Using the Repertory Grid Technique to Examine Nursing Staff’s Construal of Mothers with Mental Health Problems

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Background: This study explored the attitudes of psychiatric nursing staff towards mothers with mental health difficulties. Working with mothers experiencing mental health problems can evoke negative reactions in staff that activate value-laden beliefs regarding the capacity of these women to care for their infants, which could diminish the provision of optimal care and treatment for patients.

Method: Ten psychiatric nursing staff working in a specialist mother and baby unit in the North of England were interviewed about their views of various types of client by using the repertory grid technique.

Findings: A total of 86 constructs that clustered under 21 headings were elicited. All staff made critical judgements about some clients. Staff often described the context in which these perceptions were reached such as the behaviour of clients and the quality of the nurse–client relationship.

Conclusions: Clients with a personality disorder and those who were thought to be ‘bad’ mothers were construed as being furthest from the self and more negatively than clients with depression or psychosis. Further training is indicated for staff working with mothers displaying challenging interactional styles; however, training packages must consider the individuality of perception and experience present within staff groups. Copyright © 2011 John Wiley & Sons, Ltd.

Key Practitioner Message:
• Staff attributions and clients’ interactional style influence the staff’s ability to develop positive relationships with their clients.
• Clients labelled as having a personality disorder were differentially construed in a more negative manner than clients with depression or psychosis.
• Clinical supervision could help staff to manage challenging experiences with clients in an inpatient ward environment.

Keywords: Mental Health, Mothers, Mother and Baby Unit, Repertory Grid, Staff Attitudes

INTRODUCTION

The recent publication of the National Institute of Clinical Excellence guidance ‘Antenatal and Postnatal Mental Health’ (NICE, 2007) has drawn attention to the impact of serious mental ‘illness’ on the formation of a secure attachment between a woman and her infant and the child’s future development. Specialist knowledge and experience, and also a particularly skilful and sensitive approach, is required to meet the challenges of this complex situation. The National Institute of Clinical Excellence guidance (NICE, 2007) states that women requiring inpatient care for serious mental ‘illness’ should be admitted to a specialist mother and baby unit (MBU) with their infants unless there are specific reasons not to do so. In Scotland, the Mental Health Act (Mental Health Division, 2003) specifies that women have the right to such treatment. At present, specialist MBUs form part of the specialist perinatal mental health services within the stepped-care model currently used throughout the UK.

Within specialist MBUs, mental health nurses are the largest professional discipline providing daily care and support to service users, thus playing a fundamental role in developing valued therapeutic relationships with service users and supporting them in developing secure attachments with their infants. Consequently, the perceptions of staff towards mothers experiencing psychological distress...
are of great importance, given the role that attitudes and beliefs play in shaping an individual’s behaviour and emotional responses (Read & Harre, 2001; Read & Law, 1999; Smith & Hart, 1994). Furthermore, national guidance (DoH, 2004) highlights the important role of staff attitudes in proving good quality of care and recognizes that negative attitudes held by staff often exacerbate the stigma and discrimination experienced by service users. Despite this recognition, studies over the last three decades indicate that some mental health professionals continue to hold discriminatory attitudes towards mothers with mental health difficulties (Apfel & Handel, 1993; Eastwood, Spielvogel, & Wile, 1990). Feelings of frustration, helplessness and anxiety have also been identified, raising concerns regarding their ability to care for this specific client group (McConachie & Whitford, 2009).

Psychiatric nursing staff members support individuals with mental health difficulties in coping with psychological distress on a daily basis. This work can be demanding, involving stressful interactions and confronting difficult and challenging behaviour. In a study of stressors experienced by psychiatric nurses, Sullivan (1993) found that whilst they were exposed to stressors common to other areas of nursing (staffing levels, administrative duties and overwork), there were also demands unique to their role, particularly in situations involving the risk of violence and suicide. Processing such experiences in a non-judgemental way depends upon being able to contain emotional responses, which is facilitated by being able to reflect in the face of intense interpersonal confrontations (Ogden, 1992). Hence, if staff are to provide non-judgemental care, it will be necessary for them to be able to voice and explore their own reactions towards clients so that these difficult feelings are not acted upon unconsciously during interactions with service users (Apfel & Handel, 1993).

Despite increasing recognition of the importance of motherhood in the lives of women with mental health difficulties and the impact of stigmatizing attitudes on the quality of health care received by service users, there has been little research into the views of staff working with mothers with mental health difficulties. To date, no studies have examined individual psychiatric nurses’ perceptions of mothers admitted to a specialist MBU, the process by which these perceptions are reached and in what way these clients may be perceived by psychiatric nursing staff as different, or similar, to mothers outside of the psychiatric setting. In the absence of prior research examining staff perceptions of mothers with mental health difficulties, an exploratory approach is justified as a way of generating hypotheses that can assist in theory building and be investigated in studies with larger sample sizes and different methodologies.

Although the majority of research studies have used questionnaires incorporating hypothetical clients or case vignettes in order to examine staff perceptions of clients, the validity of such methods is questionable. First, questionnaires are often based on what researchers deem important and not on what participants themselves may wish to express about a particular question. Second, in addition to being open to ‘social desirability’ distortions, questionnaires place limitations on the amount of information that participants can provide and permit little flexibility in how participants may respond. Furthermore, analysis of questionnaire data typically leads to difficulties in interpreting the meaning of responses, and inferences are often made about participants’ intended meaning. The researcher is unable to probe participants’ responses to identify what was truly meant, thus threatening the ecological validity of the findings. Lastly, questionnaires focus on the content of views, with the process by which such views are reached being neglected. An approach that allows the researcher to examine staff perceptions about actual clients with whom they have developed interpersonal relationships, that does not place prior assumptions upon the responses that are provided by participants and that allows participants to express their views in a meaningful way is therefore required. The repertory grid technique, as developed from personal construct theory (Kelly, 1955), is one such method and was employed in the present study. Kelly (1955) took the position of ‘constructive relativism’ and proposed that individuals continuously develop and test hypotheses of the world as they experience it, a dynamic process that Kelly termed ‘construing’. More specifically, construal is the process by which an individual perceives and interprets the behaviour and actions of others within their world, a key area of investigation within the present study.

Thus, the repertory grid is a form of structured interview yielding data amenable to statistical analysis that allows participants to work with material from their own lived experiences and to use language that is personally meaningful. In addition, it permits both individual and collective analysis without amalgamating data and losing individual perceptions. Thus, the idiosyncratic focus of the repertory grid makes it a particularly effective and non-threatening means of exploring staff perception of clients. In comparison with other interview techniques, the structure imposed by the repertory grid technique minimizes researcher interpretation and bias, whereas opportunities for participants to elaborate on their perceptions are preserved (Björklund, 2008). This technique has been effectively used to explore the perceptions of healthcare professionals working in a range of settings. Pollock (1986) used role descriptions of 15 different types of clients in order to examine perceptions of caring by community psychiatric nurses; Wilkinson (1982) used the technique to assess the impact of a psychiatric placement on student nurses’ attitudes towards psychiatry, whereas Soldz (1992), when utilizing the technique to examine differences in therapists’ construal of clients and acquaintances, found that therapists were shown to construe clients more negatively than non-clients. More recently, Ralley, Allott,
Hare and Wittkowski (2009) examined nursing staffs' construal of service users with a dual diagnosis of psychosis and substance misuse. These studies illustrate the variety of ways in which this method may be used when examining staff perceptions. The current study aimed at utilizing this technique in order to explore the construal of psychiatric nursing staff working in a specialist MBU towards clients with whom they worked and in what way this was different, or similar to, participants' construal of the self and mothers whom they knew personally.

METHODOLOGY

Participants

A convenience sample of 10 nursing staff, out of a total of 17 staff working in the unit, was recruited from a specialist MBU. The unit formed part of a perinatal psychiatry service providing day and inpatient care for women in the first year of child birth experiencing postpartum mental health difficulties including depression and psychosis. Women with a personality disorder were also accepted into the unit if they experienced additional difficulties including depression and psychosis. Women with a personality disorder were also accepted into the unit if they experienced additional difficulties that impacted on their relationship with their child and/or their ability to adequately care for their infant. The inclusion criterion for staff to take part in the present study was a minimum of 6 months working with clients on the specialist MBU.

Data Collection

A repertory grid was completed with each participant during an audio-recorded semistructured interview lasting approximately 90 min. Participants were presented with eight role titles and were asked to think of people whom they had known well for the past 6 months who fitted these role titles: (1) a client with depression; (2) a client with psychosis; (3) a client with a personality disorder; (4) a client who may be perceived as a good mother; (5) a client who may be perceived as a bad mother; (6) a mother known personally with no history of mental illness; (7) a client with whom you had a good relationship; and (8) a client with whom you had a difficult relationship. ‘Yourself’ was included as an additional element forming the final role title. Constructs were elicited using the triadic opposite method (Caputi & Reddy, 1999) in order to generate bipolar constructs by comparing and contrasting three elements. Participants were presented with triads of elements and were asked to identify how two elements of the triad were similar and thereby different from the third element. The second pole of the construct was elicited by asking participants to provide the opposite to the already elicited construct. The process was repeated until 10 bipolar constructs had been generated. Participants were asked the meaning of each construct pole (e.g., ‘Could you tell me what you mean by X?’), and behavioural examples of each were elicited (e.g., ‘Could you give me an example of X?’). In addition, the descriptive information that was elicited through the acquisition of construct meanings and behavioural examples from participants was invaluable in understanding the meanings underlying participants' constructs and provided an additional ‘richness’ to the data. Participants were asked which end of each bipolar construct was perceived as the preferred end and then rated each element in turn on each of the constructs by using a seven-point rating scale. Participants were not given access to their previous ratings to ensure that they did not begin the process of comparing their ratings as they completed the grid (Fransella, Bell, & Bannister, 2004). At a second audio-recorded session, participants were shown a visual representation of their grid (repertory grid biplot) together with data on which elements and constructs were most highly associated. Respondent validity was assessed by asking participants whether the findings were a reasonable explanation of their perception.

Data Analysis

Utilizing the statistical analysis package REP IV research version 1.12 (Gaines & Shaw, 2005), analyses were conducted within and across grids. Data analysis consisted of (1) a hierarchical cluster analysis to examine the relationship between constructs and between elements within each participant's repertory grid; (2) a principal component analysis of each participants' repertory grid data providing a joint representation of the relationships between constructs and elements within single grids (PrinGrid); and (3) a mode grid analysis that represented the content of the most commonly used constructs across all of the participants but without reducing their responses to an average or consensus response (Jankowicz, 2004).

RESULTS

Ten participants, all of whom were female, aged between 26–48 years (median = 38 years), participated in the study and consisted of six qualified mental health nurses and four qualified nursery nurses. The age range, gender, qualification and length of experience on the unit (range = 2–27 years, median = 3 years) were representative of staff at specialist MBUs (Oluwatayo & Friedman, 2005). All participants produced 10 constructs (except for P3, P9 and P10), and all participants identified individuals who fitted the eight supplied role titles.

The participants' repertory grid data were examined through the use of hierarchical cluster analyses and principal component analyses. Overall, this process demonstrated the individuality and uniqueness present in the participants' construct systems and in the construal
of clients, non-clients and the self. This individuality in constrictual was particularly noticeable in the labelling of constructs. For example, although objectively, some constructs across participants appeared to encapsulate similar themes such as ‘lack of confidence–confident’ (P8), ‘self-confident–insecure’ (P7) and ‘secure–low confidence’ (P5), the meanings and behavioural examples attributed to these constructs were often quite distinct. For example, although P7 described the construct pole ‘insecure’ as ‘thinking that everyone is working against you’, P5 described the construct pole ‘low self-confidence’ as ‘worrying what people think about you’. Personal construct theory emphasizes the idiosyncrasy of individual construal and states that simply because individuals utilize the same verbal labels does not mean that they will interpret their experiences in a similar way. Consequently, within the present study, participants might have used the same verbal label, but the meanings placed on this label by the two participants could have been entirely distinct.

The elicitation of behavioural examples and meanings, in addition to the elicitation of constructs, was consequently invaluable in interpreting participants’ construal.

It was noted that although all participants worked within an acute mental health setting, few constructs were specifically linked to patient symptomatology with far more relating to interpersonal characteristics, social abilities and relationships developed with specific patients.

The Construal of Clients, Acquaintances and the Self

The mode grid biplot (see Figure 1) provided a composite grid based on the most commonly ranked position of each element across the 10 participant grids. This yielded a visual depiction of the patterns of variance among participant ratings with elements and constructs being plotted within a two-dimensional space for ease of interpretation. The first two principal components (i.e., the two components accounting for the most variance within a grid) are used as axes onto which the constructs are projected, with the first principal component as the horizontal axis and the second principal component as the vertical axis. The nine elements are then plotted as points, with elements which have similar ratings across the individual grid being plotted close to each other within a biplot. The mode grid analysis thus provides a general illustration of the way in which elements were construed across the staff group. It is important to recognize that when data are combined in this way, the integrity of individual grid data is compromised, and individual differences are concealed. Consequently, interpretation of the mode grid analysis was completed in conjunction with individual grid analyses to ensure that individual differences in construal within the staff group were not overlooked.

On examination of the mode grid biplot, it is evident that across the staff group, the first principal component (i.e., horizontal axis) distinguishes those elements rated as near to the positive poles of the various constructs (i.e., construed most preferably) from the elements that were rated towards the least positive poles of the constructs and construed more negatively. The elements ‘self’ and ‘mother known personally with no history of mental illness’ are in close proximity to each other within the mode grid biplot and towards the most preferred poles.

The client elements within the biplot were widely dispersed, suggesting clear differentiation in the way clients with different diagnoses were being construed. In particular, ‘client with depression’ and ‘client with psychosis’ were positioned close to the vertical axis suggesting variability in the way in which these two elements were construed by the staff group as a whole. ‘Client who may be perceived as a bad mother’ and ‘client with a suspected personality disorder’ were located in close proximity to ‘client with whom you had a difficult relationship’, and the staff often spoke of the negative reactions that were elicited during challenging situations with these clients. Taken together, this could be taken as indicative of a negative construal of these clients at a group level.

The Construal of Clients and the Self

Hierarchical cluster analysis was used to examine how elements clustered together on the basis of association. By using a Euclidian metric defined by a power of 2.0 (Shaw, 1980), the association between specific pairs of elements was explored. A cut-off value of 80% is typically used when examining the similarity of construal between pairs of elements (Jankowicz, 2004) and was used in the present study to explore the similarity in participants’ construct ratings of clients and themselves. As can be seen in Table 1, matches reaching 80% or above were found for five participants, whereas for the remaining participants, no such matches were found between participants’ construct ratings of clients and themselves.

Staff Construal of Clients with Psychosis

In the individual grids, it was apparent that the majority of staff (P1, P2, P3, P4, P5, P6, P8 and P10) made a distinction between the construal of the self and clients with psychosis (Table 1). This is also indicated by the relative position of the element ‘client with psychosis’ in the mode grid (Figure 1). For the majority of participants, clients with psychoses were construed towards the least preferred poles of the constructs as demonstrated in P1’s PrinGrid, which shares many features with PrinGrids from other participants in the construal of ‘client with psychosis’ (see Figure 2). In contrast, P7’s PrinGrid (see Figure 3) was more distinct in the construal of this element, construing ‘client with psychosis’ towards the more preferred construct poles and similarly to the construal of the self and ‘client with whom you had a good relationship’.
Themes relating to the construal of clients with psychosis included attributing behaviours and difficulties to the client’s mental health difficulties rather than to the individual. For example, P5 stated, ‘because she was so psychotic she was hard to pin down, I mean through the course of a shift she’d be up, she’d be down, she’d be shouting, she’d be quiet’.

Staff Construal of Depression

In contrast to psychosis, staff varied in the way they construed clients with depression. Although P9 and P4 construed ‘client with depression’ fairly neutrally, P1, P5 and P8 construed this client towards the preferred poles of the constructs (see Figure 2 for illustration). In contrast, three participants (P2, P7 and P10) construed clients with depression as not only distinct from the self but also from the other elements (see Figures 3 and 4 for illustration). Themes relating to this client group included a level of insecurity and a need for reassurance displayed by these clients. For example, P2 stated that ‘no matter how much reassurance you provide it does not make a difference’, whereas P7 stated that ‘she shows she does have some confidence in herself, a awareness of what she can do but most of the time she feels she can’t do it, so I think once she’s well the self-confidence will be there’. Difficulties engaging clients with depression were also evident (P3 stated that ‘you would have to go out of your way to get this person to engage’).

Table 1. Element matches for the element pairs between clients and the self

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<th>Participant</th>
<th>Percentage element match for ‘self’ and ‘client with depression’</th>
<th>Percentage element match for ‘self’ and ‘client with psychosis’</th>
<th>Percentage element match for ‘self’ and ‘client with personality disorder’</th>
<th>Percentage element match for ‘self’ and ‘client perceived as good mother’</th>
<th>Percentage element match for ‘self’ and ‘client perceived as bad mother’</th>
<th>Percentage element match for ‘self’ and ‘client with whom you had a good relationship’</th>
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Figure 1. Mode grid biplot

Figure 2. Mode grid biplot

Table 1. Element matches for the element pairs between clients and the self
Figure 2. PrinGrid of Participant 1

Figure 3. PrinGrid of Participant 7
**Staff Construal of Clients with a Personality Disorder**

All participants, except for P9, construed ‘client with a suspected personality disorder’ towards the least preferred construct poles and as distinct from the self (Table 1), with four participants (P3, P5, P8 and P10) construing a client with personality disorder as most similar to the client with whom they had a difficult relationship (see Figure 4). It was evident that working with this client group evoked responses within staff members, which were often difficult to manage. For example, P1 stated that ‘you find yourself stuck because you don’t know what to do to help them’, whereas P8 reported that ‘everyone had to give her space, it was like she was running the ward because when she was there everyone else just cleared off… it’s just like me, me, me all the time, she didn’t care how or what she did to get your attention so in that way she could be quite selfish and you have to give them attention because you don’t want them to harm themselves, it’s a risk that you can’t afford to take’.

**Staff Construal of the ‘Good’ and ‘Bad’ Mother**

All staff construed clients who were regarded as bad mothers in a negative manner and construed them as distinct from themselves. In contrast, clients regarded as ‘good’ mothers were ranked towards the most preferred poles of the constructs and more similarly to the construal of the self. Element matches for the element pairs ‘good mother–client with depression’, ‘good mother–client with psychosis’ and ‘good mother–client with a personality disorder’ were obtained. As can be seen from Table 2, with the exception of P2, P6 and P9, no matches were found of 80% or above for clients perceived to be good mothers and clients with depression, psychosis or a personality disorder. This suggests that these clients were rarely construed as being similar by participants.

Although a limited number of constructs related to childcare, P1, P3 and P9 were noticeably different in this respect, using constructs such as ‘not able to prioritize child’s needs–prioritizing child’s needs’ (P1) and ‘attentive to the needs of their baby–unable to attend to the needs of...
their baby’ (P3). Staff frequently commented on their perceptions of clients’ parenting ability during the elicitation of behavioural examples (P3 stated that ‘she interacted well with her baby, and she was able to meet the baby’s developmental needs’) and, in particular, clients’ ability to prioritize the needs of their infant (P1 stated that ‘even when they were hearing voices, even when they were so unwell that they couldn’t attend to their own needs, they still attended to their child’s needs’; P7 stated that ‘I know that she did have a personality disorder and that would be my perception of someone who isn’t going to be a great mother really, I mean it doesn’t mean they are going to be dreadful but my emphasis would always be on the baby and I couldn’t relate to them because my focus is on the baby, who needs that person to always be there’). This discrepancy between the amount of constructs relating to childcare and staffs’ comments regarding clients’ parenting ability may be further evidence of the idiosyncrasy in the meanings underlying construct labels. For example, P7’s comments (above) were elicited during her behavioural description of the construct ‘insecure–self-confident’.

During the audio-recorded feedback session, observations were also made by staff members on the biases that occurred within the service with regards to clients’ parenting ability. For example, P1 stated that ‘I think she was seen positively by others because she had a good career, and she came from a nice family, but she didn’t really attend to the baby’s needs, and I thought there were quite a lot of negatives around her that people were quite blinded to but she was a career woman with a nice family (and so people thought) she’ll be fine, whereas clients who don’t have a job or who have child social services involvement have more negative comments about them’, whereas P6, in relation to clients who did not have the support of their family and who were in contact with social services, reported that ‘you also see a lot of judgemental people who comment on how these women will not be able to care for their babies, and I mean it would be difficult to say but I think that there definitely would have been a different outcome if they had a family to support them’.

**Participant Validation**

Seven of the participants received individual feedback of their repertory grid data and were asked whether the findings fitted with their experiences and their construal of themselves, and the clients and non-clients, discussed in the interview. During this process, a number of participants commented on the way in which the process of completing the interview allowed them to reflect on the similarities and differences between clients, acquaintances and themselves. For example, P10 stated that ‘it allowed me to think about the reality of having a mental health problem, in the fact that it could affect anybody and the fact that just because someone has a mental health problem doesn’t mean that they will display totally abnormal characteristics, they are characteristics that people without mental health problems also share’. Additionally, P8 spoke of the influence that working on the unit had on her perception of individuals experiencing mental health difficulties (‘because it’s not got a plaster on it, they [the public] think there’s nothing wrong, that they [individuals with mental health difficulties] should pull themselves together and I had the same perception before I worked in mental health and as soon as you confront someone with mental health issues you automatically pull back and you’re scared because you think they are going to hit you or something and it’s nothing of the sort, their mind isn’t well and they don’t know how to control it, that’s all. Your perception does definitely change once you work in it [mental health field] because anyone can end up with mental health problems’).
DISCUSSION

The present study explored the idiosyncratic meanings that staff members attached to their subjective experiences by examining how they construed clients in relation to themselves and other people within their world. Few staff members within the present study construed clients in a similar manner to their construal of themselves. Echoing Kelly’s (1955) commonality corollary (‘To the extent that one person employs a construction of experience which is similar to that employed by another, his [sic] psychological processes are similar to those of the other person’), the degree to which staff members viewed clients as individuals who were similar to themselves and acquaintances whom they knew personally has been cited as an important variable in the construal of clients by mental health professionals (Sarbin & Mancuso, 1980; Soldz, 1992). Winter, Baker and Goggins (1992) posited that the observation of similarities between clients and the self could be experienced as threatening to staff members and that as a result, clients may be viewed negatively in order to maintain distance from the self and other non-clients. As detailed previously, focus on the negative aspects of clients may reduce the potential of optimum care for clients. Interestingly, not all participants showed this separation in construal between clients and themselves. Further research is indicated to examine the implications for client care given this way of construing.

Furthermore, this study also focused on the processes by which these construals had been developed, with participants often speaking of the influence that personal experience had on their construal of clients, again a process very much in line with Kelly’s so-called basic postulate that a person’s processes are channelized by anticipation based on past experience (Kelly 1955). It appeared that the attributions made by staff regarding their clients’ behaviour, as well as the interactional style of clients, negatively influenced the ability of staff members to develop positive relationships with clients, and those clients construed as demonstrating difficult interactional styles were regarded as being the most difficult clients to work with. In particular, clients labelled as having a personality disorder were consistently construed towards the negative pole of the constructs and distinct from the self, whereas the multiple grid analyses revealed that across the participants, ‘client with a suspected personality disorder’ was construed as being most similar to ‘client with whom you had a difficult relationship’. Similar findings have been found in previous research studies, which have identified that staff members construe clients labelled as having a personality disorder as manipulative and difficult to manage (Deans & Meoèvíc, 2006; Lewis & Appleby, 1988). Throughout the interviews, themes of frustration and helplessness were identified in relation to these clients, and participants spoke of the difficult and negative reactions that these clients evoked not only within themselves but also within other staff members and other clients in the unit.

Although providing a rich amount of data, the idiographic nature of the study led to some limitations. The sample size was small, meaning that the findings of the present study could not be assumed to represent the perceptions of psychiatric nursing staff working in other specialist MBUs across the UK. Replication is an important method for establishing the reliability and external validity of research findings. As a result, the extent to which findings can be generalized across other nursing staff groups working within specialist MBUs relies upon the replication of patterns of construal across larger staff populations. Caution also needs to be taken when interpreting the findings of multiple grid analyses as these types of analyses place a number of assumptions on the data. Another important factor to consider when drawing hypotheses from the multiple grid analyses is that, within the present study, staff members were free to select any individuals who they felt matched the provided role titles. As a result, it is likely that staff members selected different individuals to represent the same element. It is important to recognize therefore that the multiple grid analyses used in the present study can only provide a general representation of the construal of elements across the staff group. When all element data are combined in this way, a certain amount of integrity is lost, and individual participant differences are obscured. Consequently, careful consideration is needed when interpreting the findings of the multiple grid analyses (Leach, Freshwater, Aldridge, & Sunderland, 2001).

Within the present study, all staff members made critical judgements of some clients. When describing the context through which such perceptions were reached, staff members frequently cited challenging and demanding situations that they had been placed in with clients and the interpersonal relationships that they had developed with different clients. Importantly, some staff members also described a reluctance to engage with hostile and aggressive clients and the impact that such aggressive interactions could have on the maintenance of the staff–client relationship. Research to date, including the present study, demonstrates that the challenging experiences with clients and the interpersonal interactions between staff members and patients play an important role in how staff members construe individual clients with whom they work. Furthermore, it appears that the challenging situations that staff members experience with clients not only have an impact on the way the clients are construed but also influence the subsequent care received by clients and the amount of stress and ‘burnout’ experienced by staff members (Fagan et al., 1996).

If staff members are to be able to provide non-judgemental support and care, and at the same time ensure that they themselves are not subject to increased stress, it is vital that individual staff members, and the staff group as a
whole, have the opportunity to engage in methods of personal and professional development within the workplace to help them to manage such difficult interactions with clients and the challenging cognitive and emotional reactions that may be elicited by these experiences. The opportunity to voice and explore difficult reactions towards clients (Apfel & Handel, 1993) and the ability to separate behaviour from the individual through clinical supervision with a trained professional has been found to be important in the maintenance of productive staff–patient relationships (Bowers et al., 2006). Moreover, findings from the present study highlight the need for clinical supervision to take into account the individual experiences of staff so as to address the idiosyncratic responses to clients and increase understanding of the influence that such responses may have on their behaviour towards individual clients. Finally, group supervision with trained facilitators may also provide the opportunity for realistic goals and expectations towards individual clients to be formulated and shared by the whole staff group (Videbeck, 2007), helping to reduce the risk of team splitting and, ultimately, contributing to improved care for clients.

ACKNOWLEDGEMENTS

The authors would like to thank the staff who participated in this study and shared their views with us and also the ward manager for their support of this study.

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