
<td>grid36_r1</td>
<td>grid36_r2</td>
<td>grid36_r3</td>
<td>grid36_r4</td>
<td>grid36_r5</td>
</tr>
<tr>
<td>37) I try to look at...</td>
<td>grid37_r1</td>
<td>grid37_r2</td>
<td>grid37_r3</td>
<td>grid37_r4</td>
<td>grid37_r5</td>
</tr>
<tr>
<td>everybody's side of a disagreement before I make a decision.</td>
<td>describes me well</td>
<td></td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td>30) when I see someone being taken advantage of I feel kind of protective toward them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

|I sometimes feel helpless when I am in the middle of a very emotional situation.| 1 | 2 | 3 | 4 | 5 |

|I sometimes try to understand my friends better by imagining how things look from their perspective.| 1 | 2 | 3 | 4 | 5 |

|Becoming extremely involved in a good book or movie is somewhat rare for me.| 1 | 2 | 3 | 4 | 5 |

|When I see someone get hurt, I tend to remain calm.| 1 | 2 | 3 | 4 | 5 |

|Other people's misfortunes do not usually disturb me a great deal.| 1 | 2 | 3 | 4 | 5 |

|If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.| 1 | 2 | 3 | 4 | 5 |

|After seeing a play or movie, I have felt as though I were one of the characters.| 1 | 2 | 3 | 4 | 5 |

|Being in a tense |
emotional situation scares me.

47) When I see someone being treated unfairly, I sometimes don't feel very much pity for them.

48) I am usually pretty effective in dealing with emergencies.

49) I am often quite touched by things that I see happen.

50) I believe that there are two sides to every question and try to look at them both.

51) I would describe myself as a pretty soft-hearted person.

52) When I watch a good movie, I can very easily put myself in the place of a leading character.

53) I tend to lose control during emergencies.

54) When I'm upset at someone, I usually try to consider things from their point of view for a while.

55) When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.
56. When I see someone who badly needs help in an emergency, I go to pieces.

57. Before criticizing somebody, I try to imagine how I would feel if I were in their place.
58) Do any members of your family have a learning disability, or have you known family members who have had a learning disability? (Please tick the appropriate box).
- Yes
- No

59) Do any of your current friends or colleagues have a learning disability, or have you known friends or colleagues who have had a learning disability? (Please tick the appropriate box).
- Yes
- No

60) Have you ever had employment (paid or voluntary) that has involved caring for people with learning disabilities? (Please tick the appropriate box).
- Yes
- No

61) In a week, approximately how much contact do you have with people with learning disabilities? (Please tick the appropriate box).
- 0 hours
- 1-2 hours
- 3-4 hours
- 5-6 hours
- Over 6 hours

62) Has your work ever involved you physically intervening to stop someone with a learning disability from hurting themselves, that is, someone like Jenny? (Please tick the appropriate box).
- Yes
- No

63) Outside your work situation have you ever intervened to help someone with a learning disability, that is, someone like Jenny? (Please tick the appropriate box).
- I have encountered a situation similar to Jenny's and I intervened
- I have encountered a situation similar to Jenny's but I did not intervene
- I have never encountered a situation similar to Jenny's

64) If you say you will do something, do you always keep your promise, no matter how inconvenient it might be to do so?
- Yes
65) Does your mood often go up and down?
   - Yes
   - No

66) Once in a while do you lose your temper and get angry?
   - Yes
   - No

67) Do you occasionally have thoughts and ideas that you would not like other people to know about?
   - Yes
   - No

68) Are all your habits good and desirable ones?
   - Yes
   - No

69) Do other people think of you as being very lively?
   - Yes
   - No

70) Do you sometimes gossip?
   - Yes
   - No

71) Would you always declare everything at the customs, even if you knew that you could never be found out?
   - Yes
   - No

72) Of all the people you know, are there some whom you definitely do not like?
   - Yes
   - No

73) What do you think caused Jenny's behaviour (please type in your answer)?
74) Finally, we would like to ask whether you would be willing to give us some more of your time at a later date. This would involve reading some educational material that we are developing that will help improve the life experiences of people with a mild learning disability who engage in challenging behaviour. At the moment, all we need to do is gauge how many people would be willing to volunteer. We will then be emailing students at a later date to get volunteers more formally.

Please indicate, by ticking the relevant box, how much time you think you could give.
- None, not interested in volunteering
- Up to 1 hour per week
- Up to 1 hour per month
- Up to 1 hour every 3 months
- Up to 1 hour every 6 months
Have you completed this questionnaire before?
☐ Yes
☐ No

If you would like to be entered into the prize draw, for a chance of winning £20 (there are 10 prizes of £20 to be won), then please enter your e-mail address here:

The 10 winners of £20 will be drawn randomly out of a hat. Winners will be notified by e-mail, and asked to collect the winnings (by cash) on a day/date/place on campus that is convenient to them and the researcher.

Good Luck!
Debrief Information About the Study

Thank you for participating in this study. The following information explains what the study is about.

Below is an explanation of what the study is about:
Numerous studies have researched the cognitive, emotional and behavioural responses to Challenging Behaviour that can be displayed by people with a Learning Disability. The majority of such research has been done in relation to carer's responses to aggressive Challenging Behaviour rather than carer's responses to self-injurious Challenging Behaviour. To date, only one study has researched how healthcare students think, feel and react towards non-disabled adolescents who self-harm (Law, Rostill-Brookes & Goodman, 2008). These authors found a number of factors that had the potential to adversely affect the care and treatment received by young people who self-harm. Subsequently, Law et al., (2008) recommended that theoretical models of stigma and discrimination were incorporated into student training programmes.

There is currently no published research that has explored healthcare students' attitudes, feelings and behaviour towards people with a Learning Disability who engage in self-injurious behaviour. This is despite the fact that firstly, it is estimated that 10-50% of people with a learning disability will engage in self-injurious behaviour at some point during their lifetime (Borthwick-Duffy, 1994) and secondly, healthcare students are likely to encounter individuals who engage in self-injurious challenging behaviour in their profession in the healthcare industry.

The main aim of the current study is therefore to investigate the willingness of healthcare students to help individuals with a Learning Disability who display self-injurious Challenging Behaviour. The study focuses on the predictors of helping behaviour, in particular, attitude towards helping others, perceived ability to help, perceived pressure from significant others to help and emotional reactions to the person in need of help. By understanding these and other factors, educational programmes can be targeted more effectively.

if you would like any further information, or if you feel that your participation in this study has caused you distress, then please contact Mandy Cawley, Principal Investigator on 07968977448 or at mcd00009@surrey.ac.uk

References


Thank you for interest.
The purpose of the defining helping behaviour pilot study was to see how people would respond to Jenny's behaviour. This was done in order to help define the 'helping behaviour' variable. Both individuals that were familiar, and those who were not familiar to people with an LD that display self-injurious behaviour were involved in the pilot study. The results of the pilot study for both familiar (N=10) and non-familiar (N=10) individuals is presented below.

**Feedback from people familiar with people with an LD**
An e-mail was sent to 24 Trainee Clinical Psychologists who were in their third year of training at a University in the South of England. All of these trainees were deemed to be familiar with people with an LD because they had all completed a six month placement within an LD service, in their second year of their clinical training. The e-mail asked the trainees to read the amended vignette (the vignette which had been amended following the vignette pilot study) and then to answer the following question: "If you saw Jenny behaving like this, please describe briefly what you would do?" 10 trainees responded to the e-mail providing feedback, and their actual responses are listed below:

Respondent 1: I would approach Jenny and ask her if she is ok and if I can help. If she continued hitting her head, I would verbally encourage her to stop. If she persisted, I might gently intervene physically to stop her (and trying to minimise her becoming physically aggressive towards myself) by preventing her from banging her head with my hand. I would try and locate her family members and call for medical assistance if the injury looks like it needs immediate attention. I would try and get her to stand up, and explain to Jenny what I am doing and why and try to gain her permission ideally. I would probably stay with Jenny until somebody she is familiar with can be with her. If I needed to go to hospital with her and couldn't find her family, I would call them and or leave them a note to inform them where we are and why. I think the most important thing would be to stop her from hitting her head by gently intervening physically to stop her.

Respondent 2: Get her attention, reassure her, try (as gently as possible) to prevent her banging her head by putting my hand between her head and the pavement. I would stem the blood flow with a tissue, calm her. Call an ambulance. Get in touch with her family. Stay with her till family or ambulance arrives.

Respondent 3: I would ask her what is wrong and see if I could comfort her. This would mostly be by talking to her but might include physical contact such as putting my hand on her shoulder, and helping her to her feet, but that would depend on what I knew about her based on our relationship. If this did not work, I would knock on the door of the family home and try to get her family to help. Given the level of distress, it is possible that one of her parents might have had an accident etc, so it would be important to see if they were available and safe themselves. It would also be necessary to consider the possibility that a family member had hurt Jenny. If a family member was available, I would
want to know that they were going to take Jenny to the GP. If no family member was available, I would call for medical assistance, perhaps an ambulance dependent on the severity of the injury. If she was aggressive towards me and we were isolated, I would call the police.

Respondent 4: I think I would go and see if I could help calm her down, and on the way call for help on my mobile e.g. an ambulance if she looked like she was hurt, or if I had the contact details of anyone in her family I would call them as well or instead. I would try to talk to Jenny calmly and perhaps try to distract her initially to stop her from hurting herself. Once she had calmed down a bit I would try to find out exactly what had upset her and attempt to help her resolve it, e.g. if she was locked out, try to help her get back into the house. It would be important to stop her banging her head to prevent further injury and I might have to physically intervene to do this, i.e. pick Jenny up from the pavement.

Respondent 5: Approach Jenny and ask her if there was anything I could do to help her. If she refused and I could see the injuries were sufficient to warrant attention, I would try and see if any other neighbours had the family’s contact details or who could also assist me. If I was not able to calm her and/or contact her family, and Jenny continued to self-injure I would call for intervention from the local CLDT (if known) or call 999. I would put something on Jenny’s injured head, and help her up.

Respondent 6: The first thing I would do would be to phone an ambulance and her parents (if I had the number!). I would stay with her and put my hand gently underneath her head, in between her and the pavement.

Respondent 7: I would talk to Jenny and see if she could explain why she was upset. I would ask her if I could find anyone who could help and who that would be. I would ask her if there was anyone I could phone who could help her. If I was very worried about her, and Jenny couldn’t talk to me then I would call the police. I would stay with her until she calmed down, or until the emergency services arrived. I would try and stop her from hitting her head by gently putting my hand on her shoulder and lifting her head.

Respondent 8: Go and ask her what was wrong and whether I could do anything to help. If she needed medical attention I would call for an ambulance. I would also try to contact her family i.e. knock on the door or phone them if I had their number. I would take her arm and help her to her feet.

Respondent 9: My first priority would be to ensure her immediate safety. I would try to prevent her from doing this physically - possibly by placing my hand so that it cushioned her head. I would contact the emergency services if she continued to try and bang her head.

Respondent 10: I’d put my hand underneath her head to stop her banging her head on the pavement and offer her a tissue. Ring the doorbell of her family
home. If no one is there I would call an ambulance or take her to A and E in case she is very hurt. Then try and contact her family again if Jenny wanted me to.

*Feedback from people not familiar with people with an LD*

An opportunist sample was used to see how people who were not familiar with people with an LD would respond to Jenny’s behaviour. Friends and family members (N=10), were asked two questions; 1) “Have you ever known anyone with an LD?” and 2) “Have you ever worked with anyone with an LD?” Those that responded “No” to both of these questions were asked to read the amended vignette (the vignette which had been amended following the vignette pilot study) and then to answer the following question: “If you saw Jenny behaving like this, please describe briefly what you would you do?” (Their responses were written down by the researcher). 10 friends and family members replied “No” to the two questions above, suggesting that they were not familiar with people with an LD. The actual responses of these 10 respondents are listed below:

Respondent 11: I’m not sure what I would do in this situation, it is difficult to say unless you are actually there but I would try and help as best I could. I might help her to her feet, and/or try and stop the blood flow with a tissue or something.

Respondent 12: I’d like to help her but I’m allergic to blood so I wouldn’t be able to go too close to her. Instead I’d call the police and an ambulance and then try to find her family.

Respondent 13: I’d lift her up and put something on her head to stop the bleeding and I’d call an ambulance.

Respondent 14: I would try and stop her from hurting herself any further by putting my jacket between her head and the pavement, and when she had calmed down I would help her to her feet and take her home.

Respondent 15: I’d get a member of her family or another neighbour and get them to come and help.

Respondent 16: My first thoughts are that I would want to try and help her but I would also be frightened that she might become aggressive towards me. I would approach her slowly with caution, and ask if she was ok. If she turned on me I would move away and then call the police but if she was not aggressive towards me then I would try and stop her banging her head to prevent any further injury. If she continued to bang her head I might have to physically stop her from doing it, by helping her up from the pavement.

Respondent 17: I would go up to Jenny and try to assess the extent of her injuries without scaring her. In a soft voice I would then say, “it’s ok Jenny, I’m going to help you” and at the same time I would help her to stand up by
putting my hands under her arm pits and lifting her. I would then walk her home to her parents.

Respondent 18: I think I would ask Jenny if she was ok and whether there was anything that I could do to help her, which hopefully would distract her from what she was doing and she would talk to me and tell me what's wrong. If she did not stop banging her head and talk to me then I would have to stop her from banging her head before she knocked herself unconscious. Obviously I would be as gentle as I could, probably lifting her shoulders with my hands so that her head was away from the pavement, at the same time as protecting myself from the possibility of her lashing out at me.

Respondent 19: I would try and stop her banging her head by making her stand up and then I'd walk her home to her parents.

Respondent 20: I wouldn't want to be in this situation but if I was I would try and stop her banging her head by cushioning her blows to the pavement, with my hand or something soft. I'd get her family, and if I couldn't find them I would call an ambulance and stay with her until it came.

From the above, it is evident that familiar and non-familiar individuals intended to display both verbal and physical helping behaviour towards Jenny. The most common examples of verbal intervening behaviour described by respondents was asking Jenny if she was ok; asking her what was wrong; or "talking to her", which collectively were mentioned 10 times. Respondents also said that they would ask Jenny if she needed help, or they would "verbally encourage her to stop", which collectively were suggested three times. The two most common examples of physical intervening behaviour included "taking her arm and helping Jenny to her feet" (or words to this effect, which was suggested 10 times by respondents), and "putting your hand or jacket between Jenny's head and the pavement" (or words to this effect, which was also suggested 11 times by respondents). Respondents also suggested helping behaviours that cannot be categorised into 'verbal' and 'physical' helping behaviours. These included calling an ambulance or the police, trying to contact a family member or neighbour, and "staying with her" (until help arrives).

In summary, the most frequent responses were in relation to 'physical' helping behaviour; there was great variability in 'verbal' helping behaviours suggested by respondents, and also great variability in responses that could not be categorised as 'verbal' or 'physical' helping behaviour (e.g. calling an ambulance or family member). Due to the fact that 'physical' helping behaviour was cited more times, and due to the amount of variability in 'verbal' helping behaviour and non-categorisable helping behaviours (and thus, it is more difficult to measure these precisely), it was decided that participants in the study should only be asked about their intended 'physical' helping behaviour. The two most common examples of physical intervening behaviour ("taking her arm and helping Jenny to her feet"; "putting your hand or jacket between Jenny’s head and the pavement", or words to this effect),
were therefore presented to participants as examples of "physically intervening" at the end of the vignette, to help ensure that they knew what was meant by "physically intervening" (the intention/helping variable).
Appendix 4
Ease of Completion and Presentation of Questionnaire Pilot Study
To ensure that all participants could complete the questionnaire relatively easily, and were content with the presentation of it, a pilot study was conducted. Both individuals that were familiar, and those who were not familiar to people with an LD that display self-injurious CB were involved in the pilot study. The results of the pilot study for both familiar (N=11) and non-familiar (N=10) individuals is presented below.

**People familiar with people with an LD**

An e-mail was sent to 24 Trainee Clinical Psychologists who were in their third year of training at a University in the South of England. All of these trainees were deemed to be familiar with people with an LD because they had all completed a six month placement within an LD service, in their second year of their clinical training. The e-mail asked the trainees to follow the online link that was provided in the e-mail, to complete the online questionnaire, and then to provide feedback as to whether the questionnaire was relatively easily to read/complete or not, and whether they were content with the presentation of it. 11 trainees responded to the e-mail providing feedback, and their actual responses are listed below:

Respondent 1: That took long enough! It was fine though, all easy to understand. Good luck with it!

Respondent 2: It’s looking good! It took me about 22 minutes to do.

Respondent 3: I thought your questionnaire was really clear and easy to follow. It would be a good idea to have an idea of how long the study will take to complete and perhaps that it will involve answering some questions about myself as well as about the situation with Jenny.

Respondent 4: Generally I think it was fine and easy to use, although, the large blocks of text are a little off putting when you come to read them. I don’t know what you could do to make this easier apart from adding more heading to break text up? Or try to shorten vignette for example. Question 6 first vignette: worthless missing the last ‘s’. Debrief: in the debriefing information it is usually standard to include further details of who people can contact if any of the topics covered in the study caused distress.

Respondent 5: Questions 1 and 20 are the same, is this an error or do you want people to re-rate their answers? Questions 21-23: do you mean “cut her head” rather than “cut my head”? Took about 18mins.

Respondent 6: I just completed it on line. Very impressed with the format.....it is sooooo smart. It is quite long but I enjoyed completing it as it was interesting. At the point of the demographic part I thought that was the end and then there was more....but they were quick questions. Worthless missing an “S”.

Respondent 7: I sometimes had to be careful with my answers on the scale. E.g. I noticed I put strongly agreed…but meant to put strongly disagreed.
Because you are swopping ends a lot, but I know you need to do that. But I may have found that more difficult because I'm dyslexic so not a fare test! Though it was very good...... Very posh”. Time to do it......25 minutes-ish.

Respondent 8: Worthless is spelt wrong, q 6. To be consistent about the response anchors, I wonder whether it may be helpful to write q 13 “strongly disapprove”, “strongly approve”, same as q 14, 15, 16, and indeed all others. The message that pops up when you click the next button but have not answered all questions is confusing. It says something like “answer the highlighted question” but because of the colouring it’s not possible to see which one. Better to have message asking to check have answered all questions.

Respondent 9: Is “what gender are you” better than “what sex”? I read somewhere that way round was more preferable.

Respondent 10: I think it’s fab! One small comment, in the debrief section, 2nd time you quote Law you’ve already mentioned this study so it should be Law et al, not all authors.

Respondent 11: It’s quite long! Took 20 minutes of my valuable time! LOL! I also got irritated by answering the same questions - not sure why you did this but it’s annoying?! Typo for question 6. Good luck with the data collection!

Feedback from people not familiar with people with an LD
An opportunistic sample was used to see if people who were not familiar with people with an LD found the questionnaire relatively easily to read/complete or not, and whether they were content with the presentation of it. Friends and family members (N=10), were asked two questions; 1) “Have you ever known anyone with an LD?” and 2) “Have you ever worked with anyone with an LD?” Those that responded “No” to both of these questions were asked to complete the online questionnaire (on the laptop that was presented to them), and then to provide feedback as to whether the questionnaire was relatively easy to read/complete or not, and whether they were content with the presentation of it. (Their responses were written down by the researcher). 10 friends and family members replied “No” to the two questions above, suggesting that they were not familiar with people with an LD. The feedback from these 10 respondents is listed below:

Respondent 12: Looks good. Question 49 is a little odd though!!! . Only takes about 18-20 min to do, so not too bad compared to others I’ve done!

Respondent 13: I think it is looking very professional! Must have taken a lot of prep. One slight error, question 6, worthless spelt incorrectly.

Respondent 14: Overall very readable and very interesting. Did it in roughly 21mins. Hope it goes well.
Respondent 15: Could you show somewhere how far you are into the questionnaire, especially as after you ask about personal details, most people may be thinking that the questions are over?

Respondent 16: It’s quite hard continually having to check which end the ‘strongly agree’ or ‘strongly disagree’ is, it might be easier to have them all one end? Otherwise, it’s very impressive!

Respondent 17: There is a spelling mistake – worthless is spelt with two s’s. It took me about 20 minutes to complete, which is quicker than when they stop me on the street for a survey! I think it is very well done. All the best.

Respondent 18: I think it is very well laid out. Everything is explained at the beginning and you are guided through the questions section by section. Then you explain what the study is about and personally I find it very interesting. Please let me know how you do.

Respondent 19: Did you do this? I think it is brilliant, very posh, very well structured and organised. There is one spelling mistake that I noticed early on, worthless was spelt wrong. Please let me know the results.

Respondent 20: It is very good. It was difficult though in the big sections of questions to remember which button was ‘describes me well’ or ‘does not describe me well’. I had to keep going back to the top, which probably made it a bit longer to finish, which in total was about 22 minutes.

Respondent 21: I’ve done online surveys for marketing companies before and in some of the ones that I’ve done, you get an indicator of how much of the survey you have done and how much you have left by a little coloured bar at the top of the screen. If you could add one of these it would be better because I was constantly thinking, “How much longer is this going to take?” Much better presented compared to some that I have done!

**What changed as a consequence of the pilot?**

Following feedback from the respondents, the questionnaire was amended according. Precise details of this are described below:

Following feedback from respondent 3, information about participants being required to answer questions about themselves and about Jenny was added to the instructions page (please see Appendix 2, page 234, lines 2-3 for more details). Following feedback from respondents 3, 6, 14, and 21, the issue of participants having an idea of how long the study will take to complete was resolved by the computer technician introducing a ‘percentage bar’: Every time participants completed a page (i.e. clicked on the ‘next’ button at the bottom of each page), the percentage bar changed accordingly (e.g. from 10% complete to 15% complete). This cannot however be seen on the paper copies of the questionnaire.
Following feedback from respondent 4 and 20, in large blocks of text that contained the same Likert scale, a reminder of the Likert scale was placed mid-text, to enable it to be slightly more reader friendly (please see Appendix 2, pages 243-244 for an example). In addition, gaps were placed between questions that were presented in a large block (please see Appendix 2, page 226 for an example). The vignette was not shortened as suggested by respondent 4, as the vignette had been carefully designed using the vignette pilot study. Following respondent 4’s suggestion that the debriefing information should include details of someone that participants can contact if they were distressed by the study, this information was added (please see Appendix 2, page 250, paragraph 4 for more details). Following feedback from respondent 4 and 6, an ‘s’ was added so that ‘worthless was spelt correctly.

Nothing was changed as a consequence of respondents 5 feedback, as questions 1 and 20 are indeed measuring the same thing (the intention variable), and questions 21-23 are supposed to say “cut her head” rather than “cut my head”.

Following feedback from respondent 8, question 13 was changed to “strongly disapprove” and “strongly approve” from “disapprove” and “approve” to ensure consistency in the anchor points of the Likert scales (please see Appendix 2, page 237, question 13 for more details). In addition, the computer technician changed the automatic pop up box to say “please ensure that you have answered all of the questions” rather than “answer the highlighted question” when questions had not been completed. This cannot however be seen on the paper copies of the questionnaire.

Following feedback from respondent 9, the question “what sex are you?” was changed to “what gender are you?” (Please see Appendix 2, page 241, question 25 for more details).

Following feedback from respondent 10, in the debrief section, the second time Law, Rostill-Brookes & Goodman (2008) was written, it was altered to read Law et al., (2008). (Please see Appendix 2, page 250, paragraph 1, line 10 for more details).

Following feedback from respondent 11, namely, that it was irritating answering the same questions, unfortunately nothing could be changed as Ajzen (2002) suggests that you need several questions about the same construct for the measure to be reliable.

Following feedback from respondent 12, question 49 was not changed as it was part of Davis’s (1980) empathy measure.

Following feedback from respondents 7 and 16, unfortunately, it was not possible to change the negative and positive end points of the Likert scale (i.e. so all the ‘strongly agree’ or ‘strongly approve’ statements were at the same
end), as this would have reduced the reliability of the questionnaire, due to possible response bias.

Following feedback from respondents 4, 6, 8, 11, 13, 19 and 20, an ‘s’ was added so that ‘worthless’ was spelt correctly (please see Appendix 2, page 235, question 6 for more details).

Lastly, from the feedback provided by participants it seems that the time it takes to complete is approximately 20 minutes per person.
Appendix 5
Email Advert to Participants
Students needed to complete a short anonymous online questionnaire (should only take approx 20 minutes) about people’s responses to individuals with a learning disability that display challenging behaviour.

No knowledge of, or experience of working with individuals with a learning disability is required. However, you must be on one of the following courses to take part:

**Undergraduate:** ‘Nursing Studies’, ‘Midwifery Studies’, ‘Nutrition and Dietetics’, ‘Paramedic Practice’, or ‘Diploma of Higher Education Operating Department Practice’


This study has received a favourable opinion from the FAHS Ethics Committee.

If you have any queries, concerns, or comments about participation in the survey, you have been caused distress or upset by participation in the survey, or are finding it difficult to access the survey, then please contact Mandy at the e-mail address below. Please do not reply to the sender of this email, otherwise I may not be able to reply to you.

If you would like to participate in this study then click on the link below:

http://www.fahs.surrey.ac.uk/survey/mrp01/

If you cannot access the survey by following the link above, then please cut and paste the link into your browser, and try again.

Mandy Cawley
Trainee Clinical Psychologist
Department of Psychology
University of Surrey
mc00008@surrey.ac.uk
Appendix 6
Courses within the FHMS, and a Brief Description of Each Course
The following names and describes courses within the FHMS:

‘Nursing Studies’ (those studying adult, child or mental health nursing courses); ‘Midwifery Studies’ (those studying to become a registered midwife); ‘Nutrition and Dietetics’ (those studying to become a registered nutritionist or dietician); ‘Paramedic Practice’ (which leads to professional registration with the Health Professions Council); ‘Advanced Practice’ and ‘Learning and Teaching’ (courses for those with two years clinical experience including courses in ‘Cancer Care’, ‘Clinical Care’, ‘Midwifery’, ‘Palliative Care’ and ‘Nurse Practitioner’); ‘Health and Social Care’ (a course designed to enable individuals to analyse and evaluate complex health and social care issues); ‘Health Ergonomics’ (course which considers the philosophies which underpin this speciality); ‘Nutritional Medicine’ (course covering various aspects of nutrition and health); ‘Occupational Health and Safety’ (course designed for postgraduate practitioners in contemporary occupational health and safety practice); ‘Pharmaceutical Medicine’ (course for those wishing to work in pharmaceutical medicine); ‘Professional Practice’ (course for experienced health and social care practitioners who wish to focus on a specific field of practice, e.g. palliative care, pain management, dementia care, sexual health, mental health); ‘Public Health Practice’ (designed for health professionals seeking senior roles in professional area of interest), or ‘Systems, Safety and Ergonomics’ (course for those wishing to design safe and healthy work environments); ‘Operating Department Practice’ (course for those wishing to become part of an operating theatre team and to support patients throughout surgical procedures); ‘Biochemistry’ and ‘Biotechnology’ (various courses focusing on clinical diagnosis and pharmacological research and development); ‘Biomedical Studies’ (course offering modules in biochemistry, physiology, pharmacology and microbiology); ‘Biochemistry and Pharmacology’ (course for those wishing to work in analytical chemistry, medical biochemistry, immunology, molecular biology or clinical medicine); ‘Chemistry’ (various courses for those wishing to study chemistry, including practical work); or ‘Doctorate of Clinical Practice’ (course developed for experienced health, allied health and social care practitioners).
Appendix 7
Email Advert to Participants (including information about prize draw)
My name is Mandy Cawley and I am a trainee clinical psychologist at the University of Surrey. A while ago I asked you to complete a short anonymous online questionnaire (taking approx 20 minutes) about people’s responses to individuals with a learning disability who display challenging behaviour. I am now offering anyone who completes the online questionnaire the chance to win a prize by being entered into a prize draw.

Prizes: **10 x £20**

For those who have already completed the online questionnaire, unfortunately you will have to complete it again if you wish to be entered into the prize draw (as I cannot use the data already collected). I apologise sincerely for the inconvenience that re-doing the online questionnaire may cause.

No knowledge of, or experience of working with individuals with a learning disability is required. However, you must be on one of the following courses to take part:

**Undergraduate:** ‘Nursing Studies’, ‘Midwifery Studies’, ‘Nutrition and Dietetics’, ‘Paramedic Practice’, or ‘Diploma of Higher Education Operating Department Practice’


This study received a favourable opinion from the FAHS Ethics Committee.

If you have any queries, concerns, or comments about participation in the survey, you have been caused distress or upset by participation in the survey, or are finding it difficult to access the survey, then please contact Mandy at the e-mail address below. **PLEASE DO NOT REPLY TO THE_SENDER OF THIS EMAIL,** otherwise I may not be able to reply to you.

If you would like to participate in this study then click on the link below:

http://www.fahs.surrey.ac.uk/survey/mrp01/

If you cannot access the survey by following the link above, then please cut and paste the link into your browser, and try again.

Mandy Cawley
Trainee Clinical Psychologist
University of Surrey
mc00008@surrey.ac.uk
20th August 2009

Dear Mandy

Reference: 352-PSY-09
Title of Project: The Theory of planned behaviour applied to helping behaviour exhibited by healthcare students towards people with learning disability who display self-injurious behaviour

Thank you for your submission of the above proposal.

I am pleased to advise that this proposal has received a favourable ethical opinion from the Faculty of Arts and Human Sciences Ethics Committee provided that the following conditions are adhered to:

- Although the vignette in the online questionnaire outlines a situation that may be potentially distressing, it is reasonable to assume that most of the student cohorts that will act as participants will have encountered potentially distressing health situations in their studies and/or practice. However, this may not apply to all the selected cohorts and so a warning about the potentially distressing nature of the vignettes should be included in the 'information about the study' that is presented to potential participants before they proceed to the online questionnaire so that they can make an informed decision about whether or not to participate.

- The 'information about the study' needs to be amended to refer to anonymity rather than confidentiality.

- In the 'advert to participants', the description of the study ('people's perceptions of individuals with a learning disability') is rather vague in light of the study's specific focus. I do not require the applicants to amend this because they offer a sufficiently specific account of the study in the information that is provided to potential participants. However, I invite them to consider whether the title might more accurately reflect the focus of the study.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.
Appendix 9
Second Approval by Ethics (via E-mail)
Dear Mandy,

Thank you for submitting details of your amendments to the research study that received a favourable opinion from the Faculty of Arts and Human Sciences Ethics Committee in August 2009.

Having examined the new and revised materials that you submitted, I can confirm that your amendments do not now require further ethical consideration and that you may implement with your revised procedure. I do hope that your amendments enable you to secure a sample that will render your research feasible.

Yours sincerely,

Adrian Coyle.
Chair: Faculty of Arts & Human Sciences Ethics Committee
Intention to Help
No significant outliers were noted. Although the histogram appeared mildly negatively skewed, on the Q-Q plots the observed values fell approximately on the Normally distributed expected values line. Although the stringent Shapiro-Wilk test \((D(70)=0.14, p=0.001)\) revealed that the data was non-Normally distributed, further (less stringent) statistical analysis of skewness \((z= -1.43, p<0.01)\) and kurtosis \((z= -1.02, p<0.01)\) revealed little evidence of non-Normality.

Attitude
No significant outliers were noted. The histogram appeared Normally distributed, and on the Q-Q plots the observed values fell approximately on the Normally distributed expected values line. An analysis of skewness \((z= 1.06, p<0.01)\) and kurtosis \((z= -0.81, p<0.01)\), and the stringent Shapiro-Wilk test \((D(70)=0.07, ns, p=0.094)\) revealed little evidence of non-Normality.

Perceived Behavioural Control
One outlier was noted. This was checked against the original data source and found not to be an error in data entry. The outlier was not taken out of the data set as it was obtained from a participant in the intended sample and it is possible that with a larger sample size, other participants may have scored similarly (i.e. perceiving they have minimal behavioural control).

The histogram appeared Normally distributed, and on the Q-Q plots the observed values fell approximately on the Normally distributed expected values line. An analysis of skewness \((z= -1.71, p<0.01)\) and kurtosis \((z= 0.45, p<0.01)\), and the stringent Shapiro-Wilk test \((D(70)=0.10, ns, p=0.087)\) revealed little evidence of non-Normality.

Subjective Norm
Two outliers were noted. This was checked against the original data source and found not to be an error in data entry. The outliers were not taken out of the data set as the data was obtained from participants in the intended sample and it is possible that with a larger sample size, other participants may have scored similarly (i.e. perceiving that significant others would not help).

The histogram appeared Normally distributed, and on the Q-Q plots the observed values fell approximately on the Normally distributed expected values line. An analysis of skewness \((z= -1.23, p<0.01)\) and kurtosis \((z= -0.27, p<0.01)\), and the stringent Shapiro-Wilk test \((D(70)=0.08, ns, p=0.201)\) revealed little evidence of non-Normality.

Empathy
Four outliers were noted. This was checked against the original data source and found not to be an error in data entry. The outliers were not taken out of the data set as the data was obtained from participants in the intended sample and it is possible that with a larger sample size, other participants may have scored similarly.
The histogram appeared Normally distributed, and on the Q-Q plots the observed values fell approximately on the Normally distributed expected values line. Analysis revealed that the data was not significantly skewed ($z = -0.45, p<0.01$), but was marginally leptokurtic ($z = 2.59, p<0.01$), as the kurtosis value was 0.01 above the critical value of 2.58. Nevertheless, taking everything into consideration, including the stringent Shapiro-Wilk test ($D(70) = 0.11, \text{ns, } p = 0.113$) being non-significant, it was concluded that there was little evidence of non-Normality.

**Anticipated Regret About Action Taken**

No significant outliers were noted. The histogram appeared approximately Normally distributed, and on the Q-Q plots the observed values fell approximately on the Normally distributed expected values line. Although the stringent Shapiro-Wilk test ($D(70) = 0.15, p = 0.007$) revealed that the data was non-Normally distributed, further (less stringent) statistical analysis of skewness ($z = -0.78, p<0.01$) and kurtosis ($z = -1.63, p<0.01$) revealed little evidence of non-Normality.

**Anticipated Regret About Action Not Taken**

One very extreme outlier was noted. The histogram appeared significantly non-Normally distributed, and on the Q-Q plots the observed values did not fall on the Normally distributed expected values line. An analysis of skewness ($z = -15.20, p<0.01$) and kurtosis ($z = 42.71, p<0.01$), and the Shapiro-Wilk test ($D(70) = 0.40, p = 0.001$) revealed that the data was non-Normally distributed. Transformation of the variable did not result in Normalisation. Therefore, nonparametric tests were used in the bivariate analysis, and the extreme outlier was removed from the multiple regressions as it was skewing the analyses.
Appendix 11
Table 6 - The Results of the Hypotheses Testing
## Table 6 - The Results of the Hypotheses Testing

<table>
<thead>
<tr>
<th>Hypotheses</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>H1</em>: Attitude, Subjective Norm, and Perceived Behavioural Control will account for a significant amount of the variance in healthcare students’ intention to help a person with an LD displaying self-injurious CB.</td>
<td>Strongly supported</td>
</tr>
<tr>
<td><em>H2a</em>: Anticipated regret about action taken will significantly increase the proportion of variance explained in healthcare students’ intention to help a person with an LD displaying self-injurious CB.</td>
<td>Mildly supported</td>
</tr>
<tr>
<td><em>H2b</em>: Anticipated regret about action not taken will significantly increase the proportion of variance explained in healthcare students’ intention to help a person with an LD displaying self-injurious CB.</td>
<td>Mildly supported</td>
</tr>
<tr>
<td><em>H3</em>: Similar past behaviour will significantly increase the proportion of variance explained in healthcare students’ intention to help a person with an LD displaying self-injurious CB.</td>
<td>Not supported</td>
</tr>
<tr>
<td><em>H4</em>: Empathy will significantly increase the proportion of variance explained in healthcare students’ intention to help a person with an LD displaying self-injurious CB.</td>
<td>Mildly supported</td>
</tr>
<tr>
<td><em>H5</em>: Familiarity with people with an LD will significantly increase the proportion of variance explained in healthcare students’ intention to help a person with an LD displaying self-injurious CB.</td>
<td>Not supported</td>
</tr>
</tbody>
</table>